House of Delegates Resolutions

2019 - 2026

Last Update: 8-17-2026

AMERICAN
OSTEOPATHIC
ASSOCIATION

142 E. Ontario
Chicago, IL 60611

AMERICAN OSTEOPATHIC ASSOCIATION

2026 House of Delegates Resolutions

Actions

July 2026

AMERICAN OSTEOPATHIC ASSOCIATION

200 Series Educational Affairs Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (200 SERIES)
As of 07-18-26

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

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-200	Vital Nature of Board-Certified Physicians in Aerospace Medicine (SR-Source: H201-A/21)	BFHP	Educational Affairs	Adopted as Amended
H-201	Physician Designation~~,~~ **And** Truth in Advertising ~~And Residency/Fellowship Training Non-Physician Post-Graduate Medical Training~~ (SR-Source: H203-A/21)	BFHP	Educational Affairs	Adopted as Amended
H-202	Graduate Medical Education Funding and Incentives (SR-Source: H218-A/21)	BFHP	Educational Affairs	Adopted
H-203	Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth (SR-Source: H204 – A/21)	BOE	Educational Affairs	Adopted as Amended
H-204	Optional Correct Pronoun Demographic on General Medical Education Applications (SR-Source: H206 – A/21)	BOE	Educational Affairs	Adopted as Amended
H-205	Access to Healthcare-Developing a New Model of Administering Osteopathic Primary Care in the U.S. (SR-Source: H210 – A/21)	BOE	Educational Affairs	Adopted as Amended
H-206	Access to Mental Health Services and Awareness In **Osteopathic Physicians And Trainees** ~~U.S. Osteopathic Medical Students~~ (SR-Source: H211 – A/21)	BOE	Educational Affairs	Adopted as Amended
H-207	Disaster Response Training (SR-Source: H212 – A/21)	BOE	Educational Affairs	Adopted
H-208	Uniform Title for Osteopathic Medical Students (SR-Source: H214 – A/21)	BOE	Educational Affairs	Adopted
H-209	Preservation of Rural Healthcare provided by current GME Programs (SR-Source: H216 – A/21)	BOE	Educational Affairs	Adopted
H-210	Education and Resources for Stimulant **Misuse** ~~Abuse~~ in the Academic Setting (SR-Source: H217 – A/21)	BOE	Educational Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-211	Residency Training in Canada – Equality Between COCA-Accredited and LCME-Accredited Medical School Graduates Seeking (SR-Source: H220 – A/21)	BOE	Educational Affairs	Adopted as Amended
H-212	Recognition of COMLEX and USMLE as Equal Licensing Examinations among Residency Programs (SR-Source: H231 – A/19)	BOE	Educational Affairs	Adopted
H-213	Tobacco Free Colleges / Schools of Osteopathic Medicine (SR-Source: H215-A/21)	BORPH	Educational Affairs	Adopted as Amended
H-214	Promotion of Osteopathic Medicine to Disadvantaged High School Students (SR-Source: H219-A/21)	BORPH	Educational Affairs	Adopted
H-215	Recommending Annual Well-Being Reporting Requirements for ACGME-Accredited Residency Programs	BOT	Educational Affairs	Not Adopted
H-216	Support for Ensuring D.O. students achieve a National Standard in Osteopathic Clinical Skills Competencies	AOMA (Arizona)	Educational Affairs	Adopted
H-217	Postdoctoral Trainee Paid Leave Policy Reform	BEL	Educational Affairs	Adopted as Amended
H-218	Preserving Access to Procedural Training	BEL	Educational Affairs	Adopted as Amended
H-219	Promoting greater emphasis on the Philosophy of Osteopathic Principles and Practice	MOMA (Montana)	Educational Affairs	Adopted as Amended
H-220	Federal Loan Availability and Recognition for Health Professions	NYSOM (New York)	Educational Affairs	Not Adopted
H-221	Advancing Evidence-Based Curricular Standards in Interprofessional Practice and Education throughout the Medical Training Continuum	OPSC (California)	Educational Affairs	Withdrawn
H-222	Preserving Osteopathic Distinction	OPSC (California)	Educational Affairs	Adopted
H-223	Advocate for implementation of Skin Tone Diversity in Osteopathic Medical Curricula	MOA (Maine)	Educational Affairs	Adopted as Amended
H-224	Support of the Standardized use of NBOME COMAT Clinical Subject Examinations in Clerkships Training	SOMA	Educational Affairs	Not Adopted
H-225	Expansion of Clinical Training Capacity in Undergraduate Medical Education (UME) to address the Physician Workforce Shortage	TOMA (Texas)	Educational Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-226	Michigan State University Combining DO MD Programs	IOWA (Iowa)	Educational Affairs	Not Adopted
H-227	Advocating for Equitable representation on ACGME Review Committees for Smaller Institutions	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-228	Support of Osteopathic Recognition as the Gold Standard for Training In Graduate Medical Education	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-229	Support for the Osteopathic Equivalency Act	OOA (Ohio)	Educational Affairs	Not Adopted
H-230	Recommendation for Military Experience Requirements for Medical Advisors of HPSP Osteopathic Medical Students	AMOPS	Educational Affairs	Adopted
H-231	Protection and Support of Osteopathic Manipulative Treatment (OMT) Practice by Osteopathic Physicians in Military Graduate Medical Education, Environments	AMOPS	Educational Affairs	Adopted as Amended
H-232	GME Equity Annual Report (Source H215-A/25)	BOT	Educational Affairs	Adopted

SUBJECT: VITAL NATURE OF BOARD-CERTIFIED PHYSICIANS IN AEROSPACE MEDICINE - SOURCE: H201-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association recognizes the unique contributions and
9 advanced qualifications of Aerospace Medicine professionals; and **~~SUPPORTS~~**
10 **~~BOARD-CERTIFIED PHYSICIAN LED CARE~~** specifically opposes any and all
11 efforts to remove, reduce or replace Aerospace Medicine physician leadership in
12 civilian, corporate or government Aerospace Medicine programs and aircrew
13 healthcare support teams. The AOA will advocate against further Aerospace
14 medicine **NON-PHYSICIAN** ~~mid-level provider~~ scope of practice expansions. ~~that~~
15 ~~threaten the safety, health, and wellbeing of aircrew, patients, support personnel~~
16 ~~and the flying public~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended _

DATE: ____July 18, 2026_____

SUBJECT: PHYSICIAN DESIGNATION~~,~~ **AND** TRUTH IN ADVERTISING ~~AND RESIDENCY/FELLOWSHIP TRAINING NON-PHYSICIAN POST-GRADUATE MEDICAL TRAINING~~ - SOURCE: H203-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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

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

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

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES - SOURCE: H218-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PROTECTIVE EDUCATIONAL ENVIRONMENTS FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER, ~~AND~~ QUEER/QUESTIONING, **INTERSEX, ASEXUAL, PLUS** YOUTH - SOURCE: H204 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

WHEREAS, the Bureau of Osteopathic Education believes that the policy remains relevant now, therefore be it

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

Policy Statement

The American Osteopathic Association recognizes the importance and supports advocacy that acknowledge LGBTQ**IA2S+** identities, and the implementation of anti-bullying policies that specifically protect children from harassment based on sexual orientation or gender identity in educational settings.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 18, 2026_____

SUBJECT: OPTIONAL CORRECT PRONOUN DEMOGRAPHIC ON GENERAL MEDICAL EDUCATION APPLICATIONS - SOURCE: H206 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

3 WHEREAS, the Bureau of Osteopathic Education believes that the policy remains
4 relevant now, therefore be it

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

7 Policy Statement

8 The American Osteopathic Association (AOA) supports the inclusion of an optional
9 pronoun demographic inquiry on medical school, residency, and fellowship
10 application forms **TO THE EXTENT PERMITTED BY LAW**.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ACCESS TO HEALTHCARE-DEVELOPING A NEW MODEL OF ADMINISTERING OSTEOPATHIC PRIMARY CARE IN THE U.S. - SOURCE: H210 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

WHEREAS, the Bureau of Osteopathic Education believes that the policy remains relevant now, therefore be it

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

Policy Statement

The American Osteopathic Association will (1) increase access to primary care through expanding innovative programs which incentivize ~~the~~ osteopathic medical students to enter primary care residencies with Osteopathic Recognition **(O.R.)** by facilitating the development of high quality, outcome based, health information technology infused~~,~~ programs with a patient-centered academic system of practice and education which utilizes an integrated curriculum of a reproducible business model and standardized educational model; and (2) leverage partnerships between graduate medical education, colleges of osteopathic medicine, and government and private industry to promote initiatives to increase the number of osteopathic medical students entering primary care residencies.

Background Information: Provided by AOA Staff

Current AOA Policy: 2001; 2006 Reaffirmed as amended; 2011 Reaffirmed; 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ACCESS TO MENTAL HEALTH SERVICES AND AWARENESS IN **OSTEOPATHIC PHYSICIANS AND TRAINEES** ~~U.S. OSTEOPATHIC MEDICAL STUDENTS~~ - SOURCE: H211 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

3 WHEREAS, the Bureau of Osteopathic Education believes that the policy remains
4 relevant now, therefore be it

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

7 Policy Statement

8 The American Osteopathic Association recommends that there be increased mental
9 health awareness amongst **OSTEOPATHIC PHYSICIANS AND TRAINEES** ~~U.S.~~
10 ~~osteopathic medical students~~ and that treatment options be available that are
11 accessible, private and confidential for those affected.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: DISASTER RESPONSE TRAINING - SOURCE: H212 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

3 WHEREAS, the Bureau of Osteopathic Education believes that the policy remains
4 relevant now, therefore be it

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed as amended.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: UNIFORM TITLE FOR OSTEOPATHIC MEDICAL STUDENTS - SOURCE: H214 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

WHEREAS, the Bureau of Osteopathic Education believes that the policy remains relevant now, therefore be it

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2006, 2011 Reaffirmed as amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PRESERVATION OF RURAL HEALTHCARE PROVIDED BY CURRENT GME PROGRAMS - SOURCE: H216 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

3 WHEREAS, the Bureau of Osteopathic Education believes that the policy remains
4 relevant now, therefore be it

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: EDUCATION AND RESOURCES FOR STIMULANT **MISUSE** ~~ABUSE~~ IN THE ACADEMIC SETTING - SOURCE: H217 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

WHEREAS, the Bureau of Osteopathic Education believes that the policy remains relevant; and

WHEREAS, American Osteopathic Association (AOA) policy H436-A/25 states that AOA commits to the use of clinically accurate, non-stigmatizing, person-first terminology now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) will encourage the development of continuing medical education (CME) for physicians to recognize risk factors, ensure appropriate diagnosis, and **PROVIDE EVIDENCE-BASED TREATMENT OF CONDITIONS FOR WHICH STIMULANT MEDICATIONS ARE PRESCRIBED, INCLUDING THE PREVENTION AND IDENTIFICATION OF POTENTIAL MISUSE IN ACADEMIC SETTINGS** ~~subsequence treatment of conditions which utilize stimulants for academic performance which may be abused~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended.

Prior HOD action on similar or same topic: H436-A/25 Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: RESIDENCY TRAINING IN CANADA – EQUALITY BETWEEN COCA-ACCREDITED AND LCME-ACCREDITED MEDICAL SCHOOL GRADUATES SEEKING - SOURCE: H220 – A/21

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

WHEREAS, the Bureau of Osteopathic Education believes that the policy remains relevant now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) supports **ACCESS** ~~efforts~~ to ~~restore the equal eligibility standards and criteria for~~ Canadian residency training positions **FOR GRADUATES OF** ~~that existed prior to June 2014 for~~ both United States Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accredited medical schools **ON AN EQUAL BASIS WITH GRADUATES OF COMMITTEE ON ACCREDITATION OF CANADIAN MEDICAL SCHOOLS (CACMS)**.

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: RECOGNITION OF COMLEX AND USMLE AS EQUAL LICENSING EXAMINATIONS AMONG RESIDENCY PROGRAMS - SOURCE: H231 – A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

3 WHEREAS, the Bureau of Osteopathic Education believes that the policy has been
4 superseded by H345-A/23 AOA Support for GME Equity and the requirement
5 for annual reports to the House of Delegates, now, therefore be it

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

8 Policy Statement

9 The American Osteopathic Association promotes parity between osteopathic and
10 allopathic medical students, residents, and physicians among residency program
11 directors and will collaborate with the American Association of Colleges of
12 Osteopathic Medicine, the National Board of Osteopathic Medical Education, the
13 American Medical Association, the Accreditation Council for Graduate Medical
14 Education, and all other appropriate parties to educate residency program directors
15 on the interpretation of a Comprehensive Osteopathic Medical Licensing
16 Examination of the United States (COMLEX-USA) score with the understanding that
17 the COMLEX USA is the most appropriate standardized exam to evaluate the
18 competency of an osteopathic medical student.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: H345-A/23 AOA Support for GME Equity, H348-A/24 GME Equity Annual Report, H215-A/25 GME Equity Annual Report.

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: TOBACCO FREE COLLEGES / SCHOOLS OF OSTEOPATHIC MEDICINE -SOURCE: H215-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association ~~commits to the goal of~~ **SUPPORTS THE** establish~~ing~~**MENT OF** ~~and supporting~~ tobacco-free and vaping-free colleges of osteopathic medicine.~~ at every Commission on Osteopathic College Accreditation (COCA) accredited colleges of osteopathic medicine~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed as amended; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PROMOTION OF OSTEOPATHIC MEDICINE TO DISADVANTAGED HIGH SCHOOL STUDENTS -SOURCE: H219-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFRIMED.

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: RECOMMENDING ANNUAL WELL-BEING REPORTING REQUIREMENTS FOR ACGME-ACCREDITED RESIDENCY PROGRAMS

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Mental Health Workgroup, appointed by Robert G.G. Piccinini, DO, AOA President, drafted this policy for submission to the House of Delegates; and

WHEREAS, physician well-being is essential to safe, high-quality patient care, professional sustainability, and the ethical practice of medicine; and

WHEREAS, residents and fellows experience disproportionately high rates of burnout, depression, anxiety, and psychological distress during graduate medical education, with well-documented consequences for patient safety, workforce retention, and long-term physician health; and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) has appropriately recognized the importance of physician well-being by incorporating expectations related to resident and faculty well-being within the Common Program Requirements; and

WHEREAS, current ACGME accreditation processes assess well-being primarily through indirect mechanisms such as periodic site visits, resident and faculty surveys, and program self-evaluation, rather than through a standardized, recurring submission focused specifically on well-being implementation and outcomes; and

WHEREAS, the Annual Program Evaluation (APE) requirement emphasizes internal review, discussion, and dissemination of program performance with faculty members, residents, and the Sponsoring Institution's Designated Institutional Official (DIO) and Graduate Medical Education Committee (GMEC), rather than routine submission of standardized documentation to the ACGME for external review; and

WHEREAS, the absence of a required, structured, annual well-being report may result in variable interpretation, inconsistent documentation, and uneven accountability across residency programs regarding compliance with well-being expectations; and

WHEREAS, transparent, standardized reporting has been shown in other areas of graduate medical education to promote accountability, continuous quality improvement, and institutional prioritization of critical domains; and

WHEREAS, osteopathic medicine has a longstanding commitment to holistic care, including the well-being of the physician as an integral component of the health care system; now, therefore be it

RESOLVED, that such an annual well-being report should include, at a minimum, documentation of:

- Programmatic and institutional well-being initiatives and resources;
- Mechanisms for resident and faculty access to confidential mental health care;
- Processes for monitoring workload, fatigue mitigation, and learning environment concerns;
- Methods for collecting, reviewing, and responding to resident and faculty well-being data; and
- Evidence of continuous quality improvement efforts related to well-being; and be it further

RESOLVED, that the American Osteopathic Association (AOA) encourages the Accreditation Council for Graduate Medical Education (ACGME) to design this reporting requirement in a manner that emphasizes formative improvement, transparency, and meaningful engagement rather than punitive enforcement; and be it further

RESOLVED, that the AOA ~~shall advocate for~~ **SUPPORTS** this policy through appropriate channels, including collaboration with the ACGME, communication with sponsoring institutions, and representation within national graduate medical education forums; and be it further

RESOLVED, that the AOA reaffirms its commitment to physician well-being as a core pillar of osteopathic medicine and graduate medical education.

Background Information: Provided by AOA Staff
Current AOA Policy: H330-A/2024, H210-A/2022

Prior HOD action on similar or same topic: H330-A/2024, H634-A/2020, H356-A/2019, H210-A/2022

Other references:
ACGME Common Program Requirements revisions effective 7/1/2026
ACGME Clinical Learning Environment (CLER) CLER National Report of Findings 2025

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_____

DATE: _____July 18, 2026____

SUBJECT: SUPPORT FOR ENSURING D.O. STUDENTS ACHIEVE A NATIONAL STANDARD IN OSTEOPATHIC CLINICAL SKILLS COMPETENCIES

SUBMITTED BY: Arizona Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the osteopathic profession has the duty to self-regulate, which contributes to the ongoing protection and trust of the public; and

WHEREAS, the National Board of Osteopathic Medical Examiners Comprehensive Medical Licensing Examination for the USA (NBOME COMLEX-USA) serves as the only osteopathic medical licensure assessment accepted by all 50 states and many international jurisdictions; and

WHEREAS, clinical skills, including physical examination, gathering a patient history, and performance of osteopathic manipulative treatment (OMT) as well as communication skills, interpersonal skills, empathy, professionalism, compassion and respectfulness, are important for establishing a therapeutic relationship with patients and have direct impact on the quality of patient care, provision of equitable care, and improved patient outcomes1-6; and

WHEREAS, deficiencies in these skills lead to medical errors, delay of diagnosis and inappropriate treatment of patients, which further erodes the physician-patient relationship,7-11; and

WHEREAS, these skills can only be evaluated through direct observation 6,12-14 ; and

WHEREAS, the COVID-19 pandemic contributed to the opportunity to re-evaluate the role of national clinical skills assessments as part of the osteopathic medical licensure examination series, COMLEX-USA12-14; and

WHEREAS, the Special Commission on Osteopathic Medical Licensure Assessment convened in 2021-2023 and recommended the establishment of a “ COM-based COMLEX-USA national standardized assessment which includes an in-person, hands-on evaluation of fundamental osteopathic clinical skills including interpersonal and communications skills and OMT, with quality assurance”,15; and

WHEREAS, national medical clinical educator groups called for collaboration amongst educational institutions and licensing assessment organizations to support and require high quality clinical skill assessments; 12-15; and

WHEREAS, the NBOME has worked since 2021 to develop and pilot an assessment program to these ends, which is now known as the Core Competency Capstone for DOs (C3DO)16; and

WHEREAS, over 4000 students across seventeen Colleges of Osteopathic Medicine (COM) locations have participated in C3DO pilot testing, reducing cost and travel requirements for the continued assessment of these essential skills, two main drivers of student dissatisfaction with previous assessment models; and

WHEREAS, 89% of students participating in C3DO state that C3DO allowed them to demonstrate their osteopathic clinical skills, including history building; physical examination skills; communication, interpersonal skills and professionalism; clinical decision making; and the performance of osteopathic manipulative treatment; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports education and assessment programs that assure that all D.O. students demonstrate meeting a national standard for osteopathic clinical skills competencies prior to graduation.

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

Prior HOD action on similar or same topic: none

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

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SUBJECT: POSTDOCTORAL TRAINEE PAID LEAVE POLICY REFORM

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements, Section 4.8, require sponsoring institutions to provide residents and fellows with a minimum of six weeks of paid medical, parental, or caregiver leave, with continuation of salary and benefits during that period[1]; and

WHEREAS, this policy—while a significant step forward—falls short of the paid parental leave standards recommended by leading medical professional organizations, including the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and multiple medical specialty boards[2,3,5]; and

WHEREAS, evidence demonstrates that parental leave does not compromise clinical performance or training, as residents who take leave perform comparably to their peers in evaluations, procedural volume, and examination outcomes[4]; and

WHEREAS, international comparisons show that Canadian medical residents are offered up to 35 weeks of leave[5], British medical residents up to 52 weeks[6], and Australian medical residents up to 16 weeks of paid leave and up to one year of unpaid leave[7]; and

WHEREAS, U.S. medical residents who took more than eight weeks of maternity leave were less likely to experience postpartum depression, more likely to feel supported by colleagues and program directors, and more likely to breastfeed for longer durations[8]; and

WHEREAS, maternal mental health and breastfeeding duration are positively correlated with the length of maternity leave, and extended maternity leave is associated with lower neonatal, perinatal, postnatal, and overall child mortality[9]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourages the Accreditation Council for Graduate Medical Education (ACGME) to consider a policy review of its Institutional Requirements, Section 4.8 (Paid Leave Policy), to grant residents and fellows **THE MAXIMUM** ~~up to eight weeks of~~ paid medical, parental, or caregiver leave **IN ACCORDANCE WITH INSTITUTIONAL POLICIES, EMPLOYMENT LAWS AND BOARD ELIGIBILITY REQUIREMENTS.**

Explanatory Statement:
Current ACGME policy states "Sponsoring Institutions must provide residents/fellows with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report. They must also provide residents/fellows with at least the equivalent of 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken. Note that the requirement does not mandate vacation or sick days be used. It does, however, state that the minimum of six weeks of leave must be paid time off and that at least one week of paid time off must be reserved for use outside of these six weeks".

This resolution seeks to encourage the ACGME to consider a policy review to increase their paid leave policy from six weeks to eight weeks, understanding that this may impact residents and fellows in various ways including potential extensions of residencies at the discretion of specialty board requirements and program directors.

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Background Information: Provided by AOA Staff
Current AOA Policy: H228-A/19 Parental Leave Policies for Accreditation Council for Graduate Medical Education Residency

Should this resolution be adopted, it will have to be written to supersede H228-A/19, which encourages ACGME to adhere to the Family and Medical Leave Act, which provides up to 12 weeks of unpaid parental leave.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 18, 2026_____

SUBJECT: PRESERVING ACCESS TO PROCEDURAL TRAINING

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

WHEREAS, hands-on procedural training is a fundamental component of graduate medical education, essential to the development of clinical competence; and

WHEREAS, non-physician clinicians are increasingly utilized in various healthcare settings to perform procedures traditionally performed by physicians and physician trainees[1]; and

WHEREAS, physician-led procedural education is central to maintaining the highest standards of training, ensuring physician trainees acquire the full range of procedural skills under the guidance of experienced program faculty[2]; and

WHEREAS, access to adequate procedural training is essential to training future physicians who play a leading role in patient care and advancing patient safety; and

WHEREAS, the American College of Radiology passed a resolution in 2025 in support of physician-led procedural training in response to concern regarding a reduction in procedural opportunities for radiology trainees[3]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports that residency and fellowship programs preserve hands-on procedural training as a core component; and, be it further

~~RESOLVED, that the AOA opposes the displacement of postdoctoral trainees by non-physician clinicians in performing procedures to ensure that postdoctoral trainees maintain sufficient opportunities to develop procedural competence.~~

RESOLVED, THAT THE AOA SUPPORTS PRIORITIZING POSTDOCTORAL TRAINEES FOR PROCEDURAL TRAINING OPPORTUNITIES NECESSARY TO ACHIEVE PROCEDURAL COMPETENCE WHILE FOSTERING COLLABORATIVE PRACTICE WITH NON-PHYSICIAN CLINICIANS.

<u>References:</u>

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Background Information: Provided by AOA Staff
Current AOA Policy:
H625-A/2025 Non-Physician Clinicians

H213-A/2024 Clinical Rotations for International Medical Students and Non-Physician Trainees

Prior HOD action on similar or same topic:
H213-A/2024 Clinical Rotations for International Medical Students and Non-Physician Trainees

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: ___July 18, 2026_____

SUBJECT: PROMOTING GREATER EMPHASIS ON THE PHILOSOPHY, **HISTORY, AND SELF-DETERMINATION** OF OSTEOPATHIC PRINCIPLES AND PRACTICE

SUBMITTED BY: Montana Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, Andrew Taylor Still, DO, the founder of osteopathic medicine, established the profession with a philosophy rooted in aiding the body's ability to heal itself, emphasizing the interrelationship of structure and function, and the holistic care of the patient as a unit of body, mind, and spirit; and

WHEREAS, the Osteopathic profession has now further defined the Osteopathic approach to patient care by developing the Tenets of Osteopathic medicine; and

WHEREAS, Osteopathic Principles and Practice (OPP) encompasses a broader diagnostic and clinical reasoning framework than Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) alone, yet a majority of OPP education currently focuses on OMM/OMT due in part to the absence of a formal operational definition of OPP applicable across all specialties; and

WHEREAS, THE EDUCATIONAL COUNCIL ON OSTEOPATHIC PRINCIPLES (ECOP) CREATED AND MAINTAINS THE GLOSSARY OF OSTEOPATHIC TERMINOLOGY TO ENSURE AND MAINTAIN CONSISTENT LANGUAGE ACROSS THE OSTEOPATHIC PROFESSION; AND

WHEREAS, THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS (NBOME) HAS CREATED THE FUNDAMENTAL OSTEOPATHIC MEDICAL COMPETENCY DOMAINS 2026 TO ESTABLISH COMPETENCIES THAT INCLUDE INTEGRATED POINTS OF OSTEOPATHIC PHILOSOPHY, BUT CURRENTLY LACKS ASSOCIATED ASSESSABLE MILESTONES; AND

WHEREAS, THE HISTORY OF OSTEOPATHIC MEDICINE IS NOT EXPLICITLY INCLUDED AS A FUNDAMENTAL STANDALONE COMPETENCY WITHIN THESE FRAMEWORKS, AND DOING SO WOULD FOSTER A DEEP SENSE OF STEWARDSHIP AMONG MEDICAL STUDENTS REGARDING THE DISTINCTIVE NATURE OF THEIR TRAINING; AND

WHEREAS, NO SINGLE OSTEOPATHIC ORGANIZATION HAS ESTABLISHED DEFINITIVE MILESTONES OR COMPETENCIES EXPLICITLY MAPPING THE HISTORY OF OSTEOPATHIC MEDICINE TO PROFESSIONAL AUTONOMY; AND

WHEREAS, the AOA reaffirmed through resolution H-220-A/2019 its commitment to the inclusion of OPP in every osteopathic board certification examination regardless of specialty, stating, in part, that there are two pathways for board certification for all Osteopathic board specialties, both with OPP, and one of these with the additional pathway including OPP, as well as test items on OMM/OMT; and

WHEREAS, previous AOA resolutions, including H-426-A/2023, which acknowledges osteopathic medicine as high-value care meeting the values of the Triple Aim, H-208-A/2025, which promotes multi-specialty education and collaboration as part of high-value care and a long standing major component of the osteopathic approach to patient care, and H-209-A/2025, which supports integration of OPP into all foundational core competencies for undergraduate medical education in Colleges of Osteopathic Medicine, were, in part, attempts to define what is OPP beyond OMM/OMT; and

WHEREAS, the osteopathic profession has not yet established a formal operational definition of OPP as a diagnostic reasoning framework distinct from but inclusive of OMM/OMT, creating barriers to consistent curriculum development, faculty training, and student assessment across all levels of osteopathic education; and

WHEREAS, standardizing and simplifying OMM/OMT education could create opportunities to incorporate broader OPP education into osteopathic curricula at all levels; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) convene a workgroup including representatives from American Association of Colleges of Osteopathic Medicine (AACOM), Commission on Osteopathic College Accreditation (COCA), the National Board of Osteopathic Medical Examiners (NBOME), the American Academy of Osteopathy (AAO), American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM), the American Osteopathic Society of Executive Directors (AOSED), the Osteopathic Recognition department of the American College of Graduate Medical Education (ACGME) to develop a formal operational definition of Osteopathic Principles and Practice as a diagnostic reasoning framework, distinct from but inclusive of OMM/OMT, with associated assessable milestones for use across all levels of osteopathic education; and report findings to the HOD no later than 2027; and be it further

RESOLVED, THAT THIS WORKGROUP EXPLICITLY INCORPORATE INTO THESE ASSESSABLE MILESTONES THE HISTORY OF OSTEOPATHY

AND AN UNDERSTANDING OF HEALTHCARE SYSTEMS AS THEY DIRECTLY CORRELATE TO THE HISTORICAL EXISTENCE, DISTINCTIVENESS, AND PROFESSIONAL AUTONOMY OF THE OSTEOPATHIC PROFESSION; AND BE IT FURTHER

RESOLVED, that upon receipt of the workgroup's findings, the AOA work with osteopathic and graduate medical education stakeholders, including AACOM, COCA, NBOME, AAO, AOBNMM, ACGME, Colleges of Osteopathic Medicine, osteopathic specialty colleges, AOSED and AOA-accredited CME sponsors, to implement the operational definition and assessable milestones across all levels of osteopathic education, including standardization and simplifying of OMM/OMT education to create expanded curricular space for the broader OPP framework.

Background Information: Provided by AOA Staff
The AOA has policy that recognizes the Glossary of Osteopathic Terminology, published by the Educational Council on Osteopathic Principles (ECOP), as the source for osteopathic terms and definitions.

Current AOA Policy:
H626-A/2024 Osteopathic Terminology – Glossary of
H328-A/2025 Definition of Osteopathic Physician

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended

DATE: ____July 18, 2026_____

SUBJECT: FEDERAL LOAN AVAILABILITY AND RECOGNITION FOR HEALTH PROFESSIONS

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the House Education and Workforce Committee voted to approve its portion of the federal budget reconciliation bill. Without further correction, this legislation eliminates Grad PLUS Loans and caps federal student professional borrowing at $200,000[i] ; and

WHEREAS, a rulemaking panel of higher education stakeholders convened and negotiated to begin implementing the new law's sweeping changes, including the new lending limits. The panel ultimately "reached consensus" on which professional degree programs will be eligible for the higher lending amounts based on the definition of a professional degree established in federal regulations, which includes several examples of degree programs including Pharmacy (Pharm.D.), Dentistry (D.D.S. or D.M.D.), Veterinary Medicine (D.V.M.), Chiropractic (D.C. or D.C.M.), Law (L.L.B. or J.D.), Medicine (M.D.), Optometry (O.D.), Osteopathic Medicine (D.O.), Podiatry (D.P.M., D.P., or Pod.D.), and Theology (M.Div., or M.H.L.)[ii]; and;

WHEREAS, while current regulations include this list as examples of professional degrees, the panel would limit the definition of professional degree to just the degrees on the list'; and

WHEREAS, the U.S. Department of Education has moved forward with the proposal from the negotiated rulemaking consensus process that nursing, physician assistant, nurse practitioner, physical therapy, speech therapy, occupational therapy and audiology programs are now excluded from the definition of "professional degree" programs tied to federal graduate student loan limits of approximately $100,000 and must follow new borrowing limits; and

WHEREAS, for nursing, the entire four-year undergraduate program can range from $89,560-$211,390. Public schools cost a yearly average of $22,390 and private schools average between $27,770-$52,850 per year[iii]. Students pursuing master's degrees at public institutions can expect to pay an additional $9,340 per year while the average yearly cost of private schools ranges from $9,510-$21,440. Considering that nearly half (43 percent) of all graduate students attend school part-time, usually while working, this further limits the amount of federal loans they can receive[iv] ; and

WHEREAS, the cost for obtaining a doctorate in physical therapy (DPT), which is three years beyond college degree attainment, ranges from $43,644 to $235,082 with the average being $125,287[v]; and

WHEREAS, occupational therapists can pursue either a master's degree or doctorate as the entry-level degree to practice[vi]. The average total cost of occupational therapy programs can range from $65,000 to $200,000, with many OT schools being on the higher end, especially doctorate (OTD) programs; and[vii]

WHEREAS, the average cost across all Physician Assistant (PA) graduate degree programs (public and private) for a 27-month resident tuition for physician assistant/associate program in 2025 is $98,075 and for nonresident tuition is $107,288[viii]; and

WHEREAS, the average cost across for a Masters Degree in Speech and Language Pathology (SLP) graduate degree programs (public and private) for a 24 to 30-month program is $20,513/year ($41,026 to 51,283) with typical tuition for an in-state resident is 12,596/year and for nonresident tuition it is $29,931/year[ix] These expenses, along with undergraduate expenses, may exceed the $100,000 upper borrowing limit, especially if the student pursues a PhD; and

WHEREAS, audiology doctoral programs consist of 3-4 years of classroom and clinical training with the final stage of clinical training, commonly known as the externship, is a full-time position at a clinic for approximately one year. Many aspects of the externship vary, including setting, specialty, salary, and tuition costs. Students may be required to pay full tuition to their university, reduced tuition, or no tuition at all, and the position may be paid or unpaid. The average audiology program's total tuition cost is approximately $100,000[x]; and

WHEREAS, the proposed current definitions and loan limitations could severely discourage the pursuit of the aforementioned other health professions [xi] [xii] [xiii] [xiv] in a time of projected shortage; and

WHEREAS, osteopathic physicians work closely with these other medical professionals in the care of patients; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **SUPPORT THE RECOGNITION OF OTHER MEMBERS OF THE PATIENT CARE TEAMS AS "PROFESSIONAL DEGREES," AS IT MAY EVOLVE TO INCLUDE** ~~work with other interested entities to advocate for the recognition of~~ **:** nursing, physical therapy, occupational therapy, speech pathology, audiology, nurse practitioner and physician assistants ~~as "professional degrees" under federal guidelines~~; and be it further

RESOLVED, that the AOA ~~work with other interested entities to advocate for~~ **SUPPORT** availability of appropriate loans for students pursuing these professions.

Background Information: Provided by AOA Staff
The AOA has been supportive of the Health Professions and Nursing Education Coalition's (HPNEC) efforts to increase funding for workforce development in Title VII health professions, and Title VIII Nursing Workforce Development Programs: letter of support.

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Not Adopted_____

DATE: _____July 18, 2026_____

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[i] https://www.ed.gov/about/news/press-release/us-department-of-education-concludes-negotiated-rulemaking-session-implement-one-big-beautiful-bill-acts-loan-provisions

[ii] https://www.ed.gov/media/document/rise-2025-proposed-professional-degree-definition-submitted-taxpayer-and-public-interest-private-nonprofit-institutions-proprietary-institutions-public.pdf

[iii] https://nursejournal.org/resources/how-much-does-nursing-school-cost/

[iv] https://www.nationalnursesunited.org/blog/what-is-all-the-buzz-about-nursing-no-longer-being-designated-as-a-professional-program

[v] https://ptcasdirectory.apta.org/8529/Total-Cost-of-Education-Comparison

[vi] https://otpotential.com/blog/become-an-occupational-therapist

[vii] https://www.myotspot.com/occupational-therapy-school-cost/

[viii] https://www.aapa.org/news-central/2026/02/new-survey-shows-proposed-federal-student-loan-cap-would-shrink-the-pa-workforce/

[ix] https://www.speechpathologygraduateprograms.org/speech-pathology-tuition-and-cost/

[x] https://saa.audiology.org/it-doesnt-make-cents-audiology-education-and-return-on-investment/

[xi] https://www.myamericannurse.com/new-federal-loan-limits-will-worsen-americas-nursing-shortage-and-leave-patients-waiting-longer-for-care/

[xii] https://www.oudaily.com/news/nursing-shortage-physical-therapy-federal-loan-limits-ou/article_74b88616-c70e-469a-a298-cd30311fc8c3.html

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[xiii] https://www.aapa.org/news-central/2026/02/new-survey-shows-proposed-federal-student-loan-cap-would-shrink-the-pa-workforce/

[xiv] https://www.nbcot.org/news-events/news/statement-student-loan-changes

SUBJECT: PRESERVING OSTEOPATHIC DISTINCTION

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, Colleges of Osteopathic Medicine (COMs) in the United States (US),
2 are accredited by the American Osteopathic Association's (AOA's)
3 Commission on Osteopathic College Accreditation (COCA); and

4 WHEREAS, COMs are member institutions of the American Association of Colleges
5 of Osteopathic Medicine (AACOM); and

6 WHEREAS, US medical schools that grant the MD degree are accredited by the
7 Liaison Committee on Medical Education (LCME); and

8 WHEREAS, new COMs are sometimes developed by, or are affiliated with,
9 universities or parent institutions that may not fully recognize the
10 distinctiveness of osteopathic medical education; and

11 WHEREAS, a new COM (or its parent institution) may omit the word "Osteopathic"
12 when naming their COM; and

13 WHEREAS, omitting the word "Osteopathic" fails to identify the institution as
14 distinctly osteopathic and therefore may confuse prospective students and
15 the public; now, therefore be it

16 RESOLVED, that the American Osteopathic Association (AOA) request that
17 Commission on Osteopathic College Accreditation (COCA) include in their
18 standards that all proposed and applicant Colleges, or Schools, of
19 Osteopathic Medicine include the word "Osteopathic" within their official
20 institutional name, such as on buildings and in branding.

Background Information: Provided by AOA Staff

Current AOA Policy:

H204-A/2024 Integrity and Mission of COMs and UHSCs Granting the DO Degree
H201-A/2023 DO Degree Designation

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ADVOCATE FOR IMPLEMENTATION OF SKIN TONE DIVERSITY IN OSTEOPATHIC MEDICAL ~~CURRICULA~~ **EDUCATION**

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, individuals with skin of color make up 40.9% of the United States population, a figure projected to increase to 59.5% by 2060[4]; and

WHEREAS, 12.4% of all diagnoses made by family physicians pertain to the evaluation of skin conditions[4]; and

WHEREAS, dermatologists correctly diagnosed 72.1% of cases in individuals with lighter skin, compared to only 52.8% in patients with skin of color, with significantly lower diagnostic confidence for those with darker skin presentations ($p \leq 0.001$)[8]; and

WHEREAS, Black Americans face lower survival rates than white Americans across most cancers - including a 22% lower survival rate for melanoma - a disparity that persists even at the same stage of diagnosis, highlighting systemic issues in early detection[13]; and

WHEREAS, inadequate education on disease manifestations in diverse skin tones hinders accurate diagnosis and exacerbates health disparities, with medical trainees at all levels reporting low confidence in identifying disease in patients with skin of color[2]; and

WHEREAS, in a review of skin condition images across two osteopathic and two allopathic medical schools, the average representation of individuals with darker skin tones was 21% at osteopathic schools and 14% at allopathic schools[10]; and

WHEREAS, an analysis of over 4,000 images from widely used medical textbooks revealed that 74.5% of the photographs depicted patients with light skin tones, while only 4.5% featured those with darker skin tones[9]; and

WHEREAS, a nationwide survey of dermatology residents demonstrated lower confidence across all measured categories when caring for patients with skin of color compared to patients with white skin, while residents in programs offering tailored education on skin of color reported significantly higher confidence[6]; and

WHEREAS, implementing dermatology curricula - including modules, interactive seminars, and diagnostic training - focused on skin-of-color education has been shown to significantly improve medical students' confidence, self-assessed competency, and

ability to mitigate skin tone performance bias in diagnosing dermatologic conditions[1,7,12]; and

WHEREAS, several allopathic medical schools have created online collections of dermatologic educational tools and reference materials, including eBooks, image banks, atlases, and research resources, to increase access to representative and inclusive dermatologic content for their students, including the Inclusive Skin Color Project developed by UCSF[14]; and

WHEREAS, the National Board of Osteopathic Medical Examiners (NBOME) has stated its commitment to "improving item content to reflect diversity in patient populations, including skin tone representation in… COMLEX-USA examinations," which requires medical students to distinguish between diagnoses across diverse racial and ethnic groups[3]; and

WHEREAS, the limited availability of dermatologic images representing a range of skin tones online reduces patients' ability to assess the need for clinical evaluation, contributing to delays in care and education, and underscoring the need for physicians to develop multicultural and dermatologic fluency[11]; now, therefore, be it

WHEREAS, on April 16, 2025, the Commission on Osteopathic College Accreditation (COCA) voted to suspend enforcement of its curriculum standards and elements related to diversity, equity, and inclusion (DEI), which includes diversity in dermatologic education[15,16]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes the importance of including a diverse range of skin tones, such as those represented on the Fitzpatrick skin type scale, in **OSTEOPATHIC EDUCATION** ~~predoctoral medical education~~; and be it further

RESOLVED**,** that the AOA ~~urges~~ **ENCOURAGES** the Bureau of Osteopathic Education to assess the level of integration and identify potential gaps in current predoctoral education,
including, but not limited to, the use of diverse dermatologic images, simulation models, case-based learning, and standardized patient experiences across Colleges of Osteopathic Medicine.~~; and be it further~~

~~RESOLVED, that if the Bureau of Osteopathic Education's assessment identifies gaps or deficiencies in the quality of dermatologic education within and across the Colleges of Osteopathic Medicine, then the Bureau may recommend further action to the AOA Board of Trustees to refine standards, policies, and procedures.~~

Explanatory Statement:
As the population of the United States continues to grow more diverse, medical education must evolve to reflect the needs of all patients. Currently, both allopathic and osteopathic medical curricula lack sufficient emphasis on how dermatologic conditions present across a range of skin tones. This educational gap contributes to disparities in diagnosis, treatment, and outcomes for patients with skin of color. Given the ethical obligation of

physicians to provide equitable, evidence-based care, the American OsteopathicAssociation (AOA) can use its Bureau of Osteopathic Education to create and implement the needed standards in medical education. Medical students must be equipped with the knowledge and tools necessary to recognize and treat dermatologic conditions in all patients, regardless of skin tone or background.

Relevant Existing Policies:

SOMA Policy: (These policies have been SUNSET by SOMA)

S-21-11: INCLUSION OF MEDIUM AND DARK SKIN TONES IN MEDICAL EDUCATION AND EVALUATION

S-21-31 : RESEARCH AND TRAINING OPPORTUNITIES FOR DIAGNOSIS AND TREATMENT OF DERMATOLOGIC CONDITIONS IN PEOPLE OF COLOR

Policy of other Organizations Named in the Resolved Statements:
AMA Policy H-295.853 Representation of Dermatological Pathologies in Varying Skin Tones

Background Information: Provided by AOA Staff
Current AOA Policy:
H426-A/2025 Minority Health Disparities

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

References:

1. Abeck, F., Heinen, I., Sommer, R., Blome, C., Harter, M., Augustin, M., Schneider, S. W., Hansen-Abeck, I., & Booken, N. (2024, August 7). *Effects of a skin type diversity seminar on Undergraduate Medical Students' self-assessed competence in managing skin diseases in patients with skin of color*. BMC Medical Education. https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-024-05828-x
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4. Frazier, W. T., Proddutur, S., & Swope, K. (2022, October 12). *Common Dermatologic Conditions in Skin of Color*. American Family Physician.

https://www.aafp.org/pubs/afp/issues/2023/0100/dermatologic-conditions-skin-of-color.html
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6. Gupta, R., Ibraheim, M. K., Dao Jr., H., Patel, A. B., & Koshelev, M. (2021). *Assessing Dermatology Resident Confidence in Caring for Patients with Skin of Color*. Clinics in Dermatology. https://pubmed.ncbi.nlm.nih.gov/34785015/
7. Hardin, J., Mourad, A., Desy, J., Paget, M., Ma, I., Danya Traboulsi, Johnson, N. A., Asma Amir Ali, Parsons, L., Harvey, A., Weeks, S., & McLaughlin, K. (2023). Mitigating diagnostic performance bias in a skin-tone balanced dermatology curriculum. The Clinical Teacher, 20(6).
8. Krefting, F., Moelleken, M., Hölsken, S., Placke, J.-M., Robin Tamara Eisenburger, Lea Jessica Albrecht, Alpaslan Tasdogan, Schadendorf, D., Ugurel, S., Joachim Dissemond, & Sondermann, W. (2024). Comparison of visual diagnostic accuracy of dermatologists practicing in Germany in patients with light skin and skin of color. Scientific Reports, 14(1).
9. Louie, P., & Wilkes, R. (2018). Representations of race and skin tone in medical textbook imagery. Social Science & Medicine, 202(202), 38–42.
10. Ogunremi , O. O., Fredericksen, B., Komas, J., Ismail , S. F., & Siri Knusten-Larson, S. (2024, December 31). *Inter-Institutional Analysis of Skin of Color Representation in Dermatological Lecture Content at MD and DO Medical Schools* . DigitalCommons@KCU. https://digitalcommons.kansascity.edu/cgi/viewcontent.cgi?article=1766&context=studentpub
11. Ongoro, G., Avestruz, Z., & Stover, S. (2023, December 4). *Skin Inclusion: Addressing Deficits in Medical Education to Promote Diversity in Dermatological Diagnosis and Treatment*. Clinical, Cosmetic and Investigational Dermatology. https://www.dovepress.com/skin-inclusion-addressing-deficits-in-medical-education-to-promote-div-peer-reviewed-fulltext-article-CCID
12. Shango, K. H., Abdole, F. A., Gonzalez, S. M., Farshchian, M., & Moossavi, M. (2022, April 23). *Medical Student Confidence in Diagnosis of Dermatologic Diseases in Skin of Color*. NIH: National Library of Medicine. https://pmc.ncbi.nlm.nih.gov/articles/PMC9045593
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15. Commission of Osteopathic College Accreditation. (2025, April 25). https://osteopathic.org/index.php?aam-media=/wp-content/uploads/Suspension-of-COCA-Standards-Related-to-DEI.pdf
16. Commission of Osteopathic College Accreditation. (2025, November). https://osteopathic.org/index.php?aam-media=/wp-content/uploads/COCA-2026-COM-New-and-Developing-Accreditation-Standards.pdf

SUBJECT: SUPPORT OF THE STANDARDIZED USE OF NBOME COMAT CLINICAL SUBJECT EXAMINATIONS IN CLERKSHIPS TRAINING

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the National Board of Osteopathic Medical Examiners (NBOME) creates standardized exams to ensure osteopathic medical students are qualified to provide safe and effective care through reliable and defensible national standardized assessments[1]; and,

WHEREAS**,** studies evaluating the relationship between Comprehensive Osteopathic Medical Achievement Tests (COMATs) exam scores and COMLEX-USA Level 2-CE scores have demonstrated a strong correlation between performance on these examinations across clinical subjects[2,3]; and,

WHEREAS**,** a survey conducted by Council of Osteopathic Student Government Presidents (COSGP), examining osteopathic medical school use of NBOME COMAT exams, indicated that implementation of NBOME developed clinical training examinations is not standardized across Colleges of Osteopathic Medicine (COMs), with greater than 30% of COMs not exclusively utilizing COMAT examinations,[4] despite strong correlational relationships to COMLEX Level-2-CE performance; and

WHEREAS**,** successful completion of COMLEX Level-2-CE is required for the conferral of the Doctor of Osteopathic Medicine (DO) degree from all accredited COMs and for matriculation into residency as a DO graduate[5]; and

WHEREAS, Osteopathic Medical Education has experienced a 64.19% growth in enrollment in the last ten years,[6] with over 39,000 students enrolled as of Fall 2024,[7] corresponding with an increasing number of new osteopathic medical schools; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support national standardized examination of osteopathic medical students during their clinical years to ensure comparable clinical training standards and equitable access to training tools shown to correlate with COMLEX Level-2-CE performance; and, be it further

RESOLVED**,** that the AOA supports osteopathic distinction in osteopathic medical training during clinical clerkships ~~through~~ **BY SUPPORTING COCA TO** encourag**E**~~ing~~ the use of National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Achievement Tests (COMAT) clinical examinations for evaluation of clinical knowledge during training.

Background Information: Provided by AOA Staff

Current AOA Policy:

H231-A/2019 Recognition of COMLEX and USMLE as Equal Licensing Examinations
H345-A/2023 AOA Support for GME Equity

Prior HOD action on similar or same topic:

Other References:

COCA Standards

Element 6.11 Comparability Across Clinical Education Sites: A COM and any branch campus must ensure that the curriculum includes comparable educational experiences and equivalent methods of assessment across all core and required clinical educational sites where students learn, ensuring all students achieve similar outcomes based on educational learning objectives

Standard 11 Program and Student Assessment and Outcomes: A COM must define and assess both programmatic and individual student outcomes, including attainment of osteopathic core competencies and skills, to ensure GME readiness.

ACTION TAKEN: __Not Adopted_____

DATE: ____July 18, 2026_____

References:

1. *Our history - NBOME*. (2025, July 10). National Board of Osteopathic Medical Examiners. https://www.nbome.org/who-we-are/our-history/
2. Liu, J., Barnum, S., & Dukat, R. (2025). *Correlation Analysis between COMAT and COMLEX-USA Scores.* National Board of Osteopathic Medical Examiners. https://www.nbome.org/app/uploads/2025/01/2025-01-13_Research-Debrief-on-COMAT-Exams-and-COMLEX_v2.pdf
3. Hudson, K. M., Tsai, T. H., Finch, C., Dickerman, J. L., Liu, S., & Shen, L. (2019). A validity study of COMLEX-USA level 2-CE and COMAT clinical subjects: concurrent and predictive evidence. *Journal of Graduate Medical Education*, *11*(5), 521-526.
4. Council of Osteopathic Student Government Presidents. (n.d.). *OMELA: Osteopathic Medical Education Learning Assessment*. https://cosgpfaq.my.canva.site/omela
5. *COMLEX-USA Blueprint.* (2025). National Board of Osteopathic Medical Examiners. https://www.nbome.org/assessments/comlex-usa/comlex-usa-blueprint/introduction/#:~:text=Aligned%20with%20the%20education%20and,and%20entry%20into%20residency%20training

6. *Quick Facts*. (n.d.) American Association of Colleges of Osteopathic Medicine. https://www.aacom.org/become-a-doctor/about-osteopathic-medicine/quick-facts
7. *2025 Osteopathic Medical Education Impact Report.* (2025). American Association of Colleges of Osteopathic Medicine. https://www.aacom.org/docs/default-source/impact-report-documents/2025-osteopathic-medical-education-impact-report.pdf?sfvrsn=462a0a5a_4

SUBJECT: EXPANSION OF CLINICAL TRAINING CAPACITY IN UNDERGRADUATE MEDICAL EDUCATION (UME) TO ADDRESS THE PHYSICIAN WORKFORCE SHORTAGE

SUBMITTED BY: Texas Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the United States faces a significant and worsening physician shortage; and

WHEREAS, clinical training capacity in undergraduate medical education (UME), particularly hospital-based rotations, remains a critical bottleneck; and

WHEREAS, limited access to rotations—especially in pediatrics—impacts not only pediatric workforce development but also the viability of related training programs such as family medicine and emergency medicine, thereby affecting access to care for both children and adults; and

WHEREAS, hospitals often have the capacity to train additional medical students but face barriers including financial constraints, administrative burden, and lack of structured incentives; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **SUPPORTS** ~~advocate for~~ the expansion of clinical training capacity in Undergraduate Medical Education (UME) through supportive state and federal policies, including financial incentives and infrastructure support for hospitals and health systems; and, be it further

RESOLVED, that the AOA encourage hospitals receiving public funding to participate in osteopathic medical student education in a manner commensurate with their clinical capacity and available resources; and, be it further

RESOLVED, that the AOA collaborate with national stakeholders, including American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), specialty societies, hospital associations, and policymakers, to develop and promote best practices and model approaches to expand clinical rotation opportunities; and, be it further.

RESOLVED, that the AOA ~~develop and disseminate model legislative and regulatory language to assist~~ **SUPPORT** state osteopathic associations in advancing policies supporting expanded clinical training capacity~~; and, be it further~~

31 ~~RESOLVED, that the AOA study barriers to hospital participation in UME and~~
32 ~~propose actionable solutions to increase clinical training capacity nationwide~~.

Background Information: Provided by AOA Staff
Current AOA Policy:
H-200-A/2025 Rural Sites – Osteopathic Education in
H-439-A/2021 Physician Supply in Rural, Underserved United States – Recommendations for Improving.
H-327-A/2024 State Graduate Medical Education (GME) Funding Alternatives

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $10,000
Cost of the study as noted in the last resolved statement. If last resolved statement was removed there would be no fiscal impact.

The AOA Finance Committee does not support the fiscal impact.

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 18, 2026_____

SUBJECT: MICHIGAN STATE UNIVERSITY COMBINING DO MD PROGRAMS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, The American Osteopathic Association holds that osteopathic medicine is a complete and distinct branch of medicine[1]; and

WHEREAS, osteopathic medical school curriculum is unique in that osteopathic principals and practices are integrated throughout the curriculum[2]; and

WHEREAS, on March 11, 2026, Michigan State University announced that it would combine the DO and MD medical college programs into a single program[3]; and

WHEREAS, combining DO and MD medical school curriculum poses a significant risk to the distinct nature of osteopathic medical education; and

WHEREAS, Michigan State University College of Osteopathic Medicine is accredited by the Commission on Osteopathic College Accreditation (COCA); and

WHEREAS, 34CFR602 permits public input into COCA accreditation standards and activities[4]; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) shall notify Michigan State University of its deep concern regarding the combining of the DO and MD programs; and be it further

RESOLVED, that the House of Delegates of the American Osteopathic Association (AOA) expresses it deep concern regarding the merger of the Michigan State University (MSU) College of Osteopathic Medicine and MD degree programs to the Commission on Osteopathic College Accreditation (COCA); and be it further

RESOLVED, that the AOA closely monitor the program merger progress and as permitted under 34CFR602.23(c)(1) report to COCA any possible violations of COCA standards for their independent review.

References:

1. H414-A/21, 1 / 2026 AOA compendium 1-13-21 American osteopathic Association. American Osteopathic Association. Accessed April 25, 2026. https://osteopathic.org/index.php?aam-media=%2Fwp-content%2Fuploads%2F2021-HOD-Compendium.pdf .
2. Foundational Competencies for Undergraduate Medical Education. Foundational competencies for Undergraduate Medical Education. AAMC. Accessed April 25, 2026. https://image.email.aamc.org/lib/fe8e13727c63047f73/m/1/7d5be834-0f5b-410a-b812-fb0deca10ccc.pdf .
3. Topiwala A. Colleges of Human Medicine and Osteopathic Medicine will merge, president says. The State News. March 11, 2026. Accessed April 25, 2026. https://statenews.com/article/2026/03/colleges-of-human-medicine-and-osteopathic-medicine-will-merge-president-says?ct=content_open&cv=cbox_latest .
4. Code of Federal Regulations. Federal Register . Accessed April 25, 2026. https://www.ecfr.gov/current/title-34/subtitle-B/chapter-VI/part-602 .

Background Information: Provided by AOA Staff

Current AOA Policy: none

Prior HOD action on similar or same topic: none

FISCAL IMPACT: $0

ACTION TAKEN: ____Not Adopted_____

DATE: _____July 18, 2026_____

SUBJECT: ADVOCATING FOR EQUITABLE REPRESENTATION ON ACGME REVIEW COMMITTEES FOR SMALLER INSTITUTIONS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) Review Committees (RCs) are responsible for setting standards, reviewing programs, and making accreditation decisions that directly impact graduate medical education (GME) across the country [1]; and

WHEREAS, the current composition of ACGME RC has led to disproportionately representing larger academic institutions, which sponsor 25 or more residency or fellowship programs [2]; and

WHEREAS, smaller institutions (those representing fewer than 25 GME programs) are underrepresented in the makeup of these committees, with data suggesting that they comprise only 15% of the makeup of RCs, thereby limiting the voice and influence of rural, community-based, and non-academic programs [2]; and

WHEREAS, despite this minor representation, these institutions with less than 25 programs make up a larger 76% of the total ACGME-accredited programs in the country [2]; and

WHEREAS, the limited representation of these smaller institutions on the ACGME RCs reduces the visibility and advocacy for issues unique to osteopathic recognized programs, programs traditionally affiliated with osteopathic medical schools, rural/urban-based programs in community-affiliated training environments; now therefore be it

RESOLVED, that **THE AOA ADVOCATE** the Accreditation Council for Graduate Medical Education (ACGME) revise the selection process and composition of the Specialty Review Committees to prioritize increased and proportional representation from smaller institutions; and, be it further

RESOLVED, **THE AOA ADVOCATE** for initiatives to ensure that the voices of the rural, community-based, and osteopathically recognized programs are equitably represented in the ACGME governance and decision-making processes.

34

References:

1. Committee Members and Selection Process. Accreditation Council for Graduate Medical Education. 10 April, 2025. Doi: https://www.acgme.org/about/committees-and-members-selection-process/#:~:text=Composition%20of%20Review%20and%20Recognition,appointment%2C%20and%20a%20public%20member.
2. Stevens, W and A Long. 9 April, 2025. *10-year Retrospect of Single GME: A Review of Sponsoring Institution Types and Representation*. American Association of Colleges of Osteopathic Medicine (AACOM) Conference, 2025: Educating Leaders. Concurrent Oral Session, Expanding Osteopathic GME: Access and Excellence.

Background Information: Provided by AOA Staff

AOA is a member organization of the ACGME, nominating osteopathic representatives to ACGME's Board of Directors and specialty review committees.

AOA policy cannot direct ACGME action. It can encourage or advocate.

Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT OF OSTEOPATHIC RECOGNITION ~~AS THE GOLD STANDARD~~ FOR TRAINING IN GRADUATE MEDICAL EDUCATION

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, Osteopathic Recognition (OR) is a designation conferred by the Accreditation Council for Graduate Medical Education (ACGME) that distinctly acknowledges programs that provide structured training on osteopathic principles and practice and the tenets of osteopathic medicine in graduate medical education (GME) [1]; and

WHEREAS, the OR-Review Committee with the ACGME outlines specific standards for achieving OR status [1]; and

WHEREAS, Osteopathic Recognition has been reported to provide GME programs with tangible benefits:

- Allowing programs to apply osteopathic principles to fields of interest through support of education around quality holistic care, osteopathic manipulation, and osteopathic research [1]
- Allowing Doctors of Osteopathic Medicine (DOs), who continue to express interest in furthering their training in the philosophy of osteopathic medicine, to do so [6]
- Promoting an osteopathic approach to both improve patient satisfaction and lower cost [7]
- Providing a pathway for Medical Doctors (MDs) to pursue training in osteopathic technique [6]
- Providing standards for the training of residents/fellows in graduate medical education, which has been acknowledged as the most critical in learning Osteopathic Principles in Practice (OPP) if physicians are to retain their skills in Osteopathic Medicine [#]

WHEREAS, to date, the number of programs that have achieved OR is far smaller than the number of programs previously accredited by the American Osteopathic Association before the establishment of the Single Accreditation System (SAS) with the ACGME [2,3]; and

WHEREAS, the American Association of Colleges of Osteopathic Medicine (AACOM) published in August of 2024 the results of a study on the barriers to achieving Osteopathic Recognition, with hopes that the results would drive ideas/methods to overcome these barriers [4]; and

WHEREAS, some successful OR programs have already demonstrated viable models of maintaining and expanding high-quality osteopathic training to help in overcoming these barriers, demonstrating that collaboration, access to resources, and the championing of OR are keys to success [5]; now, therefore be it

~~RESOLVED, the American Osteopathic Association (AOA) supports the Accreditation Council for Graduate Medical Education (ACGME) Osteopathic Recognition as the gold standard for graduate medical education programs seeking to provide comprehensive osteopathic training; and, be it further~~

RESOLVED, the AOA encourages continued research, exploration, and evaluation of mechanisms to optimize the training of residents and fellows in osteopathic principles and practice; and, be it further

RESOLVED, the AOA works collaboratively with the **ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)** ~~American Association of Colleges of Osteopathic Medicine (AACOM)~~ to identify and promote successful models of Osteopathic Recognition, provide guidance and resources to programs seeking recognition to ensure the continued strength and growth of osteopathic education and training in graduate medical education.

References:

1. ACGME Osteopathic Recognition Standards. Accreditation Council for Graduate Medical Education. 2022, March 21. *doi*: https://www.acgme.org/globalassets/pfassets/programrequirements/801_osteopathicrecognition_2021v2.pdf
2. Maier R, Weaver J, Ginoza JA, Meyer D, Gothard D. Perceived Value of Osteopathic Recognition. Fam Med. 2023 Feb;55(2):107-110. doi: 10.22454/FamMed.2023.853908. PMID: 36787518.
3. Rue, Katina et al. The Value of Osteopathic Recognition. Annals of Family Medicine vol. 19,1 (2021): 86-87. doi:10.1370/afm.2663
4. Rakowsky A, Backes C, Mahan JD, Wolf K, Zmuda E. The Development of a Pediatric Osteopathic Recognition Track. Acad Pediatr. 2019 Sep-Oct;19(7):717-721. doi: 10.1016/j.acap.2019.06.005. Epub 2019 Jun 8. PMID: 31185308.
5. Former AOA Programs that have Transitioned to the ACGME Accreditation. American Osteopathic Association. Accessed Aug 8th, 2023. *doi:* https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2018/02/single-gme-transitioned -program-opportunities.pdf
6. List of Programs for or and with Osteopathic Recognition. Accreditation Council for Graduate Medical Education. Accessed on 24 Feb 2025. *doi:* http://apps.acgme.org/ads/Public/Reports/ReportRun.
7. American Association of Colleges of Osteopathic Medicine (AACOM). Aug 21, 2024. Landmark Study Answers Question: What's Next for Osteopathic Recognition?. *doi* https://www.aacom.org/news-reports/news/2024/08/21/landmark-study-answers-question---what-s-next-for-osteopathic-recognition

8. Eilerman, Andrew, Porter, Chas, Faherty, Mallory and Zmuda, Elizabeth. "Effectiveness of a program director for osteopathic medical education to support osteopathic recognition at a training site with multiple programs" *Journal of Osteopathic Medicine*, 2025. https://doi.org/10.1515/jom-2023-0253

Background Information: Provided by AOA Staff

Current AOA Policy:

H202-A/2025 Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs

H618-A/2023 Osteopathic Graduate Medical Education

H214-A/2022 Osteopathically Recognized Graduate Medical Education Programs

Prior HOD action on similar or same topic:

H213-A/25 – Support of Osteopathic Recognition and the Integrity of Osteopathic Training
Referred to author-OOA

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 18, 2026_____

SUBJECT: SUPPORT FOR THE OSTEOPATHIC EQUIVALENCY ACT

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Osteopathic Profession was founded in 1874 by Andrew Taylor Still, MD, DO, on the principles of holistic, patient-centered care; the interrelationship of structure and function; the body's innate capacity of self-healing, and the integration of scientific rigor with compassionate medical practice [1]; and

WHEREAS, despite the scientific and clinical soundness of osteopathic medicine, early osteopathic physicians faced significant systemic discrimination, including exclusion from hospitals, postgraduate training programs, and professional recognition solely due to the osteopathic degree designation [2,3]; and

WHEREAS, through perseverance, advocacy, and demonstrated excellence in patient care, osteopathic physicians overcame these barriers, achieving full licensure in all 50 states, parity in scope of practice, and integration into the United States healthcare system [2,3]; and

WHEREAS, today's osteopathic physicians (DOs) are fully licensed, independently practicing physicians who serve in every medical specialty, including primary care, surgical care, specialty care, and academic medicine, holding leadership roles within healthcare systems and governmental institutions [2,3]; and

WHEREAS, persistent misconceptions regarding osteopathic medical education, licensure exams Comprehensive Osteopathic Medical Licensure Exam, (COMLEX), training pathways, and professional equivalency continue to create unnecessary barriers for osteopathic physicians and students at the institutional and regulatory levels [4,5,6]; and

WHEREAS, the proposed Osteopathic Equivalency Act seeks to affirm in statute that Osteopathic physicians, their licensure exam, medical education, graduate medical training, board certification, and pursuit of clinical training opportunities shall be recognized as equal and equivalent to those of allopathic physicians and medical schools; and

WHEREAS, statutory affirmation of osteopathic equivalency supports physician workforce development, expands access to care, reduces unnecessary administrative burdens, and promotes fairness and clarity for healthcare institutions, regulators,; now, therefore be it

34 RESOLVED, that the American Osteopathic Association (AOA) formally endorses
35 and approves the language and intent of the Osteopathic Equivalency Act;
36 and, be it further

37 RESOLVED, that the AOA shall advocate for the adoption of the Osteopathic
38 Equivalency Act within the State of Ohio.

Background Information: Provided by AOA Staff

Current AOA Policy:

H231-A/2019 Recognition of COMLEX and USMLE as Equal Licensing Examinations
H345-A/2023 AOA Support for GME Equity
H625-A/2024 Maintenance of Licensure
H211-A/2022 Equivalency Policy for Osteopathic Continuous Certification

Prior HOD action on similar or same topic:

H215-A/2025 GME Equity Annual Report
H348-A/2024 GME Equity Annual Report

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_____

DATE: _____July 18, 2026_____

References:

1. DiGiovanna, Eileen L., et al. An Osteopathic Approach to Diagnosis and Treatment, 3e. Lippincott Williams & Wilkins, 2005
2. Jones, Bob E. The Difference a D.O. Makes: Osteopathic Medicine in the Twentieth Century. Times-Journal Publishing Company, 1978
3. Gevitz, Norman (2004). The DO's: Osteopathic Medicine in America. Baltimore, Maryland: Johns Hopkins University Press. ISBN 978-0-8018-7833-6
4. Moza MM, Guarneri BD, Morrison L, Allgood L. Exploring the Cost and Access Gap Between Osteopathic and Allopathic Medical Students When Applying for General Surgery Fourth-Year Away Rotations. Cureus. 2025 Mar 11;17(3):e80402. doi: 10.7759/cureus.80402. PMID: 40213735; PMCID: PMC11984451.
5. American Association of Colleges of Osteopathic Medicine. Senate FAIR Act Introduction Builds Momentum for DO Residency Parity. 4 Sept 2025. Accessed 1/2/26. Found at: https://www.aacom.org/news-reports/news/2025/09/04/senate-fair-act-introduction-builds-momentum-for-do-residency-parity

6. American Association of Colleges of Osteopathic Medicine. Fair Access in Residency Act, HR 751. Sept 2025. Accessed 1/2/26. Found at: https://www.aacom.org/docs/default-source/advocacy/fair-act-one-pager-118th-2-10-23.pdf?sfvrsn=5d54efe_11

7. American Osteopathic Association. The Osteopathic Equivalency Act.
IN THE GENERAL ASSEMBLY OF THE STATE OF OHIO
Osteopathic Medicine Equivalency Act
Be it enacted by the General Assembly of the State of Ohio:
Section 1. Title. This act shall be known as and may be cited as the "Osteopathic Medicine Equivalency Act."
Section 2. Purpose. To ensure adequate access to medical care, and address workforce shortages byproviding universal recognition of osteopathic medical education, training, certification and practice.
Section 3. Definitions.
(a)American Board of Medical Specialties (ABMS) is an organization of approved medical boards representing areas of specialty medicine. Member boards certify specialists in medical specialties and subspecialties.
(b)American Osteopathic Association (AOA) is the entity that serves as the primary certifying body for osteopathic physicians and formerly served as the accrediting agency for osteopathic graduate medical education.
(c)Commission on Osteopathic College Accreditation (COCA), is an independent accrediting agency recognized by the United States Department of Education to accredit colleges of osteopathic medicine in the United States.
(d)Comprehensive Osteopathic Medical Licensing Examination of the United States (aka "COMLEX-USA") is a three-level, national exam developed by the National Board of Osteopathic Medical Examiners (NBOME) for osteopathic licensure, assessing medical knowledge, skills, and is a graduation requirement for DO degrees.
(e)Doctor of Osteopathic Medicine or Osteopathic Physician (DO) means a graduate of a COCA-accredited college of osteopathic medicine (drafting note: insert practice act citation).
(f)Liaison Committee on Medical Education (LCME), is an independent accrediting agency recognized by the United States Department of Education to accredit colleges of medicine in the United States.
(g)Medical Doctor or Doctor of Medicine (MD) means a graduate of a school of medicine accredited by the Liaison Committee on Medical Education or international equivalents, as recognized in (drafting note: insert practice act citation).
(h)Osteopathic Manipulative Medicine (OMM) means the application of osteopathic philosophy, structural diagnosis and use of Osteopathic Manipulative Treatment (OMT) in the diagnosis and management of the patient, by a physician licensed to practice in this state.
(i)Osteopathic Manipulative Treatment (OMT) means the therapeutic application of manually guided forces by a physician licensed to practice in this state under (drafting note: insert practice act citation) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction.

(j)Physician means a doctor of osteopathic medicine/osteopathic physician, or a medical doctor/doctor of medicine, as defined above.United States Medical Licensing Examination (aka “USMLE) is a three-part examination that medical students and graduates must pass to become licensed to practice medicine in the United States. The USMLE is developed and sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME).

Section 4. Requirements.

(a)A person holding a license to practice medicine and surgery as a Doctor of Osteopathic Medicine shall be authorized to exercise all the same rights, privileges, duties and responsibilities possessed by licensed Doctors of Medicine in this state.

(b)Holders of MD degrees and DO degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons. Any reference to “Medical doctor”, “MD”or “physician” shall be deemed to include a Doctor of Osteopathic Medicine, DO or an osteopathic physician, unless any of those terms is specifically excluded; however,physicians shall only use the abbreviation corresponding with the school of medicine/osteopathic medicine from which they graduated, as outlined in the definitions

(c)Any entity that requires that the physician be granted or eligible for certification by an appropriate member board of the American Board of Medical Specialties (ABMS) must also recognize equally certification by the AOA. In the absence of explicit recognition, it shall be construed that ABMS also includes AOA.

(d)Students of colleges of osteopathic medicine and schools of medicine shall be accorded equal access (including via fees) to state funded training institutions including clinical rotations, postgraduate residency training programs and fellowships.

(e)Any reference to the USMLE (or its predecessor exams) shall also be deemed to include reference to the COMLEX (or its predecessor exams) for osteopathic physicians, unless specifically excluded.

Section 5. Effective.

This Act shall become effective immediately upon being enacted into law.

Section 6. Severability.

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

SUBJECT: RECOMMENDATION FOR MILITARY EXPERIENCE REQUIREMENTS FOR MEDICAL ADVISORS OF HPSP OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: Association of Military Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Health Professions Scholarship Program (HPSP) provides a vital and significant pipeline of highly qualified osteopathic physicians to the United States Armed Forces; and

WHEREAS, HPSP medical students face unique administrative, educational, and professional challenges during their undergraduate medical education, including securing active duty clerkship rotations, fulfilling specific military training requirements, and managing complex obligations prior to graduation; and

WHEREAS, navigating the intricacies of military bureaucracy—such as coordinating with military recruiters and interfacing with entities like the Army Human Resource Command (HRC)—requires specialized knowledge and firsthand experience that civilian advisors may lack; and

WHEREAS, local chapters of the Association of Military Osteopathic Physicians and Surgeons (AMOPS) serve as critical support networks for these students and require strong, experienced mentorship to thrive; and

WHEREAS, integrating military-specific medical topics (e.g., operational medicine, trauma protocols, triage, and deployment readiness) into the foundational education of these students ensures they are better prepared for military Graduate Medical Education (GME) and active duty service; and

WHEREAS, maintaining active engagement with military medical organizations ensures an advisor remains up-to-date on rapidly changing military policies, GME requirements, and advocacy initiatives; and

WHEREAS, a medical advisor who has successfully navigated these pathways is uniquely positioned to advocate effectively for the specific needs of future military physicians; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recommends that the designated medical advisor for military Health Professions Scholarship Program (HPSP) students at colleges of osteopathic medicine possess extensive medical experience as a physician in the United States military, having served either as an active duty HPSP recipient, a Uniformed Services

University of the Health Sciences (USUHS) graduate, a direct accession physician, or as a physician currently involved with the Reserves or National Guard; and, be it further

RESOLVED, that the AOA recommends that the core responsibilities of this medical advisor explicitly include:

1. Serving as a dedicated mentor to individual military medical students throughout their undergraduate medical education;

2. Collaborating closely with school administrators, registrars, and deans to promote, accommodate, and advocate for the unique administrative, scheduling, and training needs of military medical students;

3. Advocating for and facilitating military medical student clerkship rotations;

4. Assisting in the incorporation of military-specific medical topics into the college's basic undergraduate medical education curriculum;

5. Providing direct support, guidance, and mentorship to the local campus chapters of AMOPS; and

6. Actively interfacing with military recruiters and human resource commands (e.g., Army HRC) to streamline administrative processes and alleviate student issues; and, be it further

RESOLVED, that the AOA recommends that this designated medical advisor maintain active membership in the Association of Military Osteopathic Physicians and Surgeons (AMOPS) to remain current on evolving military medical issues, policies, and advocacy efforts.

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

Prior HOD action on similar or same topic: none

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PROTECTION AND SUPPORT OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) PRACTICE BY OSTEOPATHIC PHYSICIANS IN MILITARY GRADUATE MEDICAL EDUCATION, ENVIRONMENTS

SUBMITTED BY: Association of Military Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Educational Affairs

WHEREAS, Doctors of Osteopathic Medicine (DOs) receive comprehensive education and training in Osteopathic Principles and Practice (OPP) and Osteopathic Manipulative Treatment (OMT) throughout undergraduate medical education; and

WHEREAS, upon graduation from an accredited college of osteopathic medicine, successful completion of required licensing examinations (including COMLEX-USA Level 3 or equivalent), and attainment of an unrestricted medical license, DO physicians are legally authorized to independently practice the full scope of osteopathic medicine, including OMT; and

WHEREAS, the transition to a single accreditation system under the Accreditation Council for Graduate Medical Education has resulted in many osteopathic physicians training in residency programs historically led by allopathic (MD) faculty; and

WHEREAS, this dynamic is particularly evident within military graduate medical education systems, including programs within the Defense Health Agency, where osteopathic physicians frequently train under supervising physicians who may not have formal education, training, or credentialing in OMT; and

WHEREAS, some supervising physicians in such programs report a lack of formal education, training, or credentialing in OMT and consequently restrict or prohibit osteopathic residents from performing OMT, citing inability to supervise; and

WHEREAS, in military medicine, where musculoskeletal injuries, readiness optimization, and return-to-duty timelines are critical, OMT represents a valuable, evidence-informed modality that can enhance force health protection, reduce reliance on pharmacologic therapies, and improve operational readiness; and

WHEREAS, the inability or unwillingness of supervising physicians to oversee OMT creates a barrier to the continuation of osteopathic practice, undermines the

distinctiveness of osteopathic medical training, and may contribute to skill atrophy among osteopathic residents, particularly in austere or operational environments where such skills may be uniquely beneficial; and

WHEREAS, the practice of OMT by appropriately trained and licensed DO physicians does not inherently require direct supervision by a physician trained in OMT, provided that the physician performing the treatment is competent and practicing within their scope and institutional policies; and

WHEREAS, limiting the ability of osteopathic residents to perform OMT solely based on the supervising physician's lack of familiarity is inconsistent with principles applied to other specialized skills in medicine, where credentialed physicians may perform procedures independently within their scope of practice; and

WHEREAS, the osteopathic profession, including military osteopathic physicians represented by AMOPS, has a vested interest in preserving, promoting, and integrating osteopathic principles and OMT across all stages of medical training, including within military and operational settings; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) affirms that Doctors of Osteopathic Medicine who have graduated from an accredited osteopathic medical school and obtained appropriate licensure are qualified to practice Osteopathic Manipulative Treatment within their scope of practice, including during residency **AND FELLOWSHIP** training in both civilian and military graduate medical education systems; and, be it further

RESOLVED, that the AOA, with the support of the Association of Military Osteopathic Physicians and Surgeons, advocates that residency **AND FELLOWSHIP** programs within the ACGME system, including those within the Defense Health Agency, support osteopathic residents in the continued practice of OMT and osteopathic principles, regardless of whether supervising faculty are allopathically trained; and be it further

~~RESOLVED, that the AOA advocates for military and civilian institutions to develop policies that allow DO residents and staff physicians to perform OMT based on their training, demonstrated competency, and licensure, without unnecessary restriction due to supervising physician familiarity or credentialing gaps; and be it further~~

~~RESOLVED, that the AOA encourages the Defense Health Agency and affiliated graduate medical education programs to recognize the operational and readiness value of OMT and to incorporate osteopathic principles into musculoskeletal care, rehabilitation, and force health protection initiatives; and be it further~~

69 ~~RESOLVED, that the AOA promotes the development of educational resources,~~
70 ~~faculty development programs, and optional credentialing pathways to~~
71 ~~increase familiarity with osteopathic principles among non-DO faculty in both~~
72 ~~civilian and military settings, while not making such training a prerequisite for~~
73 ~~allowing DO physicians to practice OMT; and be it further~~

74 ~~RESOLVED, that the AOA supports expansion of Osteopathic Recognition and~~
75 ~~osteopathic-focused training pathways within both civilian and military~~
76 ~~residency programs to preserve and advance osteopathic distinctiveness;~~
77 ~~and be it further~~

78 RESOLVED, that the AOA will collaborate with ~~accrediting bodies, including the~~
79 ~~Accreditation Council for Graduate Medical Education~~ **ASSOCIATION OF**
80 **MILITARY OSTEOPATHIC PHYSICIANS AND SURGEONS**, and with
81 military healthcare leadership to ensure that institutional policies do not
82 unjustly restrict the practice of OMT by qualified osteopathic physicians in
83 training or in active practice; and be it further

84 ~~RESOLVED, that the AOA disseminate this policy, in partnership with the~~
85 ~~Association of Military Osteopathic Physicians and Surgeons, to residency~~
86 ~~program directors, designated institutional officials, military medical~~
87 ~~leadership, and relevant accrediting organizations to promote awareness and~~
88 ~~implementation.~~

Background Information: Provided by AOA Staff

Current AOA Policy:

H321-A/2025 Support for Osteopathic Manipulative Treatment (OMT) Privileges
H436-A/2021 Osteopathic Manipulative Medicine and Osteopathic Manipulative Treatment – Affirming the Scientific and Medical Foundation of
H213-A/2025 Support of Osteopathic Distinctiveness in Residency Training
H202-A/2025 Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

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

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Educational Affairs

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

WHEREAS, Policy H345-A/23 – AOA Support for GME Equity requires the AOA Board of Trustees to provide a report to the House of Delegates; now therefore be it

RESOLVED, that the 2026 House of Delegates accept the AOA Board of Trustees GME Equity 2026 Annual Report as outlined.

2026 GME Equity Annual Report

As the professional home for over 40,000 osteopathic medical students and 32,000 osteopathic residents and fellows, the American Osteopathic Association (AOA) remains committed to identifying and addressing barriers to equitable access to graduate medical education. Over the past year, the AOA continued to advance this work through coordinated advocacy, stakeholder engagement, data collection, and direct outreach to training programs and national organizations across the osteopathic and allopathic communities.

In collaboration with AACOM and NBOME, the AOA engaged osteopathic affiliates to strengthen and align the osteopathic voice in response to the ACGME's ongoing revisions to the Common Program Requirements. The overarching themes of the osteopathic community's recommendations to the Common Program Requirements are:

- AACOM, AOA, and NBOME recommend that ACGME explicitly address the following in the Institutional and Common Program Requirements to ensure equity and inclusion for osteopathic medical students and graduates: All programs must recognize the value of COCA-accredited osteopathic medical education and treat DO applicants and residents equitably.
- Any bias or exclusionary language—such as limiting eligibility to LCME graduates or requiring USMLE scores on program websites—violates ACGME standards. ACGME should monitor and cite programs that exhibit patterns of discrimination against DOs.
- Programs must accept COMLEX-USA for DOs from COCA-accredited schools and USMLE for MDs from LCME-accredited schools and international graduates. Programs must not require DOs to take USMLE in

addition to COMLEX-USA for application, promotion, or completion purposes. This would prevent unnecessary exam duplication, reduce financial and emotional burden, and ensure appropriate and valid licensure pathways for all residents.

- Programs should actively recruit and support a diverse and inclusive workforce that includes DOs, MDs, and international graduates. Annual reporting should include data and practices related to inclusive recruitment across these pathways.
- Program directors must ensure that all residents are informed of their eligibility and options to pursue either AOA or ABMS board certification. The ACGME should monitor compliance with this requirement and take appropriate action against programs that fail to inform or that discourage residents from pursuing AOA board certification.

The AOA also engaged directly with the Accreditation Council for Graduate Medical Education (ACGME) through formal and informal channels, including participating in stakeholder summits, submitting requirement comments, and planning education for the GME community. In December 2025, AOA and Bureau of Osteopathic Specialists (BOS) leadership participated in a virtual meeting with the ACGME Common Program Requirements Task Force, where discussions focused on ensuring that residents are appropriately informed about AOA board certification and addressing challenges associated with current board pass rate requirements, particularly for smaller programs.

To further inform and reinforce this advocacy, the AOA conducted a survey of osteopathic physicians who completed residency training after 2020, as well as AOA board-certified ACGME faculty. Survey findings highlighted ongoing gaps in awareness and advising related to osteopathic board certification:

- 68 percent of residents reported they were not informed about AOA board certification during training
- Among those who were informed, 16 percent were discouraged from pursuing certification and 13 percent were required to take an additional certifying exam
- 43 percent of AOA board certified faculty reported that their programs did not inform residents about AOA board certification

These findings continue to inform the AOA's advocacy strategy and reinforce the need for greater accountability, transparency, and education within training environments.

Throughout the year, the AOA strengthened its engagement in national governance and advisory roles across the graduate medical education continuum. The AOA solicited and advanced nominations of osteopathic physicians, residents, and students to key leadership positions, including the National Resident Matching Program (NRMP) Board of Directors, the Accreditation Council for Graduate Medical Education (ACGME) Board of Directors, and ACGME Review and Recognition Committees. These efforts are essential to ensuring that osteopathic

83 perspectives are represented in decision making bodies that shape policy,
84 accreditation standards, and the residency selection process.
85
86 The AOA expanded its direct engagement with program directors and graduate
87 medical education leaders. In November 2025, the AOA presented for the first time
88 at the Organization of Program Director Associations (OPDA), providing education
89 on AOA board certification and discussing opportunities to improve parity for
90 osteopathic medical students and residents, including acceptance of COMLEX
91 USA. This outreach builds on continued efforts to engage program leadership in
92 meaningful dialogue on equity, transparency, and the value of osteopathic training.
93 Following the OPDA presentation, AOA certifying boards continued and developed
94 new relationships with the program director associations for psychiatry, orthopedic
95 surgery, obstetrics and gynecology, family medicine, and radiology. AOA Certifying
96 Board Services will continue its outreach to all specialty program director
97 associations.
98
99 AOA staff and leadership continued to respond to concerns from osteopathic
100 medical students and physicians through the dedicated do-
101 discrimination@osteopathic.org inbox. Through this work, the AOA directly
102 communicates with programs to reinforce expectations for fair and equitable
103 treatment related to access to audition rotations, program acceptance of COMLEX-
104 USA scores, and discriminatory language in program materials or communications.
105 These efforts contributed to broader awareness of persistent barriers and informed
106 ongoing advocacy with ACGME, American Association of Medical Colleges
107 (AAMC), and NRMP.
108
109 In December 2025, the AOA filed a lawsuit against the American Board of Internal
110 Medicine (ABIM) challenging its policy that limits board certification eligibility for
111 residents and fellows based on the certification of their program director. The policy
112 does not recognize AOA board certified program directors as eligible to attest to
113 training, which restricts access to ABIM certification pathways for otherwise
114 qualified trainees and limits leadership opportunities for osteopathic physicians
115 within ACGME accredited programs. The AOA is seeking to ensure fair access to
116 certification and to preserve choice for residents and fellows in their board
117 certification pathways.
118
119 This year, the House Judiciary Committee Subcommittee published a report on the
120 residency matching program's antitrust exemption, and legislation was introduced to
121 repeal the exemption. The AOA is actively engaged in monitoring this legislation
122 and is working to ensure that the interests of osteopathic medical students and
123 residents are represented in any potential policy changes.
124
125 The AOA also continues to monitor the evolution of the single GME accreditation
126 system. In February 2026, the AOA and AACOM participated in a plenary session
127 at the ACGME Annual Educational Conference titled "Serving the Public and GME
128 Community: A Decade of Single Accreditation." The session engaged a national

audience and incorporated real time polling to better understand ongoing challenges related to equity, advising, and residency pathways.

In June 2026, the ACGME will convene Single GME Summit, which AOA and AACOM have been actively involved in the planning. The Single GME summit will bring together national allopathic and osteopathic leaders to examine how bias, inconsistency, and lack of transparency affect progression for osteopathic medical students and residents across the medical education continuum—from application through residency training. Discussions will focus on recruitment, program director decision-making, and the training environment, with particular attention to how residents are welcomed, valued for their educational background, and supported in understanding certification pathways. The summit will produce shared insights and identified actions to reduce bias, improve alignment across organizations, and strengthen the resident experience.

The AOA remains committed to advancing fairness and equity across the medical education continuum. Through continued advocacy, stakeholder engagement, and data driven insights, the AOA is working to ensure that osteopathic medical students and physicians are evaluated fairly, supported throughout training, and fully recognized for their contributions to patient care and the physician workforce.

Background Information: Provided by AOA Staff
Current AOA Policy: AOA Support for GME Equity - Source: H345-A/23; 2024 GME Equity Annual Report - Source H348 A/24 ; 2025 GME Equity Annual Report – Source H215-A/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

AMERICAN OSTEOPATHIC ASSOCIATION

300 Series Professional Affairs Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (300 SERIES)
As of 07-18-26

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

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-300	Medication for Opioid Use Disorder (MOUD) availability for Incarcerated Individuals and/or Individuals under Correctional Control (SR-Source:H300-A/21)	BFHP	Professional Affairs	Adopted
H-301	Extend~~sion of~~ the Shelf-Life Extension Program (SLEP) **to Civilian Hospitals And Retail Pharmacies** ~~By the FDA~~ (SR-Source: H304-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-302	Support of continued funding for Corporation for National and Community Service (SR-Source: H306-A/21)	BFHP	Professional Affairs	Adopted
H-303	Appropriate PPE Usage Provisions (SR-Source: H307-A/21)	BFHP	Professional Affairs	Adopted
H-304	Center of Excellence for Stroke (SR-Source: H313-A/21)	BFHP	Professional Affairs	Adopted
H-305	Osteopathic Term Protection (SR-Source: H316-A/21)	BFHP	Professional Affairs	Adopted
H-306	Medicaid Pharmaceutical Benefits (SR-Source: H320-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-307	Medication Shortages (SR-Source: H321-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-308	Health Insurance availability to Osteopathic Medical Students (SR-Source: H322-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-309	Behavioral Health Services – Funding and Access (SR-Source: H323-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-310	Congressional Budget Office Fiscal Scoring (SR-Source: H325-A/21)	BFHP	Professional Affairs	Adopted
H-311	Pain Related Education Requirements (SR-Source: H326-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-312	Non-Physician Health Care Clinician (SR-Source: H327-A/21)	BFHP	Professional Affairs	Adopted as Amended
H-313	Tricare Health Insurance for our Military (SR-Source: H329-A/21)	BFHP	Professional Affairs	Adopted

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As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-314	Inclusion of Osteopathic Manipulative Treatment (OMT) in Chronic Pain Management Guidelines (SR-Source: H330-A/21)	BFHP	Professional Affairs	Adopted
H-315	Availability of Modalities of Prescribing (SR-Source: H301-A/21)	CERA	Professional Affairs	Adopted as Amended
H-316	Patient Care at Extended Long Term Care Facilities (SR-Source: H315-A/21)	CERA	Professional Affairs	Adopted as Amended
H-317	Onsite Lab Work No. 1 (SR-Source: H335-A/21)	CERA	Professional Affairs	Adopted as Amended
H-318	Managed Care Referrals (SR-Source: H336-A/21)	CERA	Professional Affairs	Adopted as Amended
H-319	Medicare Physician Payment for Osteopathic Manipulative Treatment (SR-Source: H337-A/21)	CERA	Professional Affairs	Adopted
H-320	Drug Plan Coverage (SR-Source: H338-A/21)	CERA	Professional Affairs	Adopted as Amended
H-321	Payor Adherence to Current Procedural Terminology (CPT) and International Classification of Diseases (IDC) Coding Definitions (SR-Source: H339-A/21)	CERA	Professional Affairs	Adopted as Amended
H-322	Appropriate Payment Mechanisms **AND FLEXIBILITY** for Physician-Led Team-Based Health Care (SR-Source: H341-A/21)	CERA	Professional Affairs	Adopted as Amended
H-323	Improving Access to Physician-Led Care – White Paper (SR-Source: H343-A/21)	CERA	Professional Affairs	Adopted as Amended
H-324	Reforming the Health IT Landscape to Improve the Patient and Clinician Experience- White Paper (SR-Source: H344-A/21)	CERA	Professional Affairs	Adopted as Amended
H-325	Direct Acting Therapy for Hepatitis C Limitations (SR-Source: H303-A/21)	CSHA	Professional Affairs	Adopted
H-326	Increasing Voter Access for Hospitalized Patients (SR-Source: H305-A/21)	CSHA	Professional Affairs	Adopted
H-327	Intractable And / Or Chronic Pain (Not Associated with End-of-Life Care (SR-Source: H308-A/21)	CSHA	Professional Affairs	Adopted as Amended

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2026 RESOLUTION ROSTER (300 SERIES)
As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-328	Voting Day – AOA Supports Voting Day Policy (SR-Source: H314-A/21)	CSHA	Professional Affairs	Adopted as Amended
H-329	Good Samaritan Acts (Hold Harmless Agreement) Performed on Commercial Aircraft (SR-Source: H319-A/21)	CSHA	Professional Affairs	Adopted
H-330	Equity in Medicare and Medicaid Payments (SR-Source:H321-A/22)	CSHA	Professional Affairs	Adopted as Amended
H-331	Interference – Lawful Off-Label Treatment of Patients (SR-Source: H340-A/21)	CSHA	Professional Affairs	Adopted as Amended
H-332	Human Immunodeficiency Virus (HIV) (SR-Source: H342-A/21)	BORPH	Professional Affairs	Adopted as Amended
H-333	Support of Breastfeeding (SR-Source: H331-A/21)	BORPH	Professional Affairs	Adopted as Amended
H-334	Commitment to Organ and Tissue Donation and Transplantation Initiatives, (SR-Source: H332-A/21)	BORPH	Professional Affairs	Adopted as Amended
H-335	Health Literacy (SR-Source: H334-A/21)	BORPH	Professional Affairs	Adopted as Amended
H-336	Vaccine Supply and Distribution (SR-Source: H333-A/21)	BORPH	Professional Affairs	Adopted
H-337	Addressing the American Obesity Epidemic (SR-Source: H429-A/21)	BORPH	Professional Affairs	Adopted as Amended
H-338	Mandatory Influenza Vaccine of Healthcare Personnel (SR-Source: H430-A/21)	BORPH	Professional Affairs	Referred to BORPH
H-339	Cyberbullying through Social Media (SR-Source: H317-A/21)	BORPH	Professional Affairs	Adopted
H-340	Revision of the Invocation to Support Inclusive and Interfaith Language (SR-Source: H311/A21)	BOT	Professional Affairs	Adopted
H-341	Low Back Pain Clinical Practice Guidelines, Revision Of (Referred: H310-A25)	BORPH	Professional Affairs	Adopted as Amended
H-342	Use of Placebos in End-of-Life-Care (Referred: H310-A/24)	BORPH	Professional Affairs	Sunset
H-343	Urine Drug Screening during Pregnancy and Perinatal Care	AOAAM	Professional Affairs	Adopted as Amended
H-344	Supporting the Reestablishment of Healthcare Facilities as Protected Spaces	BEL	Professional Affairs	Adopted

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As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-345	Ensuring Universal Access to Patient Advocacy Services	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-346	Increasing Financial Access to InVitro Fertilization (IVF) Treatment	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-347	Paternity Leave for Osteopathic Physicians	OOA (Ohio)	Professional Affairs	Adopted as Amended
H-348	Support for the continuity of SNAP benefits during Government Shutdowns while upholding Program Integrity	OOA (Ohio)	Professional Affairs	Adopted as Amended

SUBJECT: MEDICATION FOR OPIOID USE DISORDER (MOUD) AVAILABILITY FOR INCARCERATED INDIVIDUALS AND/OR INDIVIDUALS UNDER CORRECTIONAL CONTROL - SOURCE: H300-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association will support the administration and/or
9 prescribing of all FDA-approved treatments for Opioid Use Disorder (OUD) for all
10 individuals with OUD who are incarcerated or under other forms of governmental or
11 private correctional control.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: EXTEND~~SION OF~~ THE SHELF-LIFE EXTENSION PROGRAM (SLEP) **TO CIVILIAN HOSPITALS AND RETAIL PHARMACIES** ~~BY THE FDA~~ - SOURCE: H304-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association **SUPPORTS** ~~petition the US Food and Drug~~
9 ~~Administration (FDA) and the Congress of the United States for~~ the expansion of
10 the Shelf-Life Extension Program to all civilian hospital and retail pharmacies.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021 Adopted as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT OF CONTINUED FUNDING FOR CORPORATION FOR NATIONAL AND COMMUNITY SERVICE - SOURCE: H306-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: APPROPRIATE PPE USAGE PROVISIONS
- SOURCE: H307-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (AOA) supports evidence-based standards
9 and national guidelines regarding the use, reuse, and proper decontamination of
10 Personal Protective Equipment (PPE), especially in circumstances of increased
11 demand. The AOA will advocate for the utmost protection of all healthcare
12 personnel, emphasizing the responsibility of the healthcare institution to provide
13 sufficient PPE within reasonable measures.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 18, 2026

SUBJECT: CENTER OF EXCELLENCE FOR STROKE
- SOURCE: H313-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: OSTEOPATHIC TERM PROTECTION
- SOURCE: H316-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: MEDICAID PHARMACEUTICAL BENEFITS
- SOURCE: H320-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 1996; 2001 Reaffirmed as amended; 2006 Reaffirmed; 2016 Reaffirmed as amended; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

SUBJECT: MEDICATION SHORTAGES - SOURCE: H321-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association will work with **INTERESTED STAKE HOLDERS** ~~the Federal Government, pharmaceutical and medical supply manufacturers, and hospital organizations~~ to **MINIMIZE** ~~ensure that~~ any interruptions ~~of~~ **TO** the **U.S.** medical supply chain~~s~~ ~~are as limited in depth and breadth as possible~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: HEALTH INSURANCE AVAILABILITY TO OSTEOPATHIC MEDICAL STUDENTS - SOURCE: H322-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association will advocate for **FINANCIALLY ACCESSIBLE COMPREHENSIVE** ~~for subsidized and more affordable healthcare~~ **HEALTH INSURANCE COVERAGE** for Osteopathic Medical Students ~~for the duration of their education~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

SUBJECT: BEHAVIORAL HEALTH SERVICES – FUNDING AND ACCESS - SOURCE: H323-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

SUBJECT: CONGRESSIONAL BUDGET OFFICE FISCAL SCORING - SOURCE: H325-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PAIN RELATED EDUCATION REQUIREMENTS – SOURCE: H326-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association **SUPPORTS PEER-REVIEWED, EVIDENCE-BASED** ~~will advocate for~~ medical education for all practitioners on proper ~~opioid prescribing practices and any state mandated pain education requirements should include proper~~ prescribing practices for opioids relating to pain treatment, opioid addiction, and identification of prescription drug abuse, misuse and diversion ~~**PER ANY STATE MANDATED PAIN EDUCATION**~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

SUBJECT: NON-PHYSICIAN HEALTH CARE CLINICIAN
- SOURCE: H327-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association will request of **C**~~c~~ongress and regulatory
9 bodies that the title**S** "health care provider" not be used in favor of the title
10 "physician and non-physician clinician."

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: TRICARE HEALTH INSURANCE FOR OUR MILITARY
- SOURCE: H329-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: INCLUSION OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN CHRONIC PAIN MANAGEMENT GUIDELINES - SOURCE: H330-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: AVAILABILITY OF MODALITIES OF PRESCRIBING - SOURCE: H301-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and

4 WHEREAS, e-prescribing has been required under federal programs since 2021,
5 and this mode of prescribing is now commonplace across physician practices
6 and care settings; and now, therefore be it

7 RESOLVED, that the Council of Economic and Regulatory Affairs recommends that
8 the following policy be ~~SUNSET.~~ **REAFFIRMED ~~-~~ AS AMENDED.**

9 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PATIENT CARE AT EXTENDED LONG TERM CARE FACILITIES - SOURCE: H315-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as amended; 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ONSITE LAB WORK NO. 1 - SOURCE: H335-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

Policy Statement

The American Osteopathic Association supports the ~~adoption~~ **ENACTMENT** of ~~national~~ **FEDERAL** legislation **ON** payment and regulation that enable~~s~~ ~~the~~ physician**S** to perform and be compensated for **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS** (CLIA) certified in-office laboratory tests. **FURTHER, THE AOA** ~~and~~ supports ~~the adoption of national legislation such~~ policies which enables ~~the~~ physician**S** to perform and be appropriately compensated for medically indicated on-site diagnostic procedures.

Background Information: Provided by AOA Staff
Current AOA Policy: 1999; 2004 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 18, 2026

SUBJECT: MANAGED CARE REFERRALS - SOURCE: H336-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

6 Policy Statement

7 The American Osteopathic Association supports ~~and promotes~~ legislation that
8 enables patient access to medical specialists by direct referral from the primary care
9 physicians without preauthorization **OR BURDENSOME PROCESSES** by the
10 managed care company.

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: MEDICARE PHYSICIAN PAYMENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT - SOURCE: H337-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy:2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: DRUG PLAN COVERAGE - SOURCE: H338-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 18, 2026_____

SUBJECT: PAYOR ADHERENCE TO CURRENT PROCEDURAL TERMINOLOGY (CPT) AND INTERNATIONAL CLASSIFICATION OF DISEASES ~~(IDC)~~ **(ICD)** CODING DEFINITIONS - SOURCE: H339-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: APPROPRIATE PAYMENT MECHANISMS **AND FLEXIBILITY** FOR PHYSICIAN-LED TEAM-BASED HEALTH CARE - SOURCE: H341-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

Policy Statement

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

The AOA will advocate to the Centers for Medicare and Medicaid Services (CMS) **TO HOLD OPEN PUBLIC COMMENT PERIODS FOR** ~~that~~ any **NEWLY PROPOSED** alternative payment models (APMs**), AND THAT MODELS** ~~proposed for inclusion in Medicare Access and CHIP Reauthorization Act (MACRA)~~ be reviewed through an administratively simple and transparent process, in a timely manner, and include an appeals process.

The AOA encourages public and private health insurers to develop a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care**, AND OPPOSES MANDATORY PARTICIPATION IN INNOVATION MODELS BEING TESTED BY THE CENTERS FOR MEDICARE AND MEDICAID INNOVATION (CMMI).**

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: IMPROVING ACCESS TO PHYSICIAN-LED CARE -WHITE PAPER - SOURCE: H343-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

WHEREAS, the Council on Economic and Regulatory Affairs (CERA) has reviewed the policy; and determined to reaffirm it with amendments to better reflect the current landscape;

WHEREAS, the CERA believes it is essential that AOA establish a clear position in promoting access to physician led care and maintains the recommendations put forward in the white paper approved in 2021; However, replacing the prior white paper with a statement of recommendations supports clear communication to the public of the AOA's position while ensuring that its recommendations are not impacted between 5-year reviews due to literature becoming outdated; now, therefore be it

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

~~White Paper~~ —Improving Access to Physician Led Care

Policy Statement

THE AMERICAN OSTEOPATHIC ASSOCIATION SUPPORTS A COMPREHENSIVE APPROACH TOWARDS IMPROVING ACCESS TO PHYSICIAN-LED, TEAM-BASED CARE AND MITIGATING PHYSICIAN WORKFORCE SHORTAGES, THEREBY ENSURING THAT PATIENTS ACROSS THE COUNTRY HAVE ACCESS TO TIMELY, HIGH-QUALITY CARE. TO ACHIEVE THIS, THE AOA RECOMMENDS:

1. **ENSURING THAT MEDICAL EDUCATION IS ACCESSIBLE AND AFFORDABLE TO FOSTER CONTINUED AND DIVERSE GROWTH IN THE PHYSICIAN WORKFORCE. THIS MAY BE ACHIEVED BY:**
    - **EXPANDING STATE AND FEDERAL LOAN FORGIVENESS PROGRAMS**
    - **SUPPORTING SCHOLARSHIP PROGRAMS TAX CREDITS OR OTHER FINANCIAL INCENTIVES FOR INDIVIDUALS WHO COMMIT TO PRACTICING IN HIGH-NEED SETTINGS AND SPECIALTIES**
2. **ENCOURAGING MEDICAL STUDENTS TO TRAIN AND SPECIALIZE IN HIGH NEED SETTINGS AND SPECIALTIES BY:**
    - **EXPANDING OPPORTUNITIES FOR MENTORSHIP AS THESE**

RELATIONSHIPS HAVE A STRONG INFLUENCE ON MEDICAL STUDENTS' DECISIONS ON WHICH RESIDENCY PROGRAMS AND SPECIALTIES THEY PURSUE;

- **IDENTIFYING AND SUPPORTING STUDENTS WHO COMMIT TO PRIMARY CARE EARLY IN THEIR EDUCATION AND TRAINING;**
- **FUNDING LONGITUDINAL PRIMARY CARE TRAINING EXPERIENCES; AND**
- **INCREASING SUPPORT FOR HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) PROGRAMS SUCH AS THE NATIONAL HEALTH SERVICE CORPS AND THE TEACHING HEALTH CENTER FOR GRADUATE MEDICAL EDUCATION PROGRAM.**

3. **ENSURING ADEQUATE PAYMENT THAT SUPPORTS DELIVERY OF PRIMARY CARE IN RURAL AND UNDERSERVED SETTINGS, INCLUDING THROUGH ESTABLISHING PARITY BETWEEN MEDICARE AND MEDICAID PAYMENT RATES.**
4. **ENSURING THAT TEAM-BASED CARE IS THE PRIMARY APPROACH TO EXPANDING ACCESS BY:**
   - **MAINTAINING CONSISTENT STANDARDS FOR PHYSICIAN LICENSURE, EDUCATION, AND COMPETENCY;**
   - **PRESERVING PHYSICIAN LEADERSHIP WITHIN CARE TEAMS;**
   - **RECOGNIZING THAT SCOPE OF PRACTICE EXPANSIONS REDUCE STANDARDS OF CARE AND INCREASE COSTS, ESPECIALLY FOR PATIENTS WITH COMPLEX NEEDS.**

ULTIMATELY, IMPROVING ACCESS TO PHYSICIAN-LED CARE REQUIRES INITIATIVES THAT TARGET EDUCATION, WORKFORCE DEVELOPMENT, AND RETENTION OF PHYSICIANS IN HIGH NEED SETTINGS.

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

~~**Improving Access to Physician-led Care**~~

~~**Overview**~~

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

~~**Background**~~

~~Numerous factors contribute to the growing physician workforce shortage in the United States, currently projected to exceed 139,000 physicians by 2030.[1] These include an aging population (including among physicians), an increase in the number of insured individuals following the enactment of the Affordable Care Act (ACA) and related state Medicaid expansions, and the~~

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

~~arbitrarily low cap on Medicare-funded graduate medical education (GME, aka "residency") positions for physicians that was established by Congress in 1997, as well as Medicare, Medicaid and other payor payment rates which have failed to keep pace with the increasing cost of providing care~~

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

~~Legislative Proposals~~

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

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

~~Physician licensure requirements are largely the same across states, and require four years of medical school, a comprehensive examination series followed by supervised postgraduate ("residency") training with progressively greater autonomy before they are allowed to independently treat patients. Medical school education is nationally standardized and includes two years of didactic study totaling upwards of 750 lecture/practice learning hours just within the first~~

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[2] No author. June 2020. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges. Report, IHS Markit Ltd., Washington, DC.
[3] *Id*.
[4] R. Garfield, K. Orgera and A. Damico. 2021. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Issue Brief, Kaiser Family Foundation, San Francisco, CA.
[5] The Consolidated Appropriations Act, 2021 enacted into law on December 27, 2020, provides the Centers for Medicare & Medicaid Services funding for 1,000 new residency slots. This will support approximately 200 new Medicare-funded residency positions per year for five years.

111 ~~two years, plus two more years of clinical rotations done in community hospitals, major medical~~
112 ~~centers and doctors' offices. Residency programs are also standardized by specialty, and are~~
113 ~~comprised of 12,000 to 16,000 hours of supervised training through which physicians develop~~
114 ~~advanced knowledge and clinical skills relating to a wide variety of patient conditions over the~~
115 ~~course of three to seven years.~~

116

117 ~~While physician licensure requirements remain largely the same across the country – and in fact,~~
118 ~~the trend has been towards *increasing* physician education and training requirements over the years~~
119 ~~– some states have begun granting similar licenses to non-physician clinicians, upon completion of~~
120 ~~as little as a two-year master's degree (which may be done largely online), a single examination and~~
121 ~~no supervised postgraduate training, as in the case of nurse practitioners (NPs).~~[6] ~~Not only do NPs~~
122 ~~complete far fewer supervised clinical hours than physicians during their educational programs,~~
123 ~~their professional organization (the American Academy of Nurse Practitioners; "AANP") actually~~
124 ~~*opposes* requiring them to complete supervised residency training before becoming licensed to~~
125 ~~practice independently.~~[7] ~~Unsurprisingly based on their relatively short educational background,~~
126 ~~evidence shows that non- physician clinicians tend to overprescribe medication~~[8]~~, issue poorer~~
127 ~~quality referrals to specialists~~[9] ~~and order unnecessary diagnostic imaging~~[10] ~~compared to physicians,~~
128 ~~all of which expose patients to potentially costly, unnecessary and high-risk interventions, because~~
129 ~~their training has not prepared them to determine which cases warrant such care.~~

130

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

136

137 ~~Despite these differences in education, training and testing, history shows that once non- physician~~
138 ~~clinicians achieve independent practice they often return to state legislatures to advocate for pay~~
139 ~~parity with physicians, thereby defeating any cost savings arguments for independent practice.~~[12] ~~All~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

177 ~~with 7.1 percent fewer emergency department visits, 14.8 percent fewer 30-day readmissions, 37.9~~
178 ~~percent fewer hospital admissions, and 28.5 percent fewer total bed days of care, saving an~~
179 ~~estimated $200,000 per year after accounting for program costs."~~

180

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

189

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

197

198 ~~Additionally, the roles and responsibilities of nurses can vary in different settings, and definitions of~~
199 ~~autonomy varied between some RCTs conducted. An analysis published in 2014 found that "[i]n~~
200 ~~the evaluated studies, the assumption is that nurses possess the competence required for substituting~~
201 ~~physicians, but the level of substitution does not seem equal among studies. While the level of~~
202 ~~training may be a critical factor for an effective outcome, the studies report incomplete descriptions~~
203 ~~of nurses' roles and competencies".[17] Among the few RCTs that have been conducted, long-term~~
204 ~~outcomes and condition management for complex cases are also not sufficiently accounted for.~~

205

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

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[17] Martinez-Gonzalez et al. "Substitution of physicians by nurses in primary care: a systematic review and meta-analysis". BMC Health Services Research. 2014, 14:214.
[18] Swan et al. "Quality of primary care by advanced practice nurses: a systematic review". International Journal for Quality in Health Care. 2015 Oct;27(5):396-404. doi: 10.1093/intqhc/mzv054.
[19] Id.

216

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

222

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

227

228 ~~**Evidence-based Solutions**~~

229

230 ~~***Targeted Funding***~~

231

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

239

240 ~~One recent example is Oregon's Health Care Provider Incentive Fund (Fund), which was~~
241 ~~established in 2017 through an initial $16 million allocation to build health care workforce capacity~~
242 ~~in rural and medically underserved parts of Oregon and to provide resources Health Care Provider~~
243 ~~Incentive Program (HCPIP).[22] The funding is administered by the Oregon Health Authority (OHA)~~
244 ~~in partnership with the Oregon Office of Rural Health (OORH), and utilizes loan forgiveness, loan~~
245 ~~repayment, insurance subsidies and scholarships (including one at the Pacific Northwest College of~~
246 ~~Osteopathic Medicine) to assist qualified health care providers who commit to serving the state's~~
247 ~~Medicaid and Medicare beneficiaries for a certain period of time in rural and underserved areas of~~
248 ~~the state~~

249

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

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[20] M. Runge. Public service loan forgiveness can help fix the shortage of primary care and rural physicians. STAT+, August 11, 2017.
[21] No author. Loan Repayment/Forgiveness/Scholarship and Other Programs. Association of American Medical Colleges, no date.
[22] No author. Health Care Provider Incentive Program: Evaluation of Program Effectiveness. *Oregon Health Authority, Health Policy and Analytics Division, Primary Care Office*, Nov. 2020.

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

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

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

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

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

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

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

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

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

292 ~~in Medicaid and the Texas Children's Health Insurance Program (CHIP), or in a~~
293 ~~Texas Juvenile Justice Department or Texas Department of Criminal Justice facility,~~
294 ~~for at least four years;~~

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

298 ~~- The Family Practice Residency Program, which provides grants to the state's 31~~
299 ~~nationally accredited family medicine residency programs, located in every region of~~
300 ~~the state, in order to help increase the number of physicians who pursue family~~
301 ~~medicine and establish their practices in rural and underserved communities in~~
302 ~~Texas.~~[24]
303

304 ~~Although 66 percent of the physicians who completed residency training in Texas between 2008 -~~
305 ~~2017 chose to remain in the state upon completion~~[25] ~~— indicating a high return on investment for the~~
306 ~~aforementioned programs — funding has been variable and over the years some programs have been~~
307 ~~forced to close permanently:~~[26]

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

311

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

314

315 ~~- The Christus St. Elizabeth Family Medicine Residency Program in Beaumont was~~
316 ~~forced to close in 2002 due to a lack of financial support. Of the 74 graduates from~~
317 ~~the program practicing medicine in 2005, 88 percent practiced in health professional~~
318 ~~shortage areas.~~
319

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

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

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

330 ~~financial loss that it incurs when physicians leave the state to train (and frequently remain)~~
331 ~~elsewhere.[28]~~

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

341 ~~***Driving Specialty Decisions at the Undergraduate Medical Education Level***~~

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

353 ~~This evidence suggests that specialty decisions are made well before graduation from medical~~
354 ~~school. Building training programs where students gain exposure to high-quality mentors in~~
355 ~~primary care, and even engage in community-oriented primary care education may ultimately make~~
356 ~~students more likely to go into a primary care specialty or practice in underserved settings.[34]~~
357 ~~Several Health Resources and Services Administration (HRSA) programs seek to strengthen~~
358 ~~primary care training and steer students at the undergraduate medical education level. Expanding~~
359 ~~these programs can be a useful tool in expanding the primary workforce in underserved~~
360 ~~communities~~

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[28] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf
[29] Knight, Victoria. "American Medical Students Less Likely To Choose To Become Primary Care Doctors." Kaiser Health News, July 3, 2019. https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/.
[30] No Author. "DO Schools Lead in Primary Care, Rural Care and Caring for Underserved in U.S. News' Medical Schools Ranking." American Osteopathic Association, April 2, 2021. https://osteopathic.org/2021/04/02/do-schools-lead-in-primary-care-rural-care-and-caring-for-underserved-in-us-news-best-medical-schools-ranking/.
[31] https://medicine.okstate.edu/hastings/index.html.
[32] American Association of Colleges of Osteopathic Medicine. "Osteopathic Medical School Graduates: Evaluation of Faculty Mentoring". 2020.
[33] "Issues in Medicare beneficiaries' access to primary care". Medicare Payment Advisory Commission Report to Congress. June 2019. http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0
[34] Magzoub, Mohi Eldin M. A. MD, PhD; Schmidt, Henk G. PhD A Taxonomy of Community-based Medical Education, Academic Medicine: July 2000 - Volume 75 - Issue 7 - p 699-707

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

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

379 ~~***Enhancing Payment for Medicaid***~~

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

385 ~~Increasing Medicaid payment to at least an equal level with Medicare will allow more physicians to~~
386 ~~accept Medicaid patients and attract them to practice in high-need settings. An analysis by Health~~
387 ~~Affairs describes how physicians cite low reimbursement rates as a deterrent to participation.~~
388 ~~Additionally, a MACPAC and University of Minnesota analysis of National Ambulatory Medical~~
389 ~~Care Survey data found that the proportion of physicians accepting new patients varies significantly~~
390 ~~based on patient coverage type. Providers were less likely to accept new patients with Medicaid,~~
391 ~~with 70.8 percent accepting new patients, than with Medicare (85.3 percent) or private insurance~~
392 ~~(90.0 percent). MACPAC also found in their analysis that state Medicaid reimbursement was~~

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[35] Pfarrwaller E, Sommer J, Chung C, Maisonneuve H, Nendaz M, Junod Perron N, Haller DM. Impact of Interventions to Increase the Proportion of Medical Students Choosing a Primary Care Career: A Systematic Review. J Gen Intern Med. 2015 Sep;30(9):1349-58. doi: 10.1007/s11606-015-3372-9. PMID: 26173529; PMCID: PMC4539313.
[36] "Seventeenth Annual Report to the Secretary of the United States Department of Health and Human Services and the Congress of the United States". Health Resources and Services Administration. October 2020.
[37] Zuckerman, Skopec, and Epstein. "Medicaid Physician Fees after the ACA Primary Care Fee Bump." Urban Institute, March 2017. https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf

393 ~~correlated with new patient acceptance. Every 1 percentage point increase in the Medicaid-to-~~
394 ~~Medicare fee ratio appears to increase acceptance by 0.78 percentage points.[38]~~

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

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

408 ~~**Conclusion**~~

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

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

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

426

Background Information: Provided by AOA Staff

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

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

Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: REFORMING THE HEALTH IT LANDSCAPE TO IMPROVE THE PATIENT AND CLINICIAN EXPERIENCE- ~~WHITE PAPER~~ - SOURCE: 344-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and

WHEREAS, the CERA believes it is essential that AOA establish a clear position in appropriate health IT regulation and maintains the recommendations put forward in the white paper approved in 2021; however, replacing the prior white paper with a statement of recommendations supports clear communication to the public of the AOA's position while ensuring that its recommendations are not impacted between 5-year reviews due to literature becoming outdated; now, therefore be it

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

Policy Statement

THE AMERICAN OSTEOPATHIC ASSOCIATION SUPPORTS EFFORTS THAT STRENGTHEN NATIONWIDE INTEROPERABILITY OF PATIENT HEALTH DATA, EMPOWER PATIENTS AS OWNERS OF THEIR DATA, AND ENSURE SEAMLESS EXCHANGE AND AVAILABILITY OF DATA AT THE POINT OF CARE. TO ACHIEVE THIS, AOA WILL SUPPORT POLICIES AND INITIATIVES THAT:

- CONTINUE TO STRENGTHEN BASELINE STANDARDS FOR DATA EXCHANGE ACROSS THE HEALTHCARE ECOSYSTEM;
- ADVANCE STANDARDS THAT FOSTER INNOVATION;
- SUPPORT EFFORTS THAT MAKE PATIENT DATA AVAILABLE AT THE POINT OF CARE, WITHIN PHYSICIAN WORKFLOWS, WHILE MINIMIZING BURDEN;
- ENSURE THAT PATIENT HEALTH DATA IS ADEQUATELY PROTECTED, INCLUDING WHEN PATIENTS ENTER DATA INTO THIRD-PARTY, CONSUMER APPLICATIONS THAT ARE NOT CURRENTLY SUBJECT TO HIPAA;

- SUPPORT NEW FORMS OF DATA EXCHANGE THAT ENABLE CARE COORDINATION WITH COMMUNITY-BASED AND OTHER PROVIDERS THAT DO NOT RELY ON AND ARE NOT HISTORICALLY CONNECTED TO ELECTRONIC MEDICAL RECORDS;

- ENABLE PHYSICIAN PRACTICES TO SUCCESSFULLY ADOPT AND IMPLEMENT INNOVATIVE HEALTH IT; AND

- SUPPORT AUTOMATION OF ADMINISTRATIVE PROCESSES.

EXPLANATORY STATEMENT: The above outlined objectives reflect the policy goals outlined in the white paper “Reforming the Health IT Landscape to Improve the Patient and Clinician Experience”. Replacing AOA policy with an evergreen statement ensures that policy is current and not tied to potentially outdated literature in a rapidly evolving technological environment.

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

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

~~Overview~~

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

~~Introduction~~

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

~~As the use of EHRs has increased, recent legislative activities have shifted to address longstanding barriers to interoperability and electronic exchange of healthcare information. This paper policy solutions to enhance interoperability of healthcare data, improve accuracy, increase efficiency, and reduce administrative burden.~~

~~The Evolution of Health Information Technology~~

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

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

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

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

~~To qualify for federal funds, eligible healthcare professionals and hospitals not only had to adopt EHRs but also demonstrate meaningful use of CEHRT by achieving minimum core objectives in each stage of the MU program. It was also~~

~~necessary to demonstrate compliance with the HIPAA security and privacy rules by conducting risk assessments. Even with the financial incentives, the requirements of the MU program were overly burdensome for physician practices and failure to meet them resulted in reduction of Medicare and Medicaid payments. While interoperability was one of the goals for the MU program, it failed in that regard. However, the financial incentive to adopt EHRs gave birth to an industry whose technology was not quite ready for its intended purpose, which is evident by the lack of uptake in the free market.~~

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

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

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

~~Data systems across the country became fragmented and were not interoperable. This was partially due to misaligned incentives in the HITECH Act that were heavily focused on provider requirements, with emphasis on adoption of an EHR with basic capabilities. As the program progressed, incentives were not shifted towards information exchange until MACRA, at which point a highly siloed health data environment had formed. In 2016, a survey of healthcare providers found that "only 6% of healthcare providers report that information accessed from exchange partners on a different EMR is delivered in an effective way that facilitates improvement to patient care." Additionally, platforms often were not designed in a usable manner, with only 8 percent of providers reporting that data could be received and located within the workflow.[v] The lack of efficient technology manifests in high rates of burnout and time taken away from patients. An observational study of physician practices found that physicians spend 27 percent of their time with patients and 49.2 percent of their time on EHR and desk work. While in the examination room with patients, physicians spent approximately 53 percent of the time face-to-face with patients and 37 percent on~~

~~the EHR.~~[vi]

~~Recent HIT Efforts and Shortcomings~~

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

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

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

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

~~Opportunities to Improve HIT Infrastructure to Support Patient Care and Clinicians~~

~~The next step in this process is to ensure that information is readily available to physicians and other clinicians at the point of care to improve the quality and~~

~~efficiency of care, and to ensure that the health IT infrastructure is improved to better serve communities that are often left behind in our health care system. Areas that critically need to be addressed to achieve these goals include the following:~~

~~Effective matching of patient data~~

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

~~Access to Data at the Point of Care~~

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

~~Streamlining Prior Authorization Processes to Eliminate Care Delays~~

~~Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for diagnostic procedures and medical treatments before they can render care to their patients. While the process is often conducted electronically, prior authorization sometimes needs to be obtained over the phone or via fax. Even when obtained electronically, payors have different processes, policies, and electronic platforms. The process for obtaining this approval is costly. The~~

~~Council for Affordable Quality Healthcare (CAQH) estimated that the financial impact of prior authorization requirements to providers in 2019 was approximately $528 million, and the average transaction takes 21 minutes of provider staff time.[xii] If the healthcare industry were to fully shift to electronic prior authorizations with consistent technical standards that allow submissions from a single platform, providers could save 17 minutes per transaction and $355 million per year. However, for providers who do submit electronic prior authorizations, the process is still partially manual, as they need to log into separate portals for each payor and complete varying documentation requirements. Because prior authorization platforms do not integrate with the provider's EHR system, the process generates significant barriers to the efficient care of patients. The current method for prior authorization is costly for providers, detracts from time spent with patients, and often forces patients to go without care or delays care. This can lead to needless increased suffering for the patient and worsening of their condition, ultimately leading to increased cost of care. In order to have a truly effective prior authorization process, fully integrated electronic universal standards must be incorporated by all payers.~~

~~Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health~~

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

~~The COVID-19 pandemic particularly highlighted the impact of social determinants on outcomes and how social factors can drive disparities. Over the course of the pandemic, data has demonstrated that housing status, socioeconomic factors, and behaviors such as smoking were significant determinants of whether an individual contracted COVID-19 and the severity of their case. A study published in 2020 highlights how beyond infection, there are other downstream consequences from the pandemic. For example, children who depend on school lunches may face nutrition issues due to school closures.[xvi]~~

~~During the pandemic, the U.S. also saw unprecedented use of telehealth to expand access to health services and improve care. However, there are clear gaps in health IT infrastructure that prevent social determinants from being recorded and addressed.~~

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

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

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

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

~~suggesting heightened privacy risks."[xviii]~~

~~Solutions~~

~~Effective Matching of Patient Data~~

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

~~Access to Data at the Point of Care~~

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

~~Streamlining Prior Authorization Processes to Eliminate Care Delays~~

~~Because of the growing burden created by prior authorization processes, some congressional and regulatory action has been taken to begin to address the issue. Most recently, CMS issued transaction standard for electronic prior authorization (ePA) under the Part D e-prescribing program. These ePA transaction standards would allow prescribers to use an electronic prescribing (eRX) system or an EHR with an eRX system to determine whether a patient's Part D plan requires prior authorization for a given medication and to receive responses in real time.[xix] While this regulation had many positive aspects,~~

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

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

~~Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health~~

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

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

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

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

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

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

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

~~There has been a willingness to work on this issue in Congress, in particular in the Senate Committee on Health, Education, Labor and Pensions (HELP), which has discussed this during public hearings, and with the introduction of legislation which seeks to address these gaps. Healthcare stakeholders must advocate for~~

~~the passage of legislation which guarantees that no third-party entities are not allowed to transfer, sell or share any individually identifiable consumer health information collected regardless of the modality used to collect such data so that patients may continue to be an active participant in their own healthcare and be protected under the law without fear of losing their privacy by their use of third-party apps.~~

~~**Conclusion**~~

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

~~As outlined above, this includes, but is not limited to, the implementation of legislative and regulatory policies which empower consumers with their personal health data while ensuring that information is seamlessly provided to physicians at the point of care. However, to have the greatest impact, we must go beyond just access to medical data for physicians. In this new digital world, we must also provide appropriate patient protections for any data which is acquired and used by any third-party apps. Finally, we must support and help implement future policies that improve community well-being by enhancing the HIT regulatory frameworks that influence non-medical social determinants of health factors that affect health outcomes. While much of the legislative and regulatory work is slow and tedious, if implemented correctly, effective EHR data has the possibility to improve quality of care while lowering costs, ultimately resulting in promoting healthy communities across the United States.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: DIRECT ACTING THERAPY FOR HEPATITIS C LIMITATIONS - SOURCE: H303-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: INCREASING VOTER ACCESS FOR HOSPITALIZED PATIENTS - SOURCE: H305-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: INTRACTABLE AND / OR CHRONIC PAIN (NOT ASSOCIATED WITH END-OF-LIFE CARE - SOURCE: H308-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

Definitions:

A. Intractable pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, a face-to-face evaluation by the attending physician and/or other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.[1]
Chronic pain means “pain that typically lasts >3 months or past the time of normal tissue healing. chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause.”[2]

Provisions:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's

treatment of the person for a diagnosed condition causing intractable and/or chronic pain. This includes patients with ~~chemical dependency and/or substance abuse history~~ **SUBSTANCE USE DISORDER** if chronic pain exists and controlled substance management is indicated. Physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

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

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

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

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

References:

Bae, Kelly. "When Should Medical Malpractice Be Criminally Culpable?" *Journal of Health & Biomedical Law*, Suffolk University, Feb. 2, 2019.

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

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

Background Information: Provided by AOA Staff

Current AOA Policy: 2005, 2010 Adopted as Amended; 2021 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: VOTING DAY – AOA SUPPORTS VOTING DAY POLICY - SOURCE: H314-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: GOOD SAMARITAN ACTS (HOLD HARMLESS AGREEMENT) PERFORMED ON COMMERCIAL AIRCRAFT - SOURCE: H319-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

7 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: EQUITY IN MEDICARE & MEDICAID PAYMENTS - SOURCE: H321-A/22

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, a related policy (H622-A/25) was to be reviewed for sunset in 2025; and

WHEREAS, the Council on State Health Affairs determined the subject matter of H622-A/25 and H321-A/22 to be substantially similar; and

WHEREAS, adding language from H622-A/25 to H321-A/22 and sunsetting H622-A/25 would provide a clear and comprehensive stance on the issue, eliminate redundancy, and streamline our policy compendium; and

WHEREAS, the Council on State Health Affairs provided the aforementioned recommendation to the 2025 House of Delegates, but H321-A/22 was inadvertently omitted, causing H622-A/25 to be referred back; and

WHEREAS, the Council on State Health Affairs has submitted both policies for review in 2026, with a recommendation to first reaffirm H321-A/22 as amended, and subsequently sunset H622-A/25; now, therefore be it

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

Policy Statement

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

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2017; 2022 Reaffirmed as Amended

Prior HOD action on similar or same topic: H622-A/25 EQUITY IN MEDICARE & MEDICAID largely covers the same topic, but H321-A/22 is more comprehensive, hence the suggestion that language from H622-A/25 be incorporated into H321-A22 and H622-A25 be Sunset.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: INTERFERENCE – ~~LAWFUL~~ OFF-LABEL TREATMENT OF PATIENTS - SOURCE: H340-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV)
-SOURCE: H342-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy and determined that it is current; now, therefore be it

RESOLVED, that the BORPH recommends that the following policy be REAFFIRMED.

Policy Statement

In accordance with the American Osteopathic Association's Code of Ethics **OSTEOPATHIC PHYSICIANS AND OSTEOPATHIC MEDICAL STUDENTS SHOULD:** (1) ~~osteopathic physicians and osteopathic medical students should~~ provide **PEER-REVIEWED, EVIDENCE-BASED** care for those at risk and those infected with Human Immunodeficiency Virus (HIV), in an atmosphere of compassion and nondiscrimination; (2) **ENDEAVOR TO PREVENT TRANSMISSION BY SCREENING ALL PATIENTS FOR THE RISK OF CONTRACTING HIV AND ADVOCATING FOR THE USE OF PRE-EXPOSED PROPHYLAXIS (PREP) AND POST-EXPOSURE PROPHYLAXIS (PEP) IN ALL CARE SETTINGS; (3)** recognize their professional and ethical obligations to care for such patients as they care for all patients; ~~(3) osteopathic physicians and osteopathic medical students in~~ **(4) HONOR** their important role as humanitarian resources to their patients, families, and communities, provide candid, effective nonjudgmental preventive education for those at risk, and serve as effective resources for their patients' families and loved ones; ~~and (4) osteopathic physicians and osteopathic medical students should be~~ **(5) ACT AS** educational resources for those at negligible risk in an effort to promote enlightened attitudes in places of work, our schools, and communities in general; and ~~(5) osteopathic physicians and osteopathic medical students should~~ **(6)** advocate for the removal of legal and systemic barriers to allow patients living with HIV to access care, and to allow healthcare workers living with HIV to provide care to their patients.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT OF BREASTFEEDING -SOURCE: H331-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association supports all hospitals and birth centers to
8 provide mothers **AND CAREGIVERS** the information ~~and~~ skills**, AND RESOURCES**
9 to initiate and continue breastfeeding their babies

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: COMMITMENT TO ORGAN AND TISSUE DONATION AND TRANSPLANTATION INITIATIVES -SOURCE: H332-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: HEALTH LITERACY -SOURCE: H334-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: VACCINE SUPPLY AND DISTRIBUTION
-SOURCE: H333-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ADDRESSING THE AMERICAN OBESITY EPIDEMIC
-SOURCE: H429-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association~~, in conjunction with its specialty and divisional affiliates, the American Association of Colleges of Osteopathic Medicine, the National Board of Osteopathic Medical Examiners and the certifying boards, will initiate~~ **SUPPORTS SCREENING FOR AT RISK INDIVIDUALS** ~~a profession-wide program to provide leadership in **THAT**~~ **TO** address the American obesity epidemic~~;~~ encourages each osteopathic physician and medical student to measure the body mass index (BMI) and waist circumference **AS APPROPRIATE AND** ~~patient and address~~ **DISCUSS OBESITY-RELATED ISSUES** with **THEIR PATIENTS;** ~~them their obesity-related issues~~, and ~~also~~ encourages each osteopathic physician and student to address any obesity-related issues in their own health as an example to their patients.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: MANDATORY INFLUENZA VACCINE OF HEALTHCARE PERSONNEL -SOURCE: H430-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association recommends mandatory seasonal Influenza
8 vaccination of all healthcare personnel and that medical exemptions to required
9 influenza immunization (e.g., life threatening allergic reaction after receiving an
10 influenza vaccine or severe allergy to a vaccine component) should be kept at a
11 minimum to ensure high coverage rates and granted only on an individual basis.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to BORPH____

DATE: ____July 18, 2026_____

SUBJECT: CYBERBULLYING THROUGH SOCIAL MEDIA
-SOURCE: H317-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: REVISION OF THE INVOCATION TO SUPPORT INCLUSIVE AND INTERFAITH LANGUAGE (SOURCE: H311- A/21)

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

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

2 WHEREAS, the AOA Board of Trustees has reviewed the policy; and

3 WHEREAS, the AOA Board of Trustees concur the policy remains relevant; and
4 now, therefore be it

5 RESOLVED, that the AOA Board of Trustees recommends that the following policy
6 be REAFFIRMED:

7 Policy Statement

8 The American Osteopathic Association (AOA) supports the use of non-
9 denominational language in all invocations to be respectful to people of all beliefs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

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

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H310-A2025 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF - SOURCE: H325-A2020 to the 2025 AOA House of Delegates and requested a one year extension; and

WHEREAS, the 2025 AOA House of Delegates referred this policy back to BORPH and approved the one year extension; and

WHEREAS, A BORPH MEMBER AND COLLEAGUES SUBMITTED A SCOPING REVIEW ON OMT AND LOW BACK PAIN TO THE JOURNAL OF OSTEOPATHIC MEDICINE WHICH HAS BEEN RECENTLY ACCEPTED AFTER UNDERGOING PEER REVIEW AND WILL BE PUBLISHED IN THE NEAR FUTURE, AND

WHEREAS, the BORPH ~~has reviewed an updated~~ **WILL REVIEW THE** Scoping Review ~~of the published literature on treating back pain, but~~ **TO DETERMINE IF ITS FINDINGS AND CONCLUSIONS CAN BE USED TO DEVELOP** ~~additional work needs to be completed to upgrade the Scoping Review to the level of~~ a Systematic Review to meet the AOA ~~Guidelines~~ standard of 1a Level of Evidence ~~in~~ **FOR THE AOA LOW BACK PAIN** Clinical ~~Research studies~~ **PRACTICE GUIDELINE**; and

WHEREAS, BORPH created a Guideline ~~development~~ **UPDATE** Process to increase external credibility of the AOA guideline, and ensure **THAT** updates are predictable, evidence based, and **CONFORM WITH CURRENT CLINICAL PRACTICE GUIDELINE STANDARDS** ~~feasible~~, now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) Guideline Update Process be approved, and be it further

RESOLVED, that AOA Bureau of Osteopathic Research and Public Health (BORPH) will provide an update on the revision of the “AOA Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain” to the 2027 House of Delegates.

AOA Guideline Update Process

Guiding Principles

AOA guideline updates should be:

- Evidence-based
- Primary-care focused
- Transparent and reproducible
- Feasible for a small guideline portfolio
- Explicit about OMT-specific considerations

1. Establish a Guideline Oversight Committee

Structure (small, standing body):

- 4 - 5 osteopathic physicians with appropriate expertise
- 1 evidence-based medicine methodologist

Responsibilities:

- Monitor emerging evidence on OMT and low back pain
- Decide when an update is needed
- Oversee all stages of the update

Conflict of Interest (COI):

- Annual disclosures required
- Majority of members must be free of relevant financial COI
- Chair must be COI-free

2. Update Cycle

- Scheduled review every 5 years (default)

- Early update triggers, including:
    - New systematic reviews or RCTs on OMT for low back pain
    - New safety signals
    - Major changes in standard low back pain management
    - Conflicts with external guidelines from other professional associations or organizations

3. Scope Confirmation and Clinical Questions (PICO)

Before updating, the committee confirms:

- Population (e.g., adults with acute, subacute, or chronic low back pain)
- Interventions (OMT)
- Comparators (usual care, sham, physical therapy, pharmacologic care)
- Outcomes (pain, function, quality of life, adverse events)

4. Commission or Update a Systematic Evidence Review

Evidence Review Approach:

- Commission a targeted systematic review through:
    - An academic partner, OR
    - A small external evidence review group
- Search strategy and inclusion criteria must be publicly documented

Evidence scope:

- RCTs and high-quality observational studies

- Separate analyses for:
    - Acute vs. chronic low back pain
    - OMT vs. sham
    - OMT vs. usual care

5. Rate Evidence and Recommendations

- The current AOA guideline uses evidence graded as Evidence level 1a.

- For future updates the AOA will consider the GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) methodology for evidence. https://methods.cochrane.org/bias/resources/cochrane-handbook

6. Develop or Revise Recommendations

Each recommendation should include:

- Clear recommendation statement
- Strength of recommendation (GRADE or Evidence level)
- Summary of supporting evidence
- Benefits vs. harms
- OMT-specific considerations

7. External Review and Public Comment (Scaled Model)

External Reviewers:

- At least 2 non-panel clinical experts

- 1 guideline methodologist
- Optional reviewer from another professional society

Public Comment:

- 21–30 day online comment period
- Responses summarized and documented

8. AOA Approval, Publication, and Dissemination

Final guideline approval by:

- AOA Bureau of Osteopathic Research and Public Health

Publication:

- The Journal of Osteopathic **MEDICINE** ~~Research~~ and AOA website
- Executive summary and clinician-friendly tools (algorithms, summaries)

9. Post-Publication Monitoring and Maintenance

After publication:

- Annual evidence scan (light-touch literature surveillance)
- Decision log documenting whether:
    - No update needed, or
    - Targeted update required

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended; 2025 Referred

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $30,000
Funding for a consultant to complete a systematic review and meta-analysis on which to base the new guideline.

The AOA Finance Committee supports the fiscal impact.

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: USE OF PLACEBOS IN END-OF-LIFE CARE – SOURCE: H310-A/24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H310-A/2024 SR END-OF-LIFE CARE – USE OF PLACEBOS IN- (Source: H322-A/19) to the 2025 AOA House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2025 AOA House of Delegates referred this policy back to BORPH and requested that BORPH review the primary scope and purpose of this resolution and update the references; and

WHEREAS, the policy was reviewed by the BORPH chair with the original authors of this policy written in 2004 and noted that the primary scope and purpose of the original resolution has devolved with the positive evolution of guideline informed, evidence based, and ethical standard of care for the treatment of pain at the end of life since 2004, and

WHEREAS, the BORPH also discussed this policy and concluded that this policy is no longer needed, now, therefore be it

RESOLVED, that the AOA Bureau of Osteopathic Research and Public Health (BORPH) recommend that the following policy be SUNSET.

End-of-Life Care – Use of Placebos In Policy Statement

The AOA approves the attached position paper on Use of Placebos for Pain Management in End-of-Life Care and will be updated according to the current literature.

USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE

The placebo effect of medication can be a significant resultant action of any prescription. However, the substitution of a placebo in place of effective pain medication has been widely recognized as unethical, ineffective and potentially harmful. ([1-9]) A number of organizations have advised against the use of placebo substitution, including the American Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical Association), American Nursing Association, and the American Society of Pain Management Nurses.

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

I. Definition of Terms

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

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

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

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

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

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

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

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

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

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

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

II. Legal Considerations in the Use of Placebos in Pain Management

While there are no specific laws governing the use of placebos in any circumstance, there is a considerable amount of legislation regarding a patient's right to pain management. There are several state statutes that address this issue, some of which are based on the Federation of State Medical Boards' Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.([15]) This document clarifies that legislative statutes accepting these guidelines understand the ongoing increased scientific knowledge of pain management, and thus have no need to modify legislation as the science of pain management changes. This document does not mention placebo usage.

The American Bar Association (ABA) ([16]) adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, "…that the American Bar Association urges federal, state, and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual's life." Placebo substitution for active pain medicine without informed consent on the part of the patients clearly violates the nature and substance of the ABA's position. Additionally, in two Supreme Court decisions regarding the right to assisted suicide, the court promoted the right of individuals to appropriate palliative care and pain management. ([17, 18])

While there is little case law concerning tort or administrative findings against physicians for inadequate pain management, this is likely to change in the near future. The main barrier to malpractice claims for inadequate pain management is use of the customary local standard to determine what constitutes ordinary care. The courts are steadily moving away from this standard to a national standard which uses clinical guidelines as the determinant of ordinary care. This is seen in the decision in the case of Nowatske v. Oserloh, where the court stated, "should customary medical practice fail to keep pace with development and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care…" ([19])

Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality ([1]), the American Pain Society, ([7]) the Healthcare Facilities Accreditation Program ([20]) as well as the Joint Commission on Accreditation of Healthcare Organizations ([21]) are good examples of sources the courts are using to determine ordinary practice. These guidelines do not support the use of placebo in any fashion except in approved research studies when the appropriate patient informed consent has been obtained. Therefore, the physician thus cannot justify the use of placebo for pain management by attempting to diagnose "addiction" or with support from any of the above regulatory agencies. ([5])
Furthermore, under California's elder abuse statute, ([22]) a physician was successfully sued by the deceased's family for inadequate pain management at the end of life. ([23])

III. Adverse Effects of Placebo Use

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

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

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

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

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

IV. Summary

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

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

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Background Information: Provided by AOA Staff
Current AOA Policy: 2004; 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Referred; 2025 Referred

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ___July 18, 2026_____

SUBJECT: URINE DRUG SCREENING DURING PREGNANCY AND PERINATAL CARE

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Professional Affairs

WHEREAS, early identification of substance use during pregnancy using a validated screening tool is essential to improving maternal and neonatal health outcomes; and

WHEREAS, substance use during pregnancy is best addressed through education, prevention, and evidence-based treatment; and

WHEREAS, routine and non-consensual urine drug testing during pregnancy is not a validated screening tool[1] and has well-documented limitations, including false positives, false negatives, and inability to diagnose substance use disorder; and

WHEREAS, results of urine drug tests do not indicate the capacity to parent, and mandatory reporting laws may cause unintended harm to mothers and newborns through criminalization, disruption of the family structure, and deterrence of prenatal care[2,3]; and

WHEREAS, Black and low-income individuals are disproportionately subjected to urine drug testing and thereby experience disproportionate harms associated with such testing[3-6] ; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports universal screening for perinatal substance use using validated screening tools; and, be it further

RESOLVED, that the AOA opposes routine and non-consensual urine drug testing as a screening tool during pregnancy; and be it further

RESOLVED that the AOA supports and promotes addressing substance use during pregnancy through education, prevention, and evidence-based treatment; and, be it further

RESOLVED, that the AOA opposes state and federal mandatory reporting legislation that permits urine drug test results to serve as the sole basis for suspected child abuse or neglect; and, be it further

29 RESOLVED, that the AOA ~~advocates for~~ **SUPPORTS** state and federal child
30 welfare laws and policies that rely on an osteopathic physician's clinical
31 judgment, assessment of maternal functional status, and infant health and
32 safety to report child protective concerns.

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Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORTING THE REESTABLISHMENT OF HEALTHCARE FACILITIES AS PROTECTED SPACES

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Professional Affairs

WHEREAS, the United States (U.S.) Department of Homeland Security (DHS) describes a “protected area” as a location that, based on the essential services or activities that occur there, is generally protected from immigration enforcement actions, which may include arrests, civil apprehensions, searches, inspections, seizures, service of charging documents, interviews, or enforcement surveillance[1]; and

WHEREAS, the DHS defines medical and mental health care facilities broadly to include hospitals, doctors’ offices, clinics, vaccination or testing sites, urgent care centers, sites serving pregnant individuals, and community health centers[1-2]; and

WHEREAS, in January 2025, DHS rescinded the 2021 memorandum, Guidelines for Enforcement Actions in or Near Protected Areas, allowing any law enforcement actions to occur in previously identified protected areas such as healthcare facilities, schools, and places of worship[3-4]; and

WHEREAS, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[5] establishes limitations on disclosure of protected health information to law enforcement, requiring compliance with specific legal standards and processes; and

WHEREAS, strict immigration policies and escalating immigration enforcement generate structural barriers to healthcare access and adversely affect the mental and physical health of all immigrant patients by decreasing access to and eligibility for care, worsening inequities, deterring health-seeking behaviors, and deepening mistrust in institutions[6-12]; and

WHEREAS, immigration policies that create fear or uncertainty among healthcare workers may threaten workforce stability, exacerbate staffing shortages, and undermine the ability of health care systems to provide consistent, high-quality patient care[13]; and

WHEREAS, inclusive, health-focused policies that protect clinical spaces positively influence social determinants of health, including trust, perceived safety, and equitable access to care[14]; now, therefore be it

31 RESOLVED, that the American Osteopathic Association (AOA) supports federal
32 policies that would reestablish healthcare facilities as protected areas in
33 order to ensure safe, uninterrupted access to medical care.

Explanatory Statement:
This resolution supports federal policies that would reestablish healthcare facilities as protected areas following the 2025 rescission of the Department of Homeland Security's Guidelines for Enforcement Actions in or Near Protected Areas. Clear protections for clinical settings reduce barriers to care, support compliance with patient privacy laws, and provide guidance for physicians navigating interactions with law enforcement. Reestablishing protected healthcare spaces also promotes workforce stability by reducing fear and uncertainty among healthcare workers, thereby supporting the delivery of safe, high-quality, and continuous patient care. This resolution aligns with existing AOA policy, including H209-A/22 and H628-A/25, and reinforces the osteopathic commitment to trust, access, and whole-person care.

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Background Information: Provided by AOA Staff

Current AOA Policy:

H209-A/22 United States Immigration Executive Order Impact on Medical Education

H628-A/25 Confidentiality of Patient Records

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ENSURING UNIVERSAL ACCESS TO PATIENT ADVOCACY SERVICES

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, patients navigating the healthcare system often face complex medical, financial, and administrative challenges that make comprehending their treatment options too difficult, directly impacting their informed decision-making; and

WHEREAS, patient advocates play a critical role in assisting patients and families by facilitating communication between healthcare teams, clarifying medical information, supporting shared decision-making, and ensuring patient rights and preferences are respected; and

WHEREAS, the presence of trained patient advocates has been shown to improve patient satisfaction, reduce preventable errors related to miscommunication, and enhance care coordination; and

WHEREAS, lack of access to patient advocacy can be especially detrimental for vulnerable populations—including those with language barriers, limited health literacy, cognitive impairment, or complex medical conditions—who are at a higher risk of misunderstanding treatment plans or experiencing adverse events; and

WHEREAS, ensuring the reliable availability of patient advocates aligns with the core mission of physicians to promote patient safety, autonomy, and equitable care; therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~advocate for~~ **SUPPORTS THE POSITION THAT** all licensed hospitals maintain readily accessible patient advocacy services**.** ~~for all patients and all families throughout the entirety of their medical care, including during hospitalization, at discharge, following outpatient visits, and throughout any subsequent care-related or medico-legal processes.~~

Background Information: Provided by AOA Staff
Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: INCREASING FINANCIAL ACCESS TO IN VITRO FERTILIZATION (IVF) TREATMENT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, infertility is a recognized disease by the World Health Organization (WHO) and affects approximately 1 in 6 individuals during their reproductive lifetime, with many requiring assisted reproductive technologies (ART), including in vitro fertilization (IVF), to achieve pregnancy; and

WHEREAS, IVF represents the most effective treatment for numerous causes of infertility, including diminished ovarian reserve, tubal factor infertility, endometriosis, male-factor infertility, and unexplained infertility; and

WHERE AS, the cost of IVF in Michigan typically ranges from $15,000–$25,000 per cycle including medications, placing significant financial strain on affected individuals and couples, and often making medically necessary care inaccessible; and

WHEREAS, lack of insurance coverage forces many patients to delay or forgo treatment, which can worsen outcomes, particularly for individuals with advancing maternal age, diminished ovarian reserve, or medical diagnoses requiring timely intervention; and

WHEREAS, at least 21 states have enacted laws requiring some level of insurance coverage for infertility diagnosis and/or IVF treatment, ~~Michigan~~ THE REMAINING STATES currently ~~provides~~ **PROVIDE** no adopted legislation, leading to INequitable access to fertility care ~~across~~ AMONG the stateS; and

~~WHEREAS, at least 21 states have enacted laws requiring some level of insurance coverage for infertility diagnosis and/or IVF treatment, Michigan currently provides no adopted legislation, leading to equitable access to fertility care across the state; and~~

WHEREAS, expanding access to IVF supports family building for a diverse range of patients, including individuals with medical infertility, cancer survivors facing gonadotoxic therapy, LGBTQ+ families, and single intended parents; therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~advocate for~~ **SUPPORTS** legislation requiring insurers to provide comprehensive and equitable coverage for infertility diagnosis and medically necessary infertility treatments, including IVF; and be it further

32 RESOLVED, that the AOA ~~advocate for~~ **SUPPORTS** coverage parity ensuring that
33 infertility care, including IVF, is not subject to more restrictive deductibles,
34 annual caps, exclusions, or lifetime limits than other medical or surgical
35 treatments; and be it further

36 RESOLVED, that the AOA support exploration of additional financial pathways to
37 increase access to IVF, such as tax credits, state-funded grants, Medicaid
38 coverage for medically indicated infertility treatment, and employer
39 incentives.

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

Prior HOD action on similar or same topic:

FISCAL IMPACT: $ 0

40 ACTION TAKEN: __Adopted as Amended__
41
42 DATE: ___July 18, 2026_____

SUBJECT: ~~PATERNITY~~ **PARENTAL** LEAVE FOR OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the health and well-being of physicians is crucial for maintaining high-quality patient care and ensuring the sustainability of the healthcare workforce[1]; and

WHEREAS, equitable parental leave policies promote gender equality and support the involvement of both parents in early child-rearing, which is beneficial for a child's development and family bonding[1]; and

WHEREAS, the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) have recognized the importance of parental leave, mandating a minimum of six weeks of parental leave for resident physicians[2,3]; and

WHEREAS, the American Medical Association (AMA) endorses equal parental leave for birth and adoption for all physicians, regardless of gender[2,3]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~advocate for~~ **ENCOURAGES** employers to implement policies that provide a minimum of six weeks of paid ~~paternity~~ **PARENTAL** leave for physicians.

References:

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Background Information: Provided by AOA Staff
Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT FOR THE CONTINUITY OF SNAP BENEFITS DURING GOVERNMENT SHUTDOWNS WHILE UPHOLDING PROGRAM INTEGRITY

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the ~~Ohio~~ AMERICAN ~~Osteopathic Association (AOOA)~~ represents osteopathic physicians who are committed to whole-person care and the osteopathic principle that health is influenced by biological, psychological, and social factors [1]; and

WHEREAS, food insecurity is a significant Social Determinant of Health (SDOH) that negatively impacts physical health, mental health, chronic disease management, and health care utilization [2]; and

WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) is a critical federal program that helps ensure food security for millions of low-income individuals and families, including children, elderly adults, and patients with chronic medical conditions [3]; and

WHEREAS, disruptions to SNAP benefits, including those that occurred during the 2025 United States Government shutdown, create immediate and harmful consequences for vulnerable patients, increase hunger, stress, and barriers to medical adherence [4]; and

WHEREAS, physicians across ~~Ohio~~ **THE UNITED STATES** directly witness the health consequences of interrupted access to nutrition, including worsening disease control, increased emergency department utilization, and preventable hospitalizations [5]; and

WHEREAS, maintaining public trust in SNAP requires strong program integrity, including appropriate safeguards to prevent fraud, waste, and abuse so that limited resources are preserved for individuals and families with legitimate need; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) ~~affirms it~~s support**S** ~~for~~ policies and efforts at the state and federal levels that prevent disruptions in Supplemental Nutrition Assistance Program (SNAP) benefits during government shutdowns or funding lapses, particularly for populations with significant Social Determinant of Health (SDOH) disparities; and, be it further

36 RESOLVED, that the AOA supports responsible efforts to reduce fraud, waste, and
37 abuse within SNAP to ensure that program funds remain available to
38 individuals and families in need of them.
39
40

References:

1) The Ohio Osteopathic Association. "Who We Are." Accessed 12/31/25. Found at: https://www.ooanet.org/aws/OOSA/pt/sp/about
2) Morelli V. Social Determinants of Health: An Overview for the Primary Care Provider. Prim Care. 2023 Dec;50(4):507-525. doi: 10.1016/j.pop.2023.04.004. Epub 2023 Jun 20. PMID: 37866828.
3) The United States Department of Agriculture Food and Nutrition Service. "Supplemental Nutrition Assistance Program." Accessed 12/31/25. Found at: https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program
4) Gosliner W, Chen WT, Johnson C, Esparza EM, Price N, Hecht K, Ritchie L. Participants' Experiences of the 2018-2019 Government Shutdown and Subsequent Supplemental Nutrition Assistance Program (SNAP) Benefit Disruption Can Inform Future Policy. Nutrients. 2020 Jun 23;12(6):1867. doi: 10.3390/nu12061867. PMID: 32585839; PMCID: PMC7353319.
5) The Ohio Capital Journal. "Food insecurity faces ripple effects of shutdown, SNAP pauses." 1 Dec 2025. Accessed on 12/31/25. Found at: https://ohiocapitaljournal.com/2025/12/01/food-insecurity-faces-ripple-effects-of-shutdown-snap-pauses/

Background Information: Provided by AOA Staff

Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

AMERICAN OSTEOPATHIC ASSOCIATION

400 Series Public Affairs Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (400 SERIES)
As of 07-18-26

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-400	Support Nutritionally balanced, low cost or free meals for Children in Schools (SR-Source: H400-A/21)	BFHP	Public Affairs	Adopted as Amended
H-401	Supporting Public Policy to encourage wholesome **NUTRITIOUS** Food Donations to those in need in America (SR-Source: H401-A/21)	BFHP	Public Affairs	Adopted as Amended
H-402	Collection of Public Health Data Concerning Firearm Fatalities (SR-Source: H402-A/21)	BFHP	Public Affairs	Sunset
H-403	AOA Firearm Policy ~~Compendium~~ (SR-Source: H409-A/21)	BFHP	Public Affairs	Adopted as Amended
H-404	Improving outcomes in Behavioral Health Care in the Emergency Department (SR-Source: H410-A/21)	BFHP	Public Affairs	Adopted
H-405	Drug Samples (SR-Source: H412-A/21)	BFHP	Public Affairs	Sunset
H-406	Lesbian, Gay, Bisexual, Transgender, Queer / Questioning, Intersex, Asexual Protection Laws (SR-Source: H434-A/21)	BFHP	Public Affairs	Adopted as Amended
H-407	Gender Identity Non-Discrimination- (H433-A/25) (Sunset after Reaffirming (H434-A21)	BFHP/ CSHA	Public Affairs	Sunset
H-408	Third Party Payors **AND PHARMACIES** Changing Classes of Medications (SR-Source: H437-A/21)	CERA	Public Affairs	Adopted as Amended
H-409	Physician Comparative Utilization and Profiling (SR-Source: H438-A/21)	CERA	Public Affairs	Adopted
H-410	Alternative Payment Models – Ensuring DO Opportunities and Patient Access ~~in~~ **THROUGH APPROPRIATE MODEL** DESIGN (SR-Source: H-440-A/21)	CERA	Public Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-411	Health Insurance Coverage for Medical and Surgical Treatments for Good Oral Health (SR-Source: H441-A/21)	CERA	Public Affairs	Adopted as Amended
H-412	Concussion, Return-to-Play and Return-to-Learn (SR-Source: H413-A/21)	CSHA	Public Affairs	Referred to BORPH
H-413	Recommendations for Improving Physician Supply in Rural, Underserved United States (SR-Source: H439-A/21)	CSHA	Public Affairs	Adopted as Amended
H-414	Physician Profiles (SR-Source: H442-A/21)	CSHA	Public Affairs	Adopted as Amended
H-415	The Framework Convention on Tobacco Control (SR-Source: H421-A/21)	BIOM	Public Affairs	Adopted
H-416	Autonomy of Osteopathic Medicine (SR-Source: H414-A/21)	BORPH	Public Affairs	Adopted as Amended
H-417	Chelation Therapy (SR-Source: H406-A/21	BORPH	Public Affairs	Adopted
H-418	Minority Health and Osteopathic Medical Education (SR-Source: H416-A/21)	BORPH	Public Affairs	Referred to BORPH
H-419	Obesity in Children (SR- Source: H417-A/21)	BORPH	Public Affairs	Adopted
H-420	Fitness, Sports and Nutrition (SR-Source: H418-A/21)	BORPH	Public Affairs	Adopted as Amended
H-421	Plastic Beverage and Food Container Recycling Act (SR-Source: H419-A/21)	BORPH	Public Affairs	Adopted
H-422	Childhood and Teenage Sexual Exposure (SR-Source: H420-A/21)	BORPH	Public Affairs	Adopted as Amended
H-423	Damage to Hearing from use of Headphones (SR-Source: H422-A/21)	BORPH	Public Affairs	Adopted as Amended
H-424	Dangers of the “Choking Game” (SR-Source: H423-A/21)	BORPH	Public Affairs	Not Adopted
H-425	Research on Medical Cannabis (SR-Source: H424-A/21)	BORPH	Public Affairs	Adopted
H-426	Blood Donors, Protection from Depletion of Iron (SR-SOURCE: H426-A/21)	BORPH	Public Affairs	Adopted

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As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-427	5-2-1-0 Campaign for America's Children (SR-Source: H427-A/21)	BORPH	Public Affairs	Sunset
H-428	Support for Title X Funded Family Planning Services (SR-Source: H431-A/21)	BORPH	Public Affairs	Adopted as Amended
H-429	Shackling of Pregnant Inmates (SR-Source: H432-A/21)	BORPH	Public Affairs	Adopted as Amended
H-430	Affirming the Scientific and Medical Foundation of Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) (SR-Source: H436-A/21)	BORPH	Public Affairs	Adopted
H-431	Patient Centered Treatment for Pain Management and Appropriate use of Opioids (SR-Source: H403-A/21)	BORPH	Public Affairs	Adopted as Amended
H-432	Minority Health Disparities (Referred: H426-A/25)	BORPH	Public Affairs	Adopted as Amended
H-433	Influenza Immunization for Health Care Workers and Educators (Referred: Interim Policy: H320-A/24)	BORPH	Public Affairs	Adopted as Amended
H-434	Meningococcal Vaccine Recommendations (Referred: Interim Policy: H411-A/22)	BORPH	Public Affairs	Adopted as Amended
H-435	Immunizations (Referred: Interim Policy: H414-A/23)	BORPH	Public Affairs	Adopted as Amended
H-436	Education on Human Papillomavirus Vaccination (Referred: Interim Policy: H421-A/22)	BORPH	Public Affairs	Adopted as Amended
H-437	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (Referred: Interim Policy: H410-A/25)	BORPH	Public Affairs	Adopted as Amended
H-438	Support for **Evidence Based Vaccination Practices** ~~THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS~~ (Referred: Interim Policy: H411-A/25	BORPH	Public Affairs	Adopted as Amended

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As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-439	**Support Of** Vaccines for Children ~~PROGRAM~~ (Referred: Interim Policy: H413-A/25)	BORPH	Public Affairs	Adopted as Amended
H-440	**INTENTIONALLY BLANK**			
H-441	Prevention of Child Injury on Playgrounds – Slide Safety	AAO-AOASM ACOP-AOAO AOCPMR	Public Affairs	Adopted as Amended
H-442	Adoption of the American Academy of Pediatrics Childhood and Adolescent Immunization Schedule	ACOP (Pediatrics)	Public Affairs	Not Adopted
H-443	Acknowledging Emerging Evidence on E-Cigarette Use and Cancer-Relevant Risk Pathways and Encouraging Integration into Osteopathic Medical Education	AOMA (Arizona)	Public Affairs	Not Adopted
H-444	National Stewardship and Centralized Digitization of Historical Osteopathic Records	MOA (Michigan)	Public Affairs	Not Adopted
H-445	Support for 24/7 Anonymous Naloxone Dispensing Strategies in High-Traffic Areas in Underserved and Rural Communities	OPSC (California)	Public Affairs	Adopted
H-446	Ensuring Equitable Veteran Access to Osteopathic Manipulative Treatment	TOMA (Texas)	Public Affairs	Adopted as Amended
H-447	Aircraft Emergency Medical Supplies (Referred: H401-A/25)	BFHP	Public Affairs	Sunset
H-448	Sharing Centralized Resources on State-Specific Reproductive Health Policies (Referred:H456-A/25)	Finance	Public Affairs	Not Adopted

SUBJECT: SUPPORT NUTRITIONALLY BALANCED, LOW COST OR FREE MEALS FOR CHILDREN IN SCHOOLS - SOURCE: H400-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (AOA) **SUPPORTS** ~~advocates for legislative~~
9 ~~efforts in support of widely~~ accessible, nutritionally-balanced, low-cost or free meals
10 for all children in the U.S. Pre-K through 12 schools.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORTING PUBLIC POLICY TO ENCOURAGE ~~WHOLESOME~~ **NUTRITIOUS** FOOD DONATIONS TO THOSE IN NEED IN AMERICA
- SOURCE: H401-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (AOA) stands in support of our current
9 public policy that increases access to **NUTRITIOUS** food for **EVERYONE IN THE**
10 **UNITED STATES**. ~~all Americans~~. The AOA supports increasing access to
11 donations of ~~wholesome~~ **NUTRITIOUS** food through the use of qualified food banks.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 18, 2026_____

SUBJECT: COLLECTION OF PUBLIC HEALTH DATA CONCERNING FIREARM FATALITIES - SOURCE: H402-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, Per the direction of the 2019 House of Delegates, H-402/A21 has been
3 incorporated into AOA Firearm Policy; and
4

5 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy;
6 therefore, be it

7 RESOLVED, the Bureau on Federal Health Programs recommends the following
8 policy be SUNSET.

9 Policy Statement

10 The American Osteopathic Association (AOA) supports the collection of public
11 health data concerning firearm fatalities. The data points to be collected should be
12 separated into the following categories: homicides, including the number of
13 domestic violence homicides; suicides and accidents; and non-fatal firearm related
14 injuries. Within each category, the ages of the victims to be noted.

15 Additional data to be collected is the hospitalizations that occurred as a result of a
16 firearm that did not result in death and include the caliber of the firearm used.

17 The AOA will advocate to make this data publicly available and develop healthcare
18 guidance and inform public policy.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 18, 2026_____

SUBJECT: AOA FIREARM POLICY ~~COMPENDIUM~~ - SOURCE: H409-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; therefore, be it

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

Policy Statement

The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.

The AOA House of Delegates adopts the following stance on firearm education, research, and policy.

Education

The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians educate families on the safe use and storage of firearms and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. ***[Editor's Note: Non-powdered guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]***

Research

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims

and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA (1) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (2) supports the collection of public health data concerning firearm fatalities separated by homicides, including the number of domestic violence homicides, suicides and accidents, and non-fatal firearm related injuries, further separated by the ages of victims of each category, and hospitalizations that occurred as a result of firearm that did not result in death and the caliber of firearm used. The AOA supports such data be publicly available to inform the development of guidance and public policy.

Policy

The American Osteopathic Association supports legislation that (1) labels gun violence as a national public health issue; (2) funds appropriate research on gun violence as part of future federal budgets; (3) establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity; (4) requires comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and (5) requires firearm safety training, including military or law enforcement training, as a condition to purchase any class of firearms.

The American Osteopathic Association opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship.

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

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

~~Referred Resolution Firearm Policy Compendium~~

~~Policy Statement~~

~~The American Osteopathic Association (AOA) House of Delegates adopts the attached policy compendium, which includes all current American Osteopathic Association policies relating to firearm violence.~~

~~AOA Policy Compendium – Firearm Policy~~

~~Introduction~~

~~The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.~~

~~The 2019 AOA House of Delegates (HOD) adopted a resolution, H437-A/19, Firearm Violence, which states that the AOA *"will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates."* In response to the adoption of this policy, the Bureau on Federal Health Programs (BFHP) concluded that having a broad array of policies on a given topic allows AOA staff to accurately respond to federal and regulatory concerns. With nuanced policy to reference, the bureau determined that the best approach to implementing this policy is to develop a comprehensive document that includes all current AOA policies relating to firearm violence. This approach is also intended to preserve any relevant background and history of individual resolutions and avoid any potential impediments to future policy changes.~~

~~The BFHP submitted a white paper to the 2020 HOD in response to the direction provided in H437-A/19 that included an overview of AOA firearm policy through 2019. Questions were raised by delegates at the 2020 HOD regarding the scope of the document submitted and whether more current data was available, and it subsequently was referred back to the BFHP. In response to this referral, the BFHP has updated its research; firearms resolutions adopted by the 2020 HOD along with updated federal statistics and citations are included in this compendium.~~

~~Background~~

~~Much of the AOA's policy is predicated on an understanding of the role of firearms on public health in the United States. According to the Centers for Disease Control and Prevention (CDC), firearm-related deaths in the U.S. reached a twenty year high in 2017[i]. In 2018, there were 39,740 firearms-related deaths in the U.S., with 109 people dying from firearm-related injury each day[ii]. The CDC estimates that 6 in 10 of these are suicide and 3 in 10 are homicide[iii]. Additionally, in 2018, more U.S. deaths were attributed to firearms than motor vehicle accidents[iv].~~

~~An analysis of 2010 data showed that the U.S. had the highest rate of firearm-related violence, suicides, and accidents among industrialized countries[v]. Beyond the impact on~~

~~the health and well-being of Americans, there is an economic impact, with gun violence in the U.S. costing $229 billion in 2015[vi].~~

~~Policies Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence~~

~~Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death, as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services.~~

~~Current Resolutions on Firearm Education:~~

- **~~H425-A/19 FIREARM SAFETY~~**

~~The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians educate families on the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014; reaffirmed as amended 2019~~

- **~~H418-A/20 FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS~~**

~~The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015; adopted as amended 2020~~
~~[Editor's Note: Non-powdered guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]~~

- **~~H340-A/16 PHYSICIAN GAG RULES – OPPOSITION TO~~**

~~The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights. 2016~~

- **~~H428-A/19 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE~~**

157 ~~While the American Osteopathic Association supports measures that save the community~~
158 ~~at large from gun violence, the AOA opposes public policy that mandates reporting of~~
159 ~~information regarding patients and gun ownership or use of guns except in those cases~~
160 ~~where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading~~
161 ~~the valuable trust established in the physician-patient relationship. 2013; reaffirmed 2019~~

162 ~~**Policies on Advancing Research to Reduce Firearm Violence**~~

163 ~~Advancing research to reduce firearm violence is a public health issue that deserves the~~
164 ~~allocation of appropriate resources. The AOA supports funding for the Centers for Disease~~
165 ~~Control and Prevention (CDC), the National Institutes of Health (NIH), and other research~~
166 ~~entities, to conduct research on firearm violence and to provide recommendations on~~
167 ~~reducing firearm violence.~~

168 ~~**Current Resolutions on Firearm Research:**~~

169 ~~• **H442-A/20 FIREARM VIOLENCE**~~

170 ~~The American Osteopathic Association (AOA) (1) supports the federal government's~~
171 ~~January 2013 clarification, "that no federal law in any way prohibits doctors or other health~~
172 ~~care providers from reporting their patients' threats of violence to the authorities, and~~
173 ~~issuing guidance making clear that the Affordable Care Act does not prevent doctors from~~
174 ~~talking to patients about gun safety"; (2) supports funding for the Centers for Disease~~
175 ~~Control and Prevention (CDC), the National Institutes of Health (NIH) and other research~~
176 ~~entities to conduct research on firearm violence and to provide recommendations on~~
177 ~~reducing firearm violence; (3) supports promotion of policies that will increase access to~~
178 ~~mental health services and for the appropriate coverage of mental health services by~~
179 ~~public and private health care programs; and (4) encourages enhanced education of gun~~
180 ~~safety and safe handling of firearms; and (5) approves the attached Policy Statement on~~
181 ~~Firearm Violence. 2013; revised 2015; adopted as amended 2020~~

182 ~~**AOA Policy Statement – Firearm Violence**~~

183 ~~The American Osteopathic Association (AOA) is dedicated to preventing violence in our~~
184 ~~communities, especially the increased prevalence of firearm violence. As physicians, we~~
185 ~~see first-hand the devastating consequences of violence to victims and their families. The~~
186 ~~AOA recognizes that laws, regulations, and policies have the potential to decrease the~~
187 ~~occurrence of violence, especially firearm violence, in our communities. The AOA~~
188 ~~supports:~~

189 ~~Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm~~
190 ~~Violence~~

191 ~~Preserving the rights of physicians and other health care professionals to counsel patients~~
192 ~~on prevention, including the prevention of injury or death as a result of firearms, is critical.~~
193 ~~Physicians play an important role in preventing firearm injuries through health screenings,~~
194 ~~patient counseling, and referral to mental health services. The AOA supports the~~
195 ~~administration's January 2013 clarification, "that no federal law in any way prohibits~~

~~doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.~~

~~Advancing Research to Reduce Firearm Violence~~

~~Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.~~

~~Improving Access to Mental Health Services and Resources~~

~~Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.~~

- ~~**H630-A/18 COMPREHENSIVE GUN VIOLENCE REFORM**~~

~~The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that:~~

1. ~~Labels gun violence as a national public health issue.~~
2. ~~Funds appropriate research on gun violence as part of future federal budgets.~~
3. ~~Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. 2018~~

~~**Additional Policies Supporting Reduced Firearm Injury**~~

- ~~**H318-A/16 FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM**~~

~~The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011; reaffirmed 2016~~

- ~~**H446-A/20 BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE**~~

~~The American Osteopathic Association (AOA) recognizes public health data demonstrating the impact of firearms on mortality and wellness in the United States and will support federal legislation requiring comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and the AOA will support efforts to require firearms safety training, including military or law enforcement training, as a condition to purchase any class of firearms. H421-A/15 is superseded by this resolution. adopted 2020~~

~~Conclusion~~

~~As noted above, the AOA House of Delegates adopted a policy in 2019 that calls for the identification of all current firearm violence policies in a single document. This compendium reflects that policy and highlights the wide range of issues addressed in AOA firearm policies which includes eight individual policies. At least two resolutions (H425-A/19 and H418-A/20) support education and recommend safety precautions for gun owners. One (H340-A/16) opposes any governmental action that would limit the right of physicians to discuss with their patients the topic of responsible gun ownership and safe storage. Another (H428-A/19) opposes any mandated reporting of patient gun ownership. Two policies (H442-A/20 and H630-A/18) support federal funding for research on firearm violence. H630-A/18 also labels gun violence as a national public health issue and supports federal legislation that would establish constitutionally appropriate restrictions on the manufacturing and sale of certain classes of firearms. Lastly, H446-A/20 supports federal legislation requiring comprehensive background checks for firearms as well as efforts to require firearm safety training.~~

~~There is a separate and distinct focus in most of these policies, with covered issues ranging from education, to protecting the rights of physicians, support for research, and support for certain restrictions on sales. As such, these policies, as well as any future firearm-related policies, should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis.~~

~~Source: H409-A/21~~

~~Status: 2021~~

Explanatory Statement:
Per the direction of the House of Delegates, all previous firearm policies have been consolidated into a single unified policy in the proposed substitute amendment, AOA Firearm Policy. This policy consolidates into a single unified policy ***H-420/A21 Collection of Health Data Concerning Firearm Fatalities*** and ***H-409/A21 AOA Firearm Policy Compendium***, which superseded the following policies:

- H-425/A19 Firearm Safety
- H-418/A20 Firearms and Non-powdered Guns – Education for Users
- H-340/A16 Physician Gag Rules – Opposition to
- H-428/A19 Physician-Patient Relationship as Related to Proposed Gun Control

Laws, Protection of the
- H-442/A20 Firearm Violence
- H-630/A18 Comprehensive Gun Violence Reform
- H-318/A16 Firearms – Commission of Crime While Using Firearm
- H-446/A20 Background Checks and Firearms Safety Training as a Condition of Firearms Purchase

Background Information: Provided by AOA Staff
Current AOA Policy: See above

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

~~[i] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.~~
~~[ii] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html~~
~~[iii] Id.~~
~~[iv] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html~~
~~[v] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.~~
~~[vi] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.~~

SUBJECT: IMPROVING OUTCOMES IN BEHAVIORAL HEALTH CARE IN THE EMERGENCY DEPARTMENT - SOURCE: H410-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (AOA) supports innovative models that
9 increase availability of emergency behavioral health care for crisis stabilization.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: DRUG SAMPLES - H412-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (1) encourages the pharmaceutical industry
9 to continue the distribution of drug samples, and/or vouchers to physicians,
10 including those drugs whose patents have expired, (2) will petition the Food and
11 Drug Administration to not limit the manufacturers' distribution of drug samples
12 and/or vouchers; and (3) will continue to defend and support policies that allow
13 osteopathic physicians to provide drug samples (including stock bottles or vouchers
14 when appropriate) free-of-charge to patients.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 1996 Reaffirmed; 2001 Revised; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 18, 2026_____

SUBJECT: **GENDER IDENTITY AND/OR SEXUAL ORIENTATION** ~~LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER / QUESTIONING, INTERSEX, ASEXUAL~~ - PROTECTION LAWS
- SOURCE: H434-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association (AOA) supports the protection of ~~Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual,~~ (~~LGBTQIA~~) individuals from discriminating practices and harassment **BASED ON GENDER IDENTITY AND/OR SEXUAL ORIENTATION** and reaffirms equal rights and protections for all patient populations as stated in the AOA Rules and Guidelines on Professional Conduct.

Citation:
Moreira JD, Bates ML, Roepke TA. Challenges and inclusive practices for LGBTQIA2S+ scientists in the American Physiological Society. Am J Physiol Heart Circ Physiol. 2022 Jul 1;323(1):H121-H124. doi: 10.1152/ajpheart.00234.2022. Epub 2022 Jun 10. PMID: 35687502; PMCID: PMC9236859.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 18, 2026_____

SUBJECT: GENDER IDENTITY NON-DISCRIMINATION - SOURCE: H433-A/25

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

WHEREAS, a related policy, H434-A/21 LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER / QUESTIONING PROTECTION LAWS, is to be reviewed for sunset in 2026; and

WHEREAS, the Council on State Health Affairs reviewed the policy and determined that the subject matter of H433-A/25 is covered by H434-A/21; and

WHEREAS, the Council on State Health Affairs recommends that H434-A/21 be reaffirmed, and H433-A/25 subsequently be sunset; now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) opposes discrimination on the basis of gender identity.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Adopted; 2020 Adopted; 2025 Adopted as Amended

Prior HOD action on similar or same topic: H434-A/21

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 18, 2026 _____

SUBJECT: THIRD PARTY PAYORS **AND PHARMACIES** CHANGING CLASSES OF MEDICATIONS - SOURCE: H437-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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

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

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

6 Policy Statement

7 The American Osteopathic Association supports ~~all~~ efforts **PREVENTING**
8 **PAYORS, PHARMACIES, AND PHARMACY BENEFIT MANAGERS FROM**
9 ~~**SUBSTITUTING PRESCRIBED MEDICATIONS, INCLUDING**~~ **REQUIRING A**
10 **CHANGE IN CLASS OF MEDICATIONS.** ~~to end the practice of requiring a change~~
11 ~~in class of medication, thereby decreasing the administrative burden and improving~~
12 ~~access to care~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PHYSICIAN COMPARATIVE UTILIZATION & PROFILING - SOURCE: H438-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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

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

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

Policy Statement

The American Osteopathic Association (AOA) adopts the following principles on physician comparative utilization and physician profiling.

The physician comparative utilization, rating, and profiling programs should exclusively use metrics that are developed with physician involvement. Where possible, measure sets and/or data points should be evidenced-based and vetted by relevant physician specialty or professional societies. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. Additionally, all evidenced-based measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.

Comparative utilization, profiling, and rating should only occur once data has been acquired from a statistically significant sample of a physician's patient population which has been risk adjusted.

Comparisons between physicians should be based on geographic/demographic (rural, urban, suburban) comparisons of similar practice specialty.

Anonymous patient satisfaction data, whether in a formal profiling program or through an informal consumer website, should be excluded.

Physicians should have the opportunity to review any data or rating for accuracy and be afforded the right to request changes to inaccurate information in advance of the publication of that data. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.

28 If comparative utilization or physician profiling data were to be made public, only
29 measures that are deemed sensitive and specific to the care being delivered are
30 used and appropriate context and methodology are shared with the public.

31 The physician rating and profiling program(s) should not adversely impact the
32 physician-patient relationship or unduly intrude upon physicians' medical judgment.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ALTERNATIVE PAYMENT MODELS – ENSURING **OSTEOPATHIC PHYSICIAN** ~~DO~~ OPPORTUNITIES AND PATIENT ACCESS ~~IN~~ **THROUGH APPROPRIATE MODEL** DESIGN - SOURCE: H440-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and

WHEREAS, the Council on Economic and Regulatory Affairs has determined that it is necessary to add language added to this policy to reflect principles discussed by the CERA in previous meetings and recent comments submitted to CMS by AOA. Revisions also seek to differentiate the intent of this policy from H341-A/21; and now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) will advance federal and state polices to ensure alternative payment models (APM) that: (1) offer high quality healthcare to all patients; (2) empower physicians to engage patients in making decisions involving their healthcare, including both economic and clinical decisions; (3) permit freedom of choice of hospital and doctors within the scope of the care model; (4) ~~allow~~ **ENCOURAGE** participation of osteopathic physicians ~~including as part of the~~ **IN** leadership, board, or other administrative body of the APM; permit the patient to make economic decisions involving ~~his~~ **THEIR** healthcare; (5) will not exclude DOs on the basis of degree or AOA certification or training; (6) will provide **PHYSICIANS AND OTHER QUALIFIED HEALTHCARE PROFESSIONALS (QHPS)** ~~providers~~ with information about the costs, risk, and payments associated with practicing in the APM; **(7) ACCOUNT FOR THE RESOURCES AND INVESTMENTS REQUIRED** ~~**NECESSARY**~~ **TO ENGAGE IN THE NECESSARY PRACTICE TRANSFORMATION FOR SUCCESSFUL PARTICIPATION; (8) UTILIZE FINANCIAL INCENTIVES DIRECTED TOWARD** ~~**TAILORED AROUND**~~ **IMPROVING CARE AND DELIVERING CARE EFFICIENTLY, WITH PERFORMANCE MEASURES THAT INCLUDE BENCHMARKS FOR PAYOR ALIGNMENT** ~~**EMPHASIZE ALIGNMENT ACROSS**~~ **PAYERS; (9) GRANT PHYSICIANS RELIEF FROM ADMINISTRATIVE BURDENS WHEN THEY ARE HELD ACCOUNTABLE FOR COSTS;** (~~7~~**10**) apprise participating physicians of the progress of the APM; (~~8~~**11**) do not exclude physicians and hospitals who are not

33 part of the APM from honest competition for any segment of the marketplace; (~~9~~**12**)
34 afford all physicians appropriate hearing and appeal processes **FOR DISPUTES IN**
35 **PERFORMANCE**

Background Information: Provided by AOA Staff
Current AOA Policy: 1988; 1993 Reaffirmed as Amended, 1994 Reaffirmed, 1999 Reaffirmed; 2004 Referred; 2006 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: HEALTH INSURANCE COVERAGE FOR MEDICAL AND SURGICAL TREATMENTS FOR GOOD ORAL HEALTH - SOURCE: H441-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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

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

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

6 Policy Statement

7 The American Osteopathic Association ~~supports the concept~~ **AFFIRMS** that medical
8 insurance coverage should include medical and surgical treatments as needed to
9 support good oral health, especially for patients with comorbid conditions

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: CONCUSSION, RETURN-TO-PLAY AND RETURN-TO-LEARN – SOURCE: H413-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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

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

WHEREAS, the scientific and legal information contained in the policy changes somewhat frequently and irregularly, rendering it out of date between sunset reviews; and

WHEREAS, external organizations cited in the policy possess in-house experts dedicated to keeping their recommendations up-to-date; and

WHEREAS, the final recommendations in the policy remain relevant and largely evergreen; and

WHEREAS, the Council on State Health Affairs believes that the recommendations should be maintained as AOA policy to provide guidance on this issue, while additional text that is frequently out-of-date should be eliminated; now, therefore be it

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

Policy Statement

~~The American Osteopathic Association (AOA) approves the Youth Concussion and Return-to-Play white paper and its position on concussion, return-to-play and return-to-learn.~~

~~**Youth Concussion and Return-To-Play White Paper**~~

~~Since 2009, every state has passed some form of legislation to address concussion safety in youth athletics. Most states' laws address the following five common areas:~~

~~1. Parent and student education,~~
~~2. Parent and student signature requirements,~~
~~3. Coach training, removal and return-to-play [RTP],~~

~~4. Return-to-learn [RTL] and~~
~~5. Clearing provider types~~

~~State laws vary, however, in the precise degree of detail and rigor of their respective requirements. The American Osteopathic Association (AOA) is committed to helping states work to address this public health risk by providing evidence-based guidance on concussion as a part of the spectrum of Traumatic Brain Injuries (TBIs), as well as RTP and RTL protocols for youth athletes. We support policies that are backed by current scientific evidence, with appropriate clarification regarding the definitions of terms and protocols. The AOA believes that allopathic and osteopathic physicians (MDs and DOs) possess the complete medical knowledge and training needed to recognize and diagnose the subtle, varying and evolving symptoms of concussion, but that coordination across all levels of the physician-led team is imperative for timely evaluation and intervention, and appropriate follow-up care. In order to ensure the appropriate level of care, team physicians should possess up- to-date documentation of knowledge, skills and experience in this area of medicine. The goal of this paper is to encourage greater consistency among the terminology used by health care organizations, and to utilize current evident to help states create a standardized approach to concussion, RTP and RTL.~~

~~Background~~

~~In recent years, a consensus has emerged among the scientific community that head injuries resulting from contact sports, including football, soccer, boxing, ice hockey and others, can have devastating long-term effects.[1] Among the consequences of repeated head injuries are headache, dizziness, difficulty concentrating or completing tasks, and in some cases, increased risk of depression and suicide.[2] Children and teenagers are especially susceptible to concussion-related injuries, because their brains lack the coating and insulation of adult brains and their heads are relatively heavy, and necks weak, compared to adults.[3] Thus, children are at risk of sustaining more serious brain injuries than adults when exposed to the same amount of force. According to the CDC, the number of TBI-related emergency department visits among youth doubled from 2002 to 2010, from approximately 500 to 1,000 per 100,000 people.[4] Further, female athletes appear to be more susceptible to sustaining concussions than males.[5]~~

~~To address this issue, all states have now implemented some form of concussion and RTP legislation. The National Center for Injury Prevention and Control (NCIPC) conducted a case study on two states that were early implementers of these laws, Washington and Massachusetts, to evaluate differences in their laws and approaches to addressing youth sports-related injuries.[6]~~

~~Washington became the first state to implement a concussion law with the passage of the "Zackery Lystedt Law" in May 2009.[7] This law mandates that~~

~~youths suspected of having sustained a head injury or concussion should be removed from competition, and returned to play *only* after an evaluation and written medical clearance from a "licensed health care provider* trained in the evaluation and management of concussion."[8] The law requires individual school districts to develop information to educate youth athletes, their parents and coaches about the nature and risk of concussions, but it does not provide any specific requirements for the content of those guidelines. The law does not require any coach training, and students are not required to complete concussion history forms.~~

~~Massachusetts' law, by contrast, requires stakeholder groups including parents, coaches, trainers, school athletic directors and school-employed physicians and nurses to participate in an athletic head injury safety training program developed by the Department of Public Health.[9] It directs the Department to utilize materials from the Centers for Disease Control and Prevention to create the program, which shall include (1) current training in recognizing the symptoms of concussions and~~

~~(2) providing students who participate in athletic activities a summary of the medical protocol for recognizing concussion symptoms, a protocol for post-concussion participation in athletics, and the short- and long-term consequences of concussions. It requires schools to implement an RTP protocol containing 17 specific items including procedures for medical review of all concussion history forms and plans for gradual RTP following injury. It also mandates that schools establish their own RTP protocol implementation teams. The law requires students to provide information about their concussion and head injury history at the start of each sports season on a form that must be signed by the student and their parent or guardian and forwarded to their coach(es). A student who becomes unconscious or is suspected of having suffered a concussion must be~~

~~[1] McCrory, Paul, Meeuwisse, Willem H., Aubry, Mark, et al. "Consensus Statement on Concussion in Sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012." *British Journal of Sports Medicine*, 2013;47:250-258. Available at: http://bjsm.bmj.com/content/47/5/250.full~~

~~[2] No author. "Long-term Effects of Brain Injuries." *Weill Cornell*, no date. Available at: http://weillcornellconcussion.org/about-concussions/long-term-effects-brain-injuries.~~

~~[3] No author. "Parents Vigilance Can Head Off Kids' Concussion Risk." *USA Today*, Sept. 29, 2012. Available at: http://www.usatoday.com/story/news/nation/2012/09/29/concussion-kids-cantu/1581173/.~~

~~[4] No author. "Rates of TBI-related Emergency Department Visits by Age Group — United States, 2001–2010." *Centers for Disease Control and Prevention*, no date. Available at: http://www.cdc.gov/traumaticbraininjury/data/rates_ed_byage.html.~~

[5] Franks, R. Robert. "Why are Concussions Worse in Females? " *Philly.com*, Apr. 12, 2013. http://www.philly.com/philly/blogs/sportsdoc/Why-are-concussions-worse-in-females.html.

[6] No author. "Implementing RTP: Learning from the Experiences of Early Implementers." *National Center for Injury Prevention and Control*, no date. Available at: http://www.cdc.gov/headsup/pdfs/policy/rtp_implementation-a.pdf.

[7] No author. "Youth Sports—Concussion and Head Injury Guidelines." Revised Code of Washington 28A.600.190 (2009). Available at: http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.600.190.

[8] *Id.*

[9] No author. "Interscholastic Athletic Head Injury Safety Training Program." Massachusetts General Laws 111 §222 (2010). Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section222.

~~* Licensed Health Care Provider is undefined by the law, and may be a volunteer removed from practice or competition and not returned to the practice or competition during which the concussion or suspected concussion occurred. The student may only return to subsequent athletic activities with the written clearance of a physician, neuropsychologist, certified athletic trainer or other "appropriately trained or licensed health care professional as determined by the Department of Public Health."~~

~~Numerous state laws in addition to Massachusetts' include athletic trainers and nurses among the "clearing provider types" who may allow a youth to return to athletic activity following a concussion. Forty-nine states (with the exception of California) license and regulate athletic trainers, and all require that certified athletic trainers work within their state practice act under the direction of a physician. All forty-nine states recognize certification by the National Athletic Trainers' Association, which will soon increase the minimum education required for certification from a bachelor's degree to a master's degree from an accredited professional athletic training education program.[10] Graduates must then pass a comprehensive examination, and meet ongoing continuing education requirements. Education programs include training in the identification of signs, symptoms, interventions and RTP criteria for brain injury including concussion, but continuing education requirements vary widely (some states require concussion management as a part of these continuing education requirements, while others do not).[11, 12, 13]~~

~~While all states license and regulate nurses, nursing education varies more widely and concussion education is not mandatory. The National Association of School Nurses (NASN) recommends a four-year bachelor's degree and registered nurse (RN) certification as the minimum standard for a school nurse.[14] The NASN has issued a position statement on the importance of the school nurse on the concussion management team; however, the RN examination does not include concussion among the list of topics and not all states require continuing education for nurses.[15, 16] As athletic trainers and school nurses are frequently on the front lines of youth concussion evaluation and management, more robust state education and training requirements are needed to ensure that these health care professionals receive current, evidence-based training in this area, particularly when these providers are listed among the state's "clearing provider types."~~

~~Washington and Massachusetts' laws illustrate the wide variation in approaches that states have taken to attempt to address concussion among student athletes, and while all 50 states now possess similar laws, these laws differ significantly in their provisions. Several physician specialty organizations have examined this issue, and published position statements which include evidence- based guidance for states.~~

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[10] No author. "After 2.5 Years of Diligent Analysis, Leaders of the Key Athletic Training Organizations Have Decided to Change the AT Degree Level to a Master's." *AT Strategic Alliance*, May 20, 2015. Available at: http://atstrategicalliance.org/statements/strategic-alliance-degree-statement.

[11] No author. "Athletic training education competencies (5th edition)." *National athletic trainers' association*, released 2011. Available at: https://www.nata.org/sites/default/files/competencies_5th_edition.pdf.

[12] No author. "Continuing education requirements for athletic trainers." *Texas department of licensing and regulation*, no date. Available at: https://www.tdlr.texas.gov/at/atce.htm#renew.

[13] No author. "Current rules and regulations." *Wyoming athletic training board*, april 16, 2020. Available at: https://rules.wyo.gov/search.aspx?agency=065&program=0001.

[14] No author. "Education, Licensure, and Certification of School Nurses: Position Statement." National Association of School Nurses, Jan. 2012. Available at: https://www.nasn.org/advocacy/professional-practice-documents/position-statements/ps-education.

[15] No author. "NCLEX-rn® examination." *national council of state boards of nursing*, effective April 2013. available at: https://www.ncsbn.org/2013_nclex_rn_test_plan.pdf.

[16] No author. "state ce requirements for licensure." *medscape*, march 29, 2021. available at: https://www.medscape.org/public/nursecestaterequirements.

~~The American Osteopathic Academy of Sports Medicine (AOASM), as a contributing author on the 2013 paper *Concussion and the Team Physician: A Consensus Statement (TPCC)*, which is still current, advocated for on-field and sideline protocols such as neurological assessments and a plan for post-injury follow-up, as well as post-game-day evaluation and treatment.[17] AOASM, via the *TPCC*, urged guidelines that encourage individualized RTP decisions not based on a rigid timeline, with the physician ultimately bearing responsibility for making the decision. The paper also advocates that treating physicians should understand the complications of concussion, including that cumulative concussions may increase subsequent risk for concussion, and other neurological and physical symptoms. Physicians should also understand prevention principles, including helmet use and the utility of educating athletes, parents and coaches about concussion risks in advance.~~

~~The Centers for Disease Control and prevention (CDC) published guidelines on the diagnosis and management of mild traumatic brain injury among children in 2018.[18] "recommendations from the CDC pediatric TBI guidelines include:~~

1. ~~Do not routinely image patients to diagnose TBI.~~
2. ~~Use validated, age-appropriate symptom scales to diagnose TBI.~~
3. ~~Assess evidence-based risk factors for prolonged recovery.~~
4. ~~Provide patients with instructions on return to activity customized to their symptoms.~~
5. ~~Counsel patients to return gradually to non-sports activities after no more than 2-3 days of rest."~~

~~The CDC has also developed an educational program called "heads up: concussion in youth sports."[19]~~

~~The American Academy of Neurology (AAN) has a position statement on sports concussion (2020) called concussion policy for youth and high school sports.[20] the AAN supports educational resources such as the CDC'S heads up: concussion in youth sports online training course for coaches and parents and processes to confirm that the education is understood by parents and athletes. The AAN supports removal from participation for any athlete who is exhibiting symptoms or signs of a concussion until they are evaluated by a qualified healthcare provider properly trained in the assessment and management of concussion, such as a neurologist and as defined by state law. AAN recommends that student athletes should not return to athletic competition until the signs and symptoms of concussion have resolved and have been cleared by a qualified healthcare professional trained in the management of concussion, such as a neurologist. Student athletes should return to full academic participation before returning to competition.~~

[17] American College of Sports Medicine, American Academy of Famly Physicians, American Academy of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, And American Osteopathic Academy Of Sports Medicine. "Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement." 2013. Available at: https://cdn.ymaws.com/www.aoasm.org/resource/resmgr/PositionPapers/ConcussionandtheTeamPhysicia.pdfhttp://www.aoasm.org/default/assets/File/ConcussionandtheTeamPhysician.pdf.

[18] Centers for Disease Control and Prevention Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children Jama Pediatr. 2018 November 01; 172(11): e182853. doi:10.1001/jamapediatrics.2018.2853

[19] no author. "heads up to youth sports." *centers for disease control and prevention*, no date. available at https://www.cdc.gov/headsup/youthsports/index.html.

[20] AAN position: sports concussion 2020. available at https://www.aan.com/policy-and-guidelines/policy/position-statements/sports-concussion.

~~The American Medical Society for Sports Medicine (AMSSM) recently published an update to their 2013 position statement on concussion in sport in 2019.[21] AMSSM recommends that any athlete suspected of having a concussion be removed from the activity and assessed by a licensed healthcare provider trained in the evaluation and management of concussions "reasons for immediate removal and prompt evaluation include loss of consciousness (LOC), impact seizure, tonic posturing, gross motor instability, confusion, or amnesia. Any of these reported or observed signs should result in removal from practice or competition for at least the rest of the day." Since concussions can cause changes in attention, learning, and short-term memory that make learning difficult, return to learn should be coordinated with school personnel to quickly implement a school support plan without delay. AMSSM recommends that "concussion-related symptoms and signs should be resolved before returning to sport. A return-to-play progression involves a gradual, stepwise increase in physical demands and sport-specific activities without return of symptoms before the final introduction of exposure to contact."~~

~~The American Academy of Pediatrics (AAP) updated their clinical report on sport-related concussion in children and adolescents in 2018.[22] AAP recommends that "testing after a sport-related concussion should be performed and conducted by providers who have been trained in the proper administration and interpretation of the tests." All athletes with a suspected concussion should be immediately removed from play. They should not return to full sports participation until they have completed a return-to-sport progression without a return of concussion symptoms. Health care providers should be aware of their state's laws regarding return to play after a concussion.~~

~~[21] HARMON KG, CLUGSTON JR, DEC K, ET AL. AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE POSITION STATEMENT ON CONCUSSION IN SPORT. BRITISH JOURNAL OF SPORTS MEDICINE. 2019; 53:213-225. AVAILABLE AT HTTPS://BJSM.BMJ.COM/CONTENT/53/4/213.~~

~~[22] HALSTEAD ME, WALTER KD, MOFFATT K. SPORT-RELATED CONCUSSION IN CHILDREN AND ADOLESCENTS. PEDIATRICS. 2018; 142(6):e20183074.~~

~~As the above position statements demonstrate, there is a need for a stronger, unified voice from the medical community in order to provide state legislatures with the best tools and up-to-date guidance as they work to combat this public health concern. The AOA believes that emphasizing the physician-led, team-based model of care, where licensed health care providers at all levels possess current education and training in concussion management, will ensure that medical professionals with comprehensive knowledge of scientific evidence and advancements are appropriately involved in patient care.~~

~~AOA Policy Development~~

~~Strong evidence of the serious, negative long-term health effects of concussions underscores the need to create policy in this AREA to help guide osteopathic advocacy in response to current and proposed state legislation. Unified, evidence-based advocacy from medical groups, including the AOA, will benefit states as they update their concussion and RTP laws, which currently vary widely.~~ The AOA adopts the following policy statements as its official position on concussion, **RETURN-TO-PLAY (**RTP**)** and **RETURN-TO-LEARN (**RTL**)** and encourages states, as well as schools, sports clubs and professional leagues to develop official rules that promote education and prevention of **TRAUMATIC BRAIN INJURIES (**TBIs**)** by incorporating these tenets:

1. **Parent and Student Education.** The AOA believes that educating students, parents and guardians about the nature, symptoms, risks and short- and long-term health effects of concussions and **TBIS** ~~traumatic brain injuries~~ will improve student safety by increasing awareness of concussion warning signs and allowing for early treatment. This has been shown to decrease the risk of subsequent injuries during recovery and improve long-term outcomes. Education should also include clarification of the RTP and RTL processes. The AOA believes that all schools and youth athletic organizations should disseminate evidence-based teaching tools such as those issued by the Centers for Disease Control (CDC), **NATIONAL CENTER FOR** Sports Safety ~~International~~ (**NCSS**~~SSI~~), certain state members of the Brain Injury Alliance (BIA) or other nationally recognized health or medical organizations to students, parents and guardians prior to the start of every school year or athletic season.~~23~~[1,2]

2. **Parent and Student Signature.** The AOA supports requiring signatures from parents/ guardians and students on an information sheet acknowledging that they have received the aforementioned education and been made aware of the risks of concussion inherent in athletic activities, and understand appropriate steps for concussion evaluation and management, prior to every school year or athletic season.

3. **Coach/Official Training.** The AOA encourages states to adopt mandatory annual training for coaches, athletic directors, school nurses and other school and youth sports officials based upon materials published by the CDC, **NCSS**~~SSI~~, BIA or other nationally recognized health or medical organizations.[3]

Training should emphasize prevention as well as the need for early identification of concussions and improve**D** treatment and management strategies, with an emphasis on prohibiting same-day return-to-play for concussed athletes in all circumstances and requiring clearance from a physician (as defined elsewhere in AOA policy) prior to allowing a concussed athlete to return to athletic activity.

4. **Removal and Return-to-Play.** The AOA believes that it is vital that youth suspected of having sustained a concussion be removed from practice or competition immediately, and examined by a member of the physician-led team who is a licensed health care provider (LHCP) with documentation reflecting current concussion training, whose scope of practice includes the evaluation and management of concussions. The AOA supports the use of baseline testing conducted by a trained health care professional prior to the start of each athletic season or school year to assess a youth's balance and cognitive function as well as the presence of any concussion symptoms.[~~25~~] At the time of a suspected concussion, results from this baseline testing can be compared to results from post-concussive testing again assessing balance and cognition. If the provider suspects a possible concussion, the athlete should be evaluated by a physician immediately. There should be no same-day return-to-play for athletes diagnosed with a concussion, and no subsequent return-to-play without written clearance by a physician with documented current concussion training. For students diagnosed with a concussion, examining physicians should work with parents/guardians, coaches, athletic trainers and other stakeholders on ongoing concussion management and gradual RTP and RTL for the student athlete. The examining physician should also coordinate with a multi-disciplinary team that may include physical therapists, occupational therapists, neuropsychologists, cognitive rehabilitation specialists and certified athletic trainers, among others, as the patient recovers from suffering from a concussion.

5. **Clearing Provider Type.** The AOA believes a LHCP member of the physician-led team who is trained in the evaluation and management of concussions, such as a certified athletic trainer or school nurse, may conduct a sideline assessment. If a youth's sideline assessment indicates a possible concussion, the youth must be evaluated by an allopathic or osteopathic physician with expertise in concussion management, who shall establish a clinical diagnosis. Proof of this expertise may include concussion training in sports medicine fellowship, or documentation of course completion in a recognized concussion course such as one from the CDC or **NCSS**~~SSI~~. Physicians possess the most comprehensive education and training of any health care provider, which enables them to recognize the variable and often subtle signs of concussion. The evaluating physician shall create a treatment plan and work with other members of the physician-led team to implement it, and the youth may only return to athletic activity with written clearance from the evaluating physician.

6. **Return-to-Learn.** The AOA recommends that the evaluating physician work

with school officials to implement an RTL protocol for students following a concussion. The physician may adjust the protocol with school officials as the patient's symptoms evolve and gradually improve, usually within one to three weeks after the injury. Each concussion is an individualized entity, however, and as such should be treated by the physician on an individualized basis with the physician making the deciding determination regarding RTL. The physician should communicate the importance of cognitive rest following a concussion to parents and school officials, emphasizing that a student may require a lighter workload, exemption from classes that appear to exacerbate concussion symptoms, and/or testing extensions until symptoms improve or disappear.

[~~23~~1] NO AUTHOR. "HEADS UP ~~TO YOUTH SPORTS: PARENTS~~." CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT **HTTPS://WWW.CDC.GOV/HEADS-UP/INDEX.HTML**.

[2] **PATRICIOS JS, SCHNEIDER KJ, DVORAK J, ET AL CONSENSUS STATEMENT ON CONCUSSION IN SPORT: THE 6TH INTERNATIONAL CONFERENCE ON CONCUSSION IN SPORT–AMSTERDAM, OCTOBER 2022BRITISH JOURNAL OF SPORTS MEDICINE 2023;57:695-711.**

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[24] NO AUTHOR. "HEADS UP TO SCHOOLS: TEACHERS, COUNSELORS, AND SCHOOL PROFESSIONALS." CENTERS FOR DISEASE CONTROL AND PREVENTION, **JANUARY 7, 2025**. AVAILABLE AT **HTTPS://WWW.CDC.GOV/HEADS-UP/TRAINING/SCHOOL-PROFESSIONALS.HTML** ·

~~[25] NO AUTHOR. "FAQS ABOUT BASELINE TESTING." CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/BASICS/BASELINE_TESTING.HTML.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Referred to BORPH___

DATE: _____July 18, 2026_____

SUBJECT: RECOMMENDATIONS FOR IMPROVING PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES - SOURCE: H439-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association will work toward improving rural physician supply and monitor the potential for nationwide implementation of the following recommendations:
Recommendations for Improving Physician Supply in Rural Underserved America

1. Support Practice Incentive / Benefit and Other Recruitment Programs
   - Federal and state rural practice incentive/benefit programs should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.
   - Physicians, medical students and residents should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, and application forms readily accessible and user friendly.
   - Area Health Education Centers need to be adequately funded through federal and state funding sources to: a) provide recruitment and retention services in rural areas; b) assist in locating reasonable housing for student and resident preceptorships; and c) provide practice support services to providers and communities, as referenced in other principles listed herein.
   - Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time practice in rural, underserved communities located within a reasonable distance of their primary practice site. ~~Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to augment their secondary practices.~~

- Physicians are urged to adopt telemedicine services in their practices as outreach to patients in underserved communities, within the scope of their licensure and receive appropriate payment, when applicable and purposeful in meeting health care needs.
- Physicians should be informed of the potential impact of the employed-practice model on their scope of practice before signing hospital employment contracts, including resources provided

2. Support Promotion of Rural Practice
    - Information on rural physician shortage areas should be readily available through coordinated websites of state agencies, area health education centers, practicing physicians, medical students, and residents seeking rural practice opportunities, ~~as well as to~~ **AND** underserved communities. To assist physicians in selecting practice opportunities, comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics {percentage child-bearing (for obstetrical needs), aged (for adult medicine-needs), etc.}, insurance status, supply of physicians and other health professionals, degree of physician shortage, socioeconomic status, as well as educational and recreational opportunities.
    - Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly funded locum tenens programs, tax credits, loan repayment opportunities, etc. Further, they should be informed of the health care infrastructure in their area, including systems of care such as federally qualified health centers, indigent care clinics, rural health clinics, hospitals (including Critical Access Hospitals), long term care facilities, emergency medical services, and hospice. They should also be informed about the availability of other health providers and services such as nursing, pharmacies, therapists, medical equipment, etc.
    - County medical societies, hospitals, and other health facilities (when available) should facilitate communication between new physicians and physicians with established practices in the community to help new physicians be better prepared for entering practice in an underserved community.
    - Physicians ~~who receive benefits through state loan repayment programs~~ should ~~also~~ be informed by state authorities of specialized practice support services, including practice start-up, billing, locum tenens, professional development and CME, staff recruitment and training, telemedicine, etc.
    - Physician practice re-entry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities. Further, when physicians allow their medical license to lapse, they should be informed by the relevant state licensing authority of the potential

obstacles to re-licensure should they decide to re-enter practice following an extended absence from practice.

- Outreach should be provided by state authorities, to physicians without a full-time medical practice to promote volunteer work or part-time practice at clinics in underserved communities.
- Federal and state policies that impact rural medicine, e.g., payment policies, should be monitored for their potential impact on the viability of rural practices. The American Osteopathic Association should continue to advocate for payment parity between Medicaid and Medicare.
- Physicians in practice and those in training programs should be informed by state authorities, of special state medical licensing provisions applicable for practice in rural, underserved areas.

3. Support for Preparing Physicians for Rural Practice
    - Medical schools and residency programs should be incentivized by state authorities to develop and adequately support rural education and training tracks. Examples:
        a. Bonuses for medical students or residents who participate in rural training tracks; and
        b. Additional state formula funding for medical student and residents in rural training tracks.
    - Appropriate criteria should be used by Post-Doctoral training programs for identifying student-applicants and residents most likely to be successful in rural practice.
    - To measure outcomes, assessments should be conducted to identify whether students and residents who participate in rural educational or training tracks are retained in the state for practice after completion of training.
    - Area health education centers should offer opportunities for community physicians who volunteer as preceptors to access information and knowledge of practices that contribute to a positive clinical learning experience. Further, educational institutions should provide adequate support and incentives to recruit and retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts. This will become increasingly important as community physicians face continuing pressures to increase productivity.
    - Medicare GME policies should allow for residency program-specific support rather than institutional support for resident training to allow GME funding to follow the resident throughout their training.
    - The Accreditation Council for Graduate Medical Education should consider allowing more flexibility for residents to travel away from their core programs to rural areas in order to achieve established training goals for minimum numbers of procedures or encounters.
    - The impact of changes in resident duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution based residency programs.

126 4. Support for Rural Access to Care
127 • Develop solutions for providing after-hours care for patients of federally-
128 funded health clinics requiring urgent or emergent care to prevent undue
129 burdens on community physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PHYSICIAN PROFILES - SOURCE: H442-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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

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

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

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

Policy Statement

It is the American Osteopathic Association's position that state medical or osteopathic boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to collect, maintain, and disseminate physician profile information to the public; supports the position that any legislation or regulations which mandate the release of physician profile information provide funding for the creation and maintenance of the profiling system without added expense to the physician; supports the position that only physician profiles that incorporate all of the following five principles (fairness, relevancy, timeliness, accuracy, and reliability) should be released to the public; opposes the inclusion of medical malpractice histories within physician profiles due to their susceptibility to misinterpretation and inherently prejudicial effect; supports the position that before physician profiles are released to the public, every physician has the opportunity to verify the accuracy of the information and to contest any incorrect information before it is disseminated to the public; and believes that the state licensing boards must include an appeal mechanism in their regulations that a physician may pursue if any information in ~~his or her~~ **THE PHYSICIAN'S** profile is inaccurate, and institute appropriate corrections.

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: THE FRAMEWORK CONVENTION ON TOBACCO CONTROL - SOURCE: H421-A/21

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

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

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

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

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

8 Policy Statement

9 The American Osteopathic Association support the efforts of international health
10 agencies in eliminating the use of tobacco products, smokeless tobacco products,
11 and vaporizing products from their societies, and encourage the United States to
12 use its experience in tobacco products control, smokeless tobacco products control,
13 and vaporizing products control to help developing countries with this health issue
14 and support the public health initiatives of the World Health Organization for
15 tobacco products control, smokeless tobacco products control, and vaporizing
16 products control by promoting the Framework Convention on Tobacco Control
17 (FCTC) and urge the President of the United States to submit the framework
18 convention on tobacco products control, smokeless tobacco products control, and
19 vaporizing products control to the United States Senate for ratification.

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: AUTONOMY OF OSTEOPATHIC MEDICINE
-SOURCE: H414-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 ~~Policy of the~~ **THE** American Osteopathic Association states that the osteopathic
8 profession, in the interest of providing the best possible healthcare to the public,
9 shall maintain its status as a complete and distinct philosophy of medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: 1959; 1965 Reaffirmed, 1974 Reaffirmed; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1996 Reaffirmed, 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: CHELATION THERAPY- SOURCE: H406-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association does not endorse chelation therapy as
8 useful treatment for other than its current Food and Drug Administration approved
9 use, and as medical evidence supports.

Background Information: Provided by AOA Staff
Current AOA Policy: 1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Referred; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: MINORITY HEALTH AND OSTEOPATHIC MEDICAL EDUCATION -SOURCE: H416-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

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

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

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

Policy Statement

The American Osteopathic Association encourages the development of internal programs to address the disproportionate incidence of preventable diseases in minority populations, the impaired access to quality healthcare in minority communities, and the under representation of minority populations in osteopathic medicine; and will work with the American Association of Colleges of Osteopathic Medicine (AACOM), and towards eliminating such disparities within its osteopathic medical educational processes, and **WILL SUPPORT** collaborat~~e~~**ION** with federal/state governments, academia, and the healthcare industry to develop programs to eliminate medical and academic disparities between minority and non-minority groups in the US.

Background Information: Provided by AOA Staff
Current AOA Policy: 1996; 2001 Reaffirmed; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Referred to BORPH___

DATE: _____July 18, 2026_____

SUBJECT: OBESITY IN CHILDREN - SOURCE: H417-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) supports programs which advocate
8 physical fitness and good nutrition for children and families.

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: FITNESS, SPORTS AND NUTRITION -SOURCE: H418-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) supports **THE GOALS OF** the
8 President's Council on Sports, Fitness and Nutrition **AND OTHER EVIDENCE-**
9 **BASED RECOMMENDATIONS FROM NATIONAL ORGANIZATIONS**
10 **REGARDING SPORTS, FITNESS AND NUTRITION.**

Background Information: Provided by AOA Staff
Current AOA Policy: 1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PLASTIC BEVERAGE AND FOOD CONTAINER RECYCLING ACT- SOURCE: H419-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) supports conservational recycling
8 and encourages that materials are made from recycled products.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990, 1995 Reaffirmed as Amended; 2000 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: CHILDHOOD AND TEENAGE SEXUAL EXPOSURE - SOURCE: H420-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy and determined that it is current; now, therefore be it

RESOLVED, that the BORPH recommends that the following policy be REAFFIRMED.

Policy Statement

The American Osteopathic Association: (1) encourages osteopathic physicians to provide anticipatory guidance to minor children **PARENTS, AND/OR CAREGIVERS** about the risks of sexual exposure and sexually-transmitted **INFECTIONS** ~~diseases, and provide this same guidance to their parents and/or caregivers~~; (2) encourages osteopathic physicians to support the development of curriculum by local, state and national educational organizations that will lead to the prevention of ~~unwanted~~ **UNINTENDED** pregnancy and **SEXUALLY TRANSMITTED** ~~transmission of~~ **INFECTIONS** ~~disease~~, using medically appropriate measures, ~~preferably~~ **INCLUDING** abstinence and avoidance of high risk sexual behavior; and (3) support public education efforts to prevent ~~unwanted~~ **UNINTENDED** pregnancy and sexually transmitted infections.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ~~DAMAGE TO HEARING~~ **INJURY** FROM USE OF **PERSONAL LISTENING DEVICES** ~~HEADPHONES~~
-SOURCE: H422-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy and determined that it is current; now, therefore be it

RESOLVED, that the BORPH recommends that the following policy be REAFFIRMED.

Policy Statement

The American Osteopathic Association (1) supports public education campaigns to increase awareness among children and their parents of the potential risk of noise-induced hearing loss that can occur from listening to ~~headphones~~ **DEVICES** at high volumes for extended periods of time; (2) encourages manufacturers to include information about the hazards of unsafe volume levels on or within product packaging and to recommend implementation of built-in mechanisms that can be enabled to limit a product's decibel output; and (3) encourages osteopathic physicians to actively educate young people and parents about the safety concerns of using **PERSONAL LISTENING DEVICES** ~~headphones~~ and the necessary safeguards to prevent **INJURY.**~~hearing damage.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: DANGERS OF THE "CHOKING GAME"
-SOURCE: H423-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy and determined that it is current; now, therefore be it

RESOLVED, that the BORPH recommends that the following policy be REAFFIRMED.

Policy Statement

The American Osteopathic Association (AOA) supports increasing awareness among parents, educators, counselors and physicians of the risks and warning signs associated with the choking game and of the resources available for educating teens about the dangers of the choking game; and supports the inclusion of information about the dangers of the "choking game" in classroom education and other school-sponsored discussions about drugs and risky behaviors.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_____

DATE: _____July 18, 2026_____

SUBJECT: RESEARCH ON MEDICAL CANNABIS -SOURCE: H424-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) supports well-controlled clinical
8 studies on the use of cannabis, commonly referred to as marijuana, and related
9 cannabinoids for patients who have significant medical conditions for which current
10 evidence suggests possible efficacy; and encourages the National Institutes of
11 Health (NIH) to facilitate the development of well-designed clinical research studies
12 into the medical use of cannabis

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: BLOOD DONORS, PROTECTION FROM DEPLETION OF IRON
-SOURCE: H426-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) encourages blood collection facilities
8 to establish guidelines to identify frequent blood donors, and institute the necessary
9 testing to monitor their iron stores.

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: 5-2-1-0 CAMPAIGN FOR AMERICA'S CHILDREN
-SOURCE: H427-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

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

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

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

8 The American Osteopathic Association (AOA) ~~recommends the continued~~ support**S**
9 ~~of~~ the 5-2-1-0+10 campaign for America's children. 5-2-1-0+10 stands for 5 servings
10 of fruits and vegetables each day, 2 hours or less of recreational screen time per
11 day, 1 hour of physical activity per day, 0 sweetened or sugary drinks, and 10 hours
12 of sleep every night for children.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed as amended; 2021 Reaffirmed as amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 18, 2026_____

SUBJECT: SUPPORT FOR TITLE X FUNDED FAMILY PLANNING SERVICES -SOURCE: H431-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

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

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

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

8 Policy Statement

9 The American Osteopathic Association(AOA) believes that Title X funded family
10 planning services are critical components of public health and primary health care
11 and **SUPPORTS** ~~shall advocate for~~ Title X funded family planning services.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SHACKLING OF PREGNANT INMATES - SOURCE: H432-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association acknowledges the potential harm shackling
8 can **INDUCE** ~~cause harm~~ to ~~both~~ the **PREGNANT INMATE** ~~mother~~ and**/OR** fetus,
9 including miscarriage, and premature birth; and supports **THE RESTRICTION OF**
10 **ANY FORM OF SHACKLING, WITH THE EXCEPTION WHEN THE PREGNANT**
11 **INMATE IS IN IMMEDIATE HARM TO SELF OR OTHERS, OR IF A**
12 **SUBSTANTIAL FLIGHT RISK.** ~~restricting the use of any form of shackling on an~~
13 ~~inmate who is pregnant or in labor unless the woman is an immediate and serious~~
14 ~~threat to herself or others or if the woman is a substantial flight risk.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: AFFIRMING THE SCIENTIFIC AND MEDICAL FOUNDATION OF OSTEOPATHIC MANIPULATIVE MEDICINE (OMM) AND OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) -SOURCE: H436-A21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) continues to affirm its position that
8 the scientific and medical foundation of osteopathic manipulative medicine (OMM)
9 and osteopathic manipulative treatment (OMT) is integral to this distinctive practice;
10 and advocates for proper recognition of the scientific and medical foundation of
11 osteopathic manipulative medicine (OMM) and osteopathic manipulative treatment
12 (OMT) to all political bodies, research groups, third party payers, and any other
13 entity that formulates policy on OMM and OMT.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PATIENT CENTERED TREATMENT FOR PAIN MANAGEMENT AND APPROPRIATE USE OF OPIOIDS – SOURCE: H403-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has
3 reviewed the policy and determined that it is current; now, therefore be it

4 RESOLVED, that the BORPH recommends that the following policy be
5 REAFFIRMED.

6 Policy Statement

7 The American Osteopathic Association (AOA) support increased access to
8 evidence-based pharmacotherapy for treatment of chronic pain, with a lens that
9 places value on the functional status of the patient ~~rather than~~ **IN ADDITION TO** the
10 Milligram Morphine Equivalent (MME) of the prescription. The AOA will continue to
11 support risk management in terms of toxicology monitoring, volume prescribed, and
12 the use of the Prescription **DRUG** Monitoring Program **(PDMP)** ~~(PMP)~~ and the AOA
13 will continue to promote ~~referral for~~ patient centered treatment when a SUD is
14 diagnosed.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: MINORITY HEALTH DISPARITIES -Source-H426-A/25

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H426-A25 Minority Health Disparities (SR-SOURCE-H428-A/20) to the 2025 House of Delegates during the sunset review process and recommended that it be reaffirmed; and

WHEREAS, the 2025 House of Delegates referred this policy back to BORPH and requested that BORPH update the policy and provide references; **AND** ~~therefore be it~~

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

~~MINORITY HEALTH DISPARITIES~~

WHEREAS, THE BORPH HAS DETERMINED THAT ~~M~~**m**inority health disparities are influenced by multiple factors and may vary across disease-specific conditions and populations.[1] They refer to measurable differences in health outcomes that adversely affect racial and ethnic minority populations. Contributing factors include barriers in understanding, communication, and effective interaction between clinicians and patients from diverse cultural backgrounds. Cultural competency reflects physicians' ability to understand, communicate with, and effectively engage individuals across diverse cultural contexts, including awareness of their own perspectives and recognition of differences that may influence care.[2] Affected populations include **BUT ARE NOT LIMITED TO** Blacks/African Americans, Hispanics/Latinos, Asians, American Indians/Alaska Natives, and Native Hawaiians/Other Pacific Islanders. These disparities are reflected in measurable differences across major causes of morbidity and mortality.

Although the top causes of death are broadly similar across populations, the rank order varies. The 2023 National Vital Statistics Reports indicate that chronic lower respiratory diseases appear among the top five causes of death for non-Hispanic White populations, whereas diabetes mellitus is more prominent among several minority populations.[3]

According to the Centers for Disease Control and Prevention, the National Center for Health Statistics, and the National Vital Statistics System (2023), age-adjusted mortality rates show variation across major disease categories by race and ethnicity.[4] The following summarizes key disparities identified in the 2023 data.

Cerebrovascular Disease. Non-Hispanic Black (54.1 per 100,000) show notably higher rates, and non-Hispanic Native Hawaiian/Other Pacific Islander populations (38.7 per 100,000) show modestly higher rates, compared with non-Hispanic White (38.0 per 100,000).[4]

Accidents (unintentional injuries). Non-Hispanic American Indian/Alaska Native (79.6 per 100,000) and non-Hispanic Black (78.0 per 100,000) populations show modestly higher rates compared with non-Hispanic White (63.3 per 100,000).[4]

Diabetes mellitus. Non-Hispanic Native Hawaiian/Other Pacific Islander (42.1 per 100,000), non-Hispanic Black (37.9 per 100,000), and non-Hispanic American Indian/Alaska Native (30.6 per 100,000) populations reflect modestly higher rates compared with non-Hispanic White (20.8 per 100,000).[4]

Diseases of the heart and malignant neoplasms. Non-Hispanic Black populations (200.0 and 156.8 per 100,000, respectively) have higher rates compared with non-Hispanic White (163.3 and 144.8 per 100,000). For several other minority populations, rates for these conditions are lower than those observed among non-Hispanic Whites.[4]

While this summary highlights disparities across the five (5) leading causes of death, differences also persist in other important health indicators, including maternal and infant outcomes, cancer screening, immunizations, and mental health conditions.

These findings reinforce that minority health disparities are multifactorial and vary across conditions and populations. Measurable differences in mortality are not confined to a single disease category but span the five (5) leading causes of death. The persistence of these patterns highlights the role of communication, access to care, and broader social and environmental contexts in shaping health outcomes across diverse populations.

~~AOA Policy Statements~~NOW THEREFOR BE IT RESOLVED, THAT THE BUREAU OF OSTEOPATHIC RESEARCH AND PUBLIC HEALTH RECOMMENDS THAT THE FOLLOWING POLICY BE REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) continues to support osteopathic physicians in efforts to address minority health disparities and strengthen cultural competency across the profession.

1. The AOA promotes the education of osteopathic physicians and health care providers on racial and ethnic health care needs, all healthcare disparities, and implicit or explicit biases that may influence clinical decision-making.

2. The AOA supports increased access to care through the evaluation and analysis of medical information, targeting populations who are at greatest risk.

3. The AOA encourages the development of strategies to engage osteopathic physicians within the minority **AND UNDER-REPRESENTED** communities they

serve while integrating community-based resources to better support that population.

4. The AOA supports the inclusion of cultural competency training throughout the continuum of osteopathic education.

5. The AOA supports effective physician–patient communication for underserved minority populations, including translation and other language assistance services.

References

1. Alvidrez, J., Castille , D., Laude-Sharp , M., Rosario , A., & Tabor, D. (2019, January 30). The National Institute on Minority Health and Health Disparities Research Framework. American Journal of Public Health, 5. Retrieved 02 17, 2026, from National Library of Medicine National Center for Biotechnology Information: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304883

2. Flaskerud, PhD, RN, FAAN, J. H. (2009, July 9). Cultural Competence: What is It? Taylor & Francis Online. Retrieved 2026, from Taylor & Francis Online: https://www.tandfonline.com/doi/full/10.1080/01612840600998154?scroll=top&needAccess=true

3. Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2023. National Vital Statistics Reports; vol 74, no 1. Hyattsville, MD: National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/175204

4. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2024 on CDC WONDER Online Database, released in 2026. Data are from the Multiple Cause of Death Files, 2018-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Feb 19, 2026 1:09:06 AM

~~Minority Health Disparities Policy Statement~~

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

~~**POSITION STATEMENT ON MINORITY HEALTH DISPARITIES**~~

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

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

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

~~Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high-quality care.~~

~~Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.~~

~~The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities.~~ **~~REACH GRANTS HAVE BEEN FUNDED THROUGH 2028.~~**

~~The identified Areas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) infectious diseases (i.e., Covid-19, influenza, HIV/Aids); and 6) child and adult immunizations;~~ **~~AND 7).~~** ~~In addition, serious disparities exist in the provision of care for mental health problems, substance abuse and suicide prevention.~~

~~The American Osteopathic Association calls for~~ **~~SUPPORTS~~** ~~the following actions to be taken to address minority health disparities and to improve cultural competency of its physician members:~~

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

2. ~~The promotion of education regarding implicit or explicit biases among healthcare professionals that may play a role in clinical decision-making;~~

3. ~~The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk;~~
4. ~~The identification of new methods to involve physician members in the communities in which they serve;~~
5. ~~The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government;~~
6. ~~The inclusion of cultural competency training throughout the continuum of osteopathic education;~~
7. ~~The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties;~~
8. ~~The development of approaches to encourage all physicians to provide care to underserved minority populations.~~
9. ~~The adoption of strategies to assist physicians to effectively communicate with their patients, addressing translation and other barriers to patient understanding.~~

~~Source: H428-A/20~~

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Adopted; 2015; 2020 Adopted as Amended; 2025 Referred

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS -SOURCE: H320-A24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, three vaccine policies were referred to BORPH by the 2025 House of Delegates with the request that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve interim policies if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to three referred and four current AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H320-A/24 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

Policy Statement

INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS

The American Osteopathic Association (AOA) strongly supports and recommends influenza vaccinations for all health care workers and educators according to **EVIDENCE-BASED IMMUNIZATION STRATEGIES FOR VACCINE PREVENTABLE DISEASES**. ~~current guidelines of the Centers for Disease Control and Prevention (CDCP).~~

Background Information: Provided by AOA Staff

Current AOA Policy: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted; Interim Policy BOT 12/9/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: MENINGOCOCCAL VACCINE RECOMMENDATIONS – SOURCE: H411-A22

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, three vaccine policies were referred to BORPH by the 2025 House of Delegates with the request that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve interim policies if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to three referred and four current AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H411-A/22 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

MENINGOCOCCAL VACCINE RECOMMENDATIONS

The American Osteopathic Association supports the administration of meningococcal vaccines **ACCORDING TO BEST AVAILABLE EVIDENCE-BASED MEDICINE PRINCIPLES** ~~as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP);~~ and urges adequate public and private insurance coverage for vaccines. ~~in patient populations as recommended by the ACIP.~~

Background Information: Provided by AOA Staff

Current AOA Policy: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed; Interim Policy BOT 12/9/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: ____July 18, 2026_____

SUBJECT: IMMUNIZATIONS – SOURCE: H414-A/23

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, three vaccine policies were referred to BORPH by the 2025 House of Delegates with the request that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve interim policies if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to three referred and four current AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H414-A/23 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

IMMUNIZATIONS

The American Osteopathic Association (AOA) supports ~~the Centers for Disease Control and Prevention in its~~ efforts to achieve a high compliance rate among infants, children and adults by encouraging osteopathic physicians to immunize patients of all ages when appropriate~~; supports the HHS National Vaccine Implementation Plan;~~ **PROMOTES EVIDENCE-BASED IMMUNIZATION STRATEGIES FOR VACCINE PREVENTABLE DISEASES** and encourages third-party payers to pay for vaccines and their administration.

Background Information: Provided by AOA Staff

Current AOA Policy: 1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted; 12/9/2025 BOT Interim Policy

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: ____July 18, 2026_____

SUBJECT: EDUCATION ON HUMAN PAPILLOMAVIRUS VACCINATION
-SOURCE: H421-A/22

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, three vaccine policies were referred to BORPH by the 2025 House of Delegates with the request that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve interim policies if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to three referred and four current AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H421-A/22 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

EDUCATION ON HUMAN PAPILLOMAVIRUS VACCINATION

The American Osteopathic Association supports efforts to educate the general public regarding the Human Papilloma Virus (HPV) and its relationship to certain cancers and genital warts; urges osteopathic physicians to educate themselves and their patients regarding the availability and benefits of administering HPV vaccine to patients **ACCORDING TO BEST AVAILABLE EVIDENCE-BASED MEDICINE PRINCIPLES** ~~as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP);~~ urges adequate public and private insurance coverage for HPV vaccines; ~~in~~ **~~APPROPRIATE~~** ~~patient populations~~ ~~as recommended by the Advisory Committee on Immunization Practices (ACIP);~~ and supports ongoing research to determine whether HPV vaccine is beneficial to other groups in the general population.

Background Information: Provided by AOA Staff

Current AOA Policy: 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed; Interim Policy BOT 12/9/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 18, 2026_____

SUBJECT: PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS -SOURCE-H410-A/25

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H-410-A/25 Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (SR-Source-H402-A/20) to the 2025 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2025 House of Delegates referred this policy back to BORPH and requested that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve an interim policy if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H-410-A/25 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS

The American Osteopathic Association (AOA) supports the widespread use and high compliance rate of **VACCINES** ~~the Health and Human Services National Vaccine Implementation Plan~~ for infants, children, and adults through education of the public using media and marketing tools available to

30 its organization.
31
32 **RESOLVED THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA)**
33 **SUPPORTS VACCINE RECOMMENDATIONS FROM THE AMERICAN**
34 **ACADEMY OF PEDIATRICS (AAP) FOR INFANTS AND CHILDREN, AND**
35 **THE INFECTIOUS DISEASE SOCIETY OF AMERICA (IDSA) FOR**
36 **ADULTS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed; 2025 Referred; Interim Policy BOT 12/9/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT FOR **EVIDENCE BASED VACCINATION PRACTICES** ~~THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS~~ -SOURCE-H411-A/25

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H-411-A/25 Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (SR-Source-H403-A/20) to the 2025 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2025 House of Delegates referred this policy back to BORPH and requested that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve an interim policy if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H-411-A/25 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

SUPPORT FOR **EVIDENCE BASED VACCINATION PRACTICES** ~~THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS~~

The American Osteopathic Association (AOA) encourages osteopathic physicians **TO** consider the vaccination history as an integral part of their patient's health record and should counsel their patients on appropriate

30 vaccinations for their age and health conditions. Osteopathic physicians
31 should take all reasonable steps to ensure their patients of all ages are fully
32 immunized against vaccine preventable illnesses and make vaccine
33 recommendations to their patients according to **BEST AVAILABLE**
34 **EVIDENCE-BASED MEDICINE PRINCIPLES.** ~~the recommendations of the~~
35 ~~Advisory Committee on Immunization Practices (ACIP) and published in the~~
36 ~~Morbidity and Mortality Weekly Report (MMWR) and should not advocate~~
37 ~~alternative schedules.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed; 2025 Referred; 12/9/2025 BOT Interim Policy

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: **SUPPORT OF** VACCINES FOR CHILDREN ~~PROGRAM~~
-SOURCE-H413-A/25

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H413-A/25 Vaccines for Children Program to the 2025 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2025 House of Delegates referred this policy back to BORPH and requested that BORPH monitor the oversight of vaccine policy by CDC/ACIP and request that the Board of Trustees approve an interim policy if significant changes occur in CDC/ACIP vaccine policies which no longer align with AOA vaccine policies; and

WHEREAS, BORPH discussed concerns about the decision making process behind revisions to the COVID and the MMRV vaccines discussed at the Sept 18-19, 2025 ACIP meeting; and

WHEREAS, BORPH determined that CDC/ACIP actions warranted revisions to AOA vaccine policies to remove language supporting CDC/ACIP vaccine recommendations and insert language stating the AOA's support of best available evidence-based medicine principles; and

WHEREAS, H-411-A/25 with the amended language was submitted by BORPH and approved by the AOA Board of Trustees at their December 9, 2025 meeting as an interim policy to be submitted to the July 2026 HOD; and

WHEREAS, CDC/ACIP continues to revise vaccine recommendations that do not support best available evidence-based medicine principles now, therefore be it

RESOLVED, that the interim policy be approved:

SUPPORT OF VACCINES FOR CHILDREN ~~PROGRAM~~

The American Osteopathic Association (AOA) supports ~~the V~~ vaccines for ~~C~~ children ~~(VFC) Program~~ to include all ~~Advisory Committee on Immunizations Practices (ACIP)~~ age-appropriate vaccines **IN ACCORDANCE WITH THE BEST AVAILABLE EVIDENCE-BASED MEDICINE**. ~~for all underinsured children, in keeping with the original goals of the program.~~ **AND BE IT FURTHER**
RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION

31 **(AOA) OPPOSE THE ADOPTION, ENDORSEMENT, OR**
32 **IMPLEMENTATION OF ANY CHILDHOOD IMMUNIZATION SCHEDULE**
33 **THAT IS NOT FIRMLY BASED ON EVIDENCE-BASED RESEARCH FROM**
34 **TRUSTED, VALIDATED, AND UNBIASED SCIENTIFIC SOURCES.**
35

Background Information: Provided by AOA Staff

Current AOA Policy: 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed; 2025 Referred; Interim Policy BOT 12/9/2025

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 18, 2026_____

SUBJECT: PREVENTION OF CHILD INJURY ON PLAYGROUNDS – SLIDE SAFETY

SUBMITTED BY: American Academy of Osteopathy
American Osteopathic Academy of Sports Medicine
American College of Osteopathic Pediatricians
American Osteopathic Academy Orthopedics
American Osteopathic College of Physical Medicine and Rehabilitation

REFERRED TO: Committee on Public Affairs

WHEREAS, some of the playground apparatuses that children enjoy are slides; and

WHEREAS, parents, other adults, and older children may at times accompany them on these devices; and

WHEREAS, between 2002 and 2015, an estimated 352,698 children less than 6 years of age were injured on slides in the United States with children between 12-23 months representing the highest percentage[i] [ii]; and

WHEREAS, over one-fifth of all Emergency Department visits for US playground-related injuries are due to slides, and 4.5% of these have required hospitalization

WHEREAS, overall, the affected body part was the lower extremity in 26% of those injured and the most frequent diagnosis was a fracture (36%), which may actually be underestimated due to the occurrence of occult fractures, especially of the tibia; and

WHEREAS, the younger the age of the child, the higher the percentages of injuries involving the lower extremity and children were noted to be on the lap of another person at the time of the injury (both $p < 0.001$); and

WHEREAS, children less than 3 years of age were 12 times more likely to be identified from narratives as being on another person's lap at the time of injury

WHEREAS, the size and weight of adults apparently play a big role in the potential for injury. A young child sliding by themselves is unlikely to get a severe injury to their leg even if the foot catches due to the relatively low forces; and

WHEREAS, it is reasonable to assert that a preventable source of significant injury for children playing on slides is for adults to refrain from accompanying them; be it therefore

26 RESOLVED, that the American Osteopathic Association (AOA) advocate and
27 disseminate the statistics of slide injuries of children under six years old to its
28 members **THAT THE AOA WILL ENCOURAGE MEMBERS TO**
29 **COMMUNICATE SLIDE INJURY STATISTICS AND SAFETY OF**
30 **CHILDREN ON SLIDES TO CAREPERSONS WHEN APPLICABLE**; about
31 safety for ~~children on slides to be communicated to families~~; and be it further

32 RESOLVED, that the AOA also **SUPPORTS** ~~advocates for~~ playground companies
33 and municipalities ~~to~~ place appropriate signage advising of the danger **OF**
34 **SLIDE INJURIES** and advising against adults accompanying children on
35 slides.

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

[i] https://www.eurekalert.org/news-releases/490925

[ii] Jennissen CA, Koos M, Denning G. Playground slide-related injuries in preschool children: increased risk of lower extremity injuries when riding on laps. Inj Epidemiol. 2018 Apr 10;5(Suppl 1):13. doi: 10.1186/s40621-018-0139-x. PMID: 29637487; PMCID: PMC5893512.- abstract - https://pubmed.ncbi.nlm.nih.gov/29637487/ ; full article - https://pmc.ncbi.nlm.nih.gov/articles/PMC5893512/

SUBJECT: ADOPTION OF THE AMERICAN ACADEMY OF PEDIATRICS CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Public Affairs

WHEREAS, the American College of Osteopathic Pediatricians (ACOP) is the recognized representative body for osteopathic pediatricians within the American Osteopathic Association (AOA); and

WHEREAS, the American Academy of Pediatrics (AAP) has developed and annually updates a Childhood and Adolescent Immunization Schedule for individuals under 18 years of age based on decades of rigorous, evidence-based, scientifically validated research; and

WHEREAS, the 2026 AAP Childhood and Adolescent Immunization Schedule differs from a recently issued immunization schedule from the Centers for Disease Control and Prevention (CDC); and

WHEREAS, the AAP and CDC historically collaborated to create a unified childhood immunization schedule that was scientifically validated annually for decades, but recent changes to the CDC schedule represent a departure from longstanding evidence-based medical standards; and

WHEREAS, the AAP Childhood and Adolescent Immunization Schedule is supported and formally endorsed by twelve national medical and health organizations representing more than one million clinicians, physicians, pharmacists, and pediatric healthcare professionals, including the American Academy of Family Physicians, American College of Nurse Midwives, American College of Obstetricians and Gynecologists, American Medical Association, American Pharmacists Association, Council of Medical Specialty Societies, Infectious Diseases Society of America, National Association of Pediatric Nurse Practitioners, National Medical Association, Pediatric Infectious Diseases Society, Pediatric Pharmacy Association, and the Society for Adolescent Health and Medicine; and

WHEREAS, the ACOP fully supports the AAP Childhood and Adolescent Immunization Schedule and affirms that decades of evidence demonstrate this schedule to be both safe and effective in preventing infectious diseases and protecting child and community health; and

WHEREAS, maintaining vaccine recommendations grounded in unbiased, scientifically trusted, and evidence-based research is essential to

safeguarding pediatric health and promoting public trust in immunization programs; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates formally adopt and recognize the American Academy of Pediatrics Childhood and Adolescent Immunization Schedule as the recommended immunization schedule for children and adolescents under 18 years of age; and be it further

RESOLVED, that the American Osteopathic Association (AOA) oppose the adoption, endorsement, or implementation of any childhood immunization schedule that is not firmly based on evidence-based research from trusted, validated, and unbiased scientific sources; and be it further

RESOLVED, that the AOA affirm its commitment to evidence-based medicine by supporting immunization recommendations that reflect the best available scientific data for the prevention of illness and the protection of pediatric and public health.

Background Information: Provided by AOA Staff

Current AOA Policy:

H450-A-25-Reaffirming-Commitment-to-Evidence-Based-Protection-Against-Vaccine-Preventable-Illnesses

H411-A-25-Support-for-Advisory-Committee-on-Immunizations-Practices-ACIP-Recommendations (new title: Support for Evidence-Based Vaccination Practices – BOT interim policy 12-9-2025)

H410-A-25-Public-Education-Regarding-the-Importance (BOT interim policy 12-9-2025)

H413-A-25-Vaccines-for-Children-Program.pdf (new title: Support for Vaccines for Children - BOT interim policy 12-9-2025)

H320-A-24-Influenza-Immunization-for-Health-Care-Workers-and-Educators (BOT interim policy 12-9-2025)

H414-A-23_Immunizations (BOT interim policy 12-9-2025)

H411-A-22_Meningococcal_Vaccine_Recommendations (BOT interim policy 12-9-2025)

H421-A-22_Education_on_Human_Papillomavirus (BOT interim policy 12-9-2025)

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_ _____

DATE: _____July 18, 2026_____ _

SUBJECT: ACKNOWLEDGING EMERGING EVIDENCE ON E-CIGARETTE USE AND CANCER-RELEVANT RISK PATHWAYS AND ENCOURAGING INTEGRATION INTO OSTEOPATHIC MEDICAL EDUCATION

SUBMITTED BY: Arizona Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, data from the 2024 National Youth Tobacco Survey (NYTS) demonstrate that e-cigarettes remain the most commonly used tobacco product among U.S. middle and high school students, reinforcing the clinical relevance of vaping exposure in current and future patient populations[5] ; and

WHEREAS, 2024 surveillance data report that 5.9% of middle and high school students used e-cigarettes currently, including frequent and daily use patterns among current users[8]; and

WHEREAS, contemporary peer-reviewed research continues to document patterns of co-use of e-cigarettes with other nicotine products among U.S. youth, which may complicate clinical counseling and preventive care strategies[3]; and

WHEREAS, peer-reviewed evidence updates and systematic reviews evaluating vaping and cancer-related outcomes conclude that the overall evidence linking e-cigarette use to cancer risk remains limited and evolving, requiring further rigorous longitudinal research [6,7]; and

WHEREAS, a 2025 systematic review suggests a potential association between e-cigarette use and increased lung cancer risk, particularly among dual users, while emphasizing that causality cannot be established due to limited longitudinal evidence and study heterogeneity[7]; and

WHEREAS, a 2025 evidence update reports substantial evidence that e-cigarette exposure is associated with biomarkers reflective of cancer disease risk, while also concluding that overall evidence on cancer risk remains limited and should be further investigated by future population-based research and clinical studies[6]; and

WHEREAS, a 2025 meta-analysis reported that e-cigarette exposure is associated with alterations in biomarkers relevant to cancer risk pathways, supporting continued clinician awareness while long-term outcomes evidence develops[1]; and

WHEREAS, peer-reviewed experimental evidence indicates that exposure to e-cigarette aerosols can induce DNA damage and other cellular changes relevant to carcinogenesis, reinforcing the importance of cautious preventive counseling and ongoing research [2,4]; and

WHEREAS, osteopathic physicians are trained to deliver whole-person, preventive, and patient-centered care, and should be equipped to counsel patients using current evidence regarding evolving nicotine delivery products and associated long-term health concerns; and

WHEREAS, accurate and up-to-date education on e-cigarette use trends and emerging cancer-relevant evidence may strengthen preventive counseling by supporting appropriate interpretation of evolving data and its limitations [1,6,7]; and

WHEREAS, E-cigarette use remains prevalent in the United States, including among adolescents and young adults, and continues to represent an evolving public health issue. Contemporary peer-reviewed evidence has increasingly explored vaping exposure through cancer-relevant biomarkers, epigenetic changes, and cellular damage pathways, while also emphasizing that the overall evidence establishing definitive causal cancer outcomes remains limited and requires further rigorous longitudinal research. As the scientific understanding of vaping-related harms continues to develop, osteopathic physicians-in-training benefit from timely, accurate, and appropriately framed education regarding current use trends and emerging health risks. This resolution seeks to have AOMA and AOA acknowledge these evolving findings and encourage osteopathic medical schools to incorporate updated statistics and evidence trends into relevant didactic and case-based learning to strengthen preventive care counseling and risk reduction education in alignment with osteopathic principles; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) acknowledges e-cigarette use as a significant and evolving public health issue relevant to preventive care and future patient health outcomes, including cancer risk.

References:

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3. Han, D. H., Harlow, A. F., Miech, R. A., et al. (2025). Nicotine pouch and e-cigarette use and co-use among US youths in 2023 and 2024. JAMA Network Open, 8(4), e256739. https://doi.org/10.1001/jamanetworkopen.2025.6739
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5. Jamal, A., et al. (2024). Tobacco product use among middle and high school students—United States, 2024. MMWR. Morbidity and Mortality Weekly Report, 73(41), 1–7.
6. Kundu, A., et al. (2025). Evidence update on the cancer risk of vaping e-cigarettes. [Journal information not provided]. https://pubmed.ncbi.nlm.nih.gov/39877383/
7. Mohapatra, S., et al. (2025). The risk of lung cancer from vaping or e-cigarette usage: A systematic review. ESMO Open, 10(12), 105910. https://doi.org/10.1016/j.esmoop.2025.105910
8. Park-Lee, E., et al. (2024). Notes from the field: E-cigarette and nicotine pouch use among middle and high school students—United States, 2024. MMWR. Morbidity and Mortality Weekly Report, 73(35), 1–2.

Background Information: Provided by AOA Staff

Current AOA Policy:
H441-A-25-Regulation-of-ECigarettes-and-Nicotine-Vaping

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted _____

DATE: _____July 18, 2026_____

SUBJECT: NATIONAL STEWARDSHIP AND CENTRALIZED DIGITIZATION OF HISTORICAL OSTEOPATHIC RECORDS

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the future of osteopathic medicine and its crucial role in global healthcare depends upon its continuation as a profession with distinct values and philosophy; and

WHEREAS, the preservation of the history of osteopathic medicine is essential to maintaining this identity and the profession's unique standing within the overall field of medicine; and

WHEREAS, over a century of historical, educational, and scientific records are currently fragmented across various locations and institutions, which could result in risk of loss or inconsistent/inadequate access; and

WHEREAS, centralized national stewardship and digitization of these records would enhance research, support education, and strengthen the governmental and public's understanding of osteopathic medicine; and

WHEREAS, the American Osteopathic Association (AOA) is uniquely positioned to lead the profession in establishing ethical standards for historical stewardship and digital governance; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) formally recognize **AND ENCOURAGE** the ~~importance~~ of preservation of ~~historical~~ **ADMINSTRATIVE AND ORGANIZATIONAL** records as a professional priority essential to the ~~enhancement and~~ advancement of osteopathic identity **THROUGH ITS HISTORY**; and be it further

RESOLVED, that the AOA ~~establish~~ **ENDORSE THE ESTABLISHMENT** OF a workgroup or task force to ~~develop~~ **FOSTER DEVELOPMENT OF** a centralized national digital repository for non-clinical historical records in collaboration with affiliated organizations and partner institutions **SUCH AS THE MUSEUM OF OSTEOPATHIC MEDICINE, THE AMERICAN OSTEOPATHIC FOUNDATION, THE OSTEOPATHIC HERITAGE FOUNDATION, THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS, AND THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE FOR FUNDING, RESOURCES, AND CONTENT**; and be it further

~~RESOLVED, that such a repository explicitly exclude patient medical records and Protected Personal Information (PPI), focusing solely on historical and organizational materials; and be it further~~

~~RESOLVED, that participation be voluntary, with contributing institutions retaining ownership of their materials subject to their own licensing and donor policies; and be it further~~

~~RESOLVED, that the AOA consider convening a multidisciplinary advisory group to establish non-binding guidance on governance, data security, and the ethical use of repository materials; and be it further~~

RESOLVED, that the AOA encourage its affiliates and colleges of osteopathic medicine to digitize **AND SHARE** their historical documentation.~~; and be it further~~

~~RESOLVED, that the AOA explore pathways to provide financial support for these efforts and encourage its affiliates, institutions and colleges of osteopathic medicine to do so as well, and report on all of these efforts to the AOA House of Delegates in 2027.~~

Background Information: Provided by AOA Staff

Current AOA Policy: The AOA does have a Record Retention and Destruction Policy which governs the retention of internal documentation. The resolution is ambiguous as to what types of records it is seeking be maintained in a central repository. Because of this, caution should be exercised as to creating guidance which would contradict internal document retention and destruction policies. Policies which do permit and encourage periodic file maintenance reduce risk (e.g., from data breaches or identity theft), increase efficiency by making it easier to locate relevant documents and manage active files, reduce data storage costs and provide legal protection.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Approximately $100K to develop; $50K annually for maintenance
Actual costs are unknown and approximate costs have been provided as a fiscal impact. Costs would be expected in developing the IT framework for the repository which is estimated to have an implementation cost of about $50k and an ongoing operating fee of about $30k (variable dependent on amount of storage). There are also redaction costs (variable depending on the volume of documents - $100/hr. anticipated rate), and the financial support requested; such costs could be significant.

The AOA Finance Committee does not support the fiscal impact.

ACTION TAKEN: __Not Adopted _____

DATE: ___July 18, 2026_____

SUBJECT: SUPPORT FOR 24/7 ANONYMOUS NALOXONE DISPENSING STRATEGIES IN HIGH-TRAFFIC AREAS IN UNDERSERVED AND RURAL COMMUNITIES

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Public Affairs

WHEREAS, the opioid crisis continues to be a significant public health challenge, with over one hundred thousand deaths in 2023 due to drug overdose and nearly 76% of those deaths involving an opioid[1-2]; and

WHEREAS, naloxone is a proven, life-saving medication that effectively reverses opioid overdoses[3]; and

WHEREAS, timely prehospital administration of naloxone can safely stabilize many overdoses and reduce the need for prolonged emergency care, as demonstrated by the Hospital Observation Upon Reversal (HOUR) study which showed that those with a normal exam one hour after reversal had a 95.6% negative predictive value for adverse events, with only one requiring repeat naloxone[16]; and

WHEREAS, individuals in rural areas often experience barriers to accessing naloxone due to stigma and fear of legal consequences[4,12,13]; and

WHEREAS, rural communities frequently lack nearby healthcare infrastructure, resulting in critical delays in overdose care, and many rural Emergency Medical Services (EMS) agencies have closed or are currently at risk of closure, further exacerbating barriers to timely medical access[15]; and

WHEREAS, intensive care admissions for opioid overdoses have risen sharply, with a national analysis of 162 hospitals showing that the average ICU cost per overdose admission increased from $58,517 in 2009 to $92,408 in 2015, reflecting the high expense of severe cases that progress without timely reversal[17]; and

WHEREAS, evidence shows that low-barrier access points, such as public health vending machines, increase distribution and utilization of harm reduction supplies, especially to those less connected to healthcare[5-7]; and

WHEREAS, the implementation of anonymous naloxone vending machines in underserved settings, such as six county jails in Michigan, led to a 63.5% increase in naloxone distribution within six months, demonstrating that the ability to access naloxone privately and without stigma was a key factor in this significant rise[14]; and

WHEREAS, multiple states, including Nevada, have successfully implemented naloxone in public health vending machines, leading to increased naloxone use, improved overdose response times, and immediate reductions in opioid-involved overdose fatalities[8]; and

WHEREAS, the American Osteopathic Association (AOA) supports the continued availability of naloxone as an over-the-counter medication and advocates for the education and training of its use for patients at risk of overdose, family members, and caregivers to prevent opioid-related deaths (Policy H603-A/23); and

WHEREAS, the AOA, through Policy H429-A2022, supports harm reduction strategies aimed at reducing morbidity and mortality and advocates for increased availability of harm reduction modalities at the local, state, and federal level; and

WHEREAS**,** although existing AOA policy supports harm reduction strategies and naloxone accessibility broadly, additional approaches that provide 24/7, anonymous, low-barrier access may further improve access in rural and underserved communities; now, therefore be it

RESOLVED**,** that the American Osteopathic Association (AOA) supports policies that expand access to 24/7, anonymous, low-barrier naloxone dispensing mechanisms, including vending machines and similar approaches, in underserved, rural, and other high-risk communities; and be it further

RESOLVED**,** that the AOA supports the targeted education and outreach initiatives that increase public awareness of the availability and use of anonymous naloxone dispensing mechanisms and promote training on naloxone administration in underserved and rural regions; and be it further

RESOLVED**,** that the AOA supports efforts to better understand access, utilization, and outcomes associated with harm reduction strategies, including anonymous naloxone dispensing approaches in high-need communities.

References:

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content/uploads/policies/Policy_H416-A-23_Opioid_Overdose_Deaths_in_America_-_Epidemic_(H423-A18).pdf

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Background Information: Provided by AOA Staff

H-347-A/2024 Expanding Opioid Reversal Agents' Availability and Accessibility: Promoting Emergency Use in Communities to Treat Opioid Overdose
Current policy covers the intent of the resolves included in the proposed resolution.

Current AOA Policy:

H347-A-24-Expanding-Opioid-Reversal-Agents-availability-and-accessibility-promoting-Emergency-use

H416-A-23_Opioid_Overdose_Deaths_in_America_-_Epidemic

H603A23_Increasing_the_Education_and_Availibility_of_Naloxone_Use_for_Opioid_Overdose

H322-A-22_Naloxone_and_other_Opioid_Antagonists

H429-A-22_Harm_Reduction_Modalities_for_People_Who_Inject_Drugs-White_Paper

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ENSURING EQUITABLE VETERAN ACCESS TO OSTEOPATHIC MANIPULATIVE TREATMENT

SUBMITTED BY: Texas Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the United States Department of Veterans Affairs (VA) is the largest integrated healthcare system in the United States and is committed to a Whole Health model emphasizing non-pharmacologic, patient-centered approaches to pain management; and

WHEREAS, Osteopathic Manipulative Treatment (OMT) is a safe, evidence-informed, non-opioid modality that aligns directly with national priorities to reduce opioid dependence and improve functional outcomes in patients with musculoskeletal and related conditions; and

WHEREAS, the VA formally recognizes osteopathic principles and OMT within its Whole Health framework and maintains extensive training partnerships through the VA Office of Academic Affiliations with colleges of osteopathic medicine; and

WHEREAS, despite this recognition, access to OMT within VA facilities remains inconsistent due to workforce limitations and lack of standardized implementation of OMT services; and

WHEREAS, under the VA MISSION Act of 2018, veterans may be eligible for community care when access standards are not met, yet in practice, access to OMT through community care networks is often not reliably available; and

WHEREAS, veterans are often denied access to OMT even when they have access to other non-pharmacologic pain management modalities, including chiropractic care and interventional pain management services, creating inequities in access to osteopathic-specific care; and

WHEREAS, expanding access to OMT for veterans directly supports American Osteopathic Association (AOA) strategic priorities by promoting the distinct value of osteopathic medicine, advancing patient-centered care, and strengthening the profession's national visibility and credibility; now, therefore be it;

RESOLVED, that the American Osteopathic Association (AOA) **SUPPORTS** ~~advocate for~~ federal policy within the United States Department of Veterans Affairs to ensure that all veterans have equitable access to Osteopathic

31 Manipulative Treatment (OMT) as part of comprehensive, non-pharmacologic
32 pain management services; and, be it further

33 RESOLVED, that the AOA **SUPPORTS** ~~advocate for~~ expansion of direct care
34 capacity for OMT within VA facilities through increased **PHYSICIAN**
35 **TRAINING OPPORTUNITIES**, hiring, credentialing, and privileging of
36 osteopathic physicians trained in OMT; and, be it further

37 RESOLVED, that the AOA **SUPPORTS** ~~advocate for~~ strengthened implementation
38 of the VA MISSION Act of 2018 with respect to OMT to ensure that veterans
39 have reliable access to OMT through community care networks, with access
40 standards and reimbursement structures equivalent to those for other non-
41 pharmacologic and interventional pain management services; and, be it
42 further

43 RESOLVED, that the AOA collaborate with federal agencies, policymakers, and
44 national stakeholders to eliminate administrative, credentialing, and
45 reimbursement barriers that limit access to OMT; and, be it further

46 RESOLVED, that the AOA support and promote research, data collection, and
47 outcomes reporting within the VA system to further demonstrate the
48 effectiveness, cost-efficiency, and patient-centered benefits of OMT.

Background Information: Provided by AOA Staff

FY 2026 Military Construction, Veterans Affairs, and Related Agencies Appropriations bill includes language reinforcing the use of OMT as a critical nonpharmacologic therapy for veterans managing chronic pain.

Coverage Details: OMT is formally categorized as a rehabilitation service with the VA health system. Veterans must have a referral from a VA primary care provider or specialist to access the service.

Many VA medical centers employ D.O.s who provide OMT directly, If OMT is not available at a specific VA facility, the VA may cover treatment through the VA Community Care Program with on outside physician.

Current AOA Policy:
H311-A/15 Supporting the use of OMM in the VA

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: AIRCRAFT EMERGENCY MEDICAL SUPPLIES - SOURCE: H401-A/25

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

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

3 WHEREAS, the Bureau on Federal Health Programs believes that resolves in the
4 policy is incorporated in existing AOA policies, therefore be it

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

7 Policy Statement

8 The American Osteopathic Association (AOA) supports the concept that airlines,
9 under the control of the Federal Aviation Administration, maintain a policy for
10 adequately equipping commercial aircraft of greater than 19 seats with at least
11 minimal diagnostic and emergency medical supplies and supports legislation and
12 regulation that any physician providing emergency service while on board aircraft be
13 immune from any liability or legal action.
14

Background Information: Provided by AOA Staff

Current AOA Policy:

Resolve statements in H-401/A25 (H-447/A26) are incorporated in H-342/A24 *Airline Medical Kits,* and with guidance from the American Osteopathic College of Occupational & Preventive Medicine (AOCOPM), the other resolve in H-401 is included in H-319/A21 *Good Samaritan Act (Hold Harmless Agreement) Performed on Commercial Aircraft.* It is the recommendation of CSHA and BFHP that the two policies remain independent of each other due to their distinct issues. And recommends that H-401/A25 (H-447/A26) be SUNSET

Prior HOD action on similar or same topic: See above

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 18, 2026_____

MEMO

Date: May 2026

To: Committee on Public Affairs

From: Teresa A. Hubka, DO, Chair, AOA Finance Committee

RE: Res. No. H-456-A/2025- Sharing Centralized Resources on State-Specific Reproductive Health Policies (*Referred to the Finance Committee on July 20, 2025)*

Background: Resolution number H-456-A/2025- Sharing Centralized Resources on State-Specific Reproductive Health Policies was referred to the AOA Finance Committee on July 20, 2025. In 2025, the AOA Board of Trustees' position was to not support the resolution due to the significant fiscal impact and staff resources needed.

AOA Finance Committee Position: The AOA Finance Committee does not support the resolution due to the $150,000 fiscal impact.

SUBJECT: SHARING CENTRALIZED RESOURCES ON STATE-SPECIFIC REPRODUCTIVE HEALTH POLICIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, federal changes limiting access to reproductive health information on federal health websites have left physicians and patients unaware of reproductive rights on a national scale[1]; and

WHEREAS, variations in access to comprehensive reproductive health care exist across states and are constantly changing; for example, Mississippi prohibits pregnancy termination once a fetal heartbeat is detected and Alabama criminalizes pregnancy termination unless the mother's life is threatened-highlighting the need for centralized guidance[2]; and

WHEREAS, the lack of clarity and uncertain enforcement of state reproductive health laws by regulatory agencies creates a challenging landscape for physicians to navigate[3]; and

WHEREAS, without clear guidance from the profession, physicians practicing in states with restrictive reproductive health laws are hesitant to refer patients out of state for legal pregnancy termination or provide patients with online resources about pregnancy termination - that not only impacts patient access to reliable health information and care, but it also negatively affects the patient-physician relationship [4,5]; and

WHEREAS, tools, such as the Guttmacher Interactive Map[7] and the Kaiser Family Foundation's State Profiles for Women's Health[8], showing reproductive health care access across various states are available but should be shared within medical communities to raise awareness and provide centralized access to reliable, evidence-based information; and

WHEREAS, the American Osteopathic Association (AOA) is committed to protecting the sanctity of the patient-physician relationship from interference laws[9,10] and recognizes the importance of having access to federal health data and guidance[11]; and now, therefore be it

~~RESOLVED, that the American Osteopathic Association (AOA)~~ **~~MAKES AVAILABLE EXISTING~~** ~~shares evidence-based, validated tools~~ **~~WITHIN THE OSTEOPATHIC PHYSICIAN COMMUNITY~~** ~~to improve physician access to~~ **~~ACCURATE~~** ~~reproductive health information.~~

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ENCOURAGES THE SHARING OF ACCURATE UP TO DATE EXISTING, EVIDENCE-BASED VALIDATED TOOLS ON STATE-SPECIFIC REPRODUCTIVE RIGHTS INCORPORATED SUCH AS CONTINUING MEDICAL EDUCATION OR SHARED RESOURCES TO IMPROVE PHYSICIAN ACCESS TO ACCURATE REPRODUCTIVE HEALTH INFORMATION.

References:

1. Shafiq, S. (2025, January 21). *US government website offering resources on abortion, reproductive rights goes offline*. USA TODAY. https://www.usatoday.com/story/news/politics/2025/01/21/reproductive-rights-government-website-shut-down/77846157007/.
2. Aiken, A. R. A. (2019). Erosion of women's reproductive rights in the United States. BMJ, l4444. https://doi.org/10.1136/bmj.l4444
3. J. Kelly (2022). Statement on state laws impacting patient access to necessary medicine. American Medical Association. Statement on state laws impacting patient access to necessary medicine | American Medical Association
4. *KFF. (2023, June 21). A national survey of OBGYNs' experiences after Dobbs. KFF. https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/*
5. Oberman, M., & Lehmann, L. S. (2023). Doctors' duty to provide abortion information. *Journal of Law and the Biosciences*, 10(2), lsad024. https://doi.org/10.1093/jlb/lsad024
6. Madison, K. (2024). *Discordant Discipline: Implications of State-Legislated Medicine for the Regulation of Physicians*. Retrieved February 14, 2025, from https://www.pennstatelawreview.org/wp-content/uploads/2024/12/3.-Madison_63-125.pdf
7. Guttmacher Institute. (n.d.). Interactive Map: US abortion policies and access after Roe. https://states.guttmacher.org/policies
8. KFF. (n.d.). State Profiles for Women's Health. KFF. https://www.kff.org/interactive/womens-health-profiles/united-states/abortion-policies/
9. American Osteopathic Association. (2022, June 26). AOA statement on Supreme Court repeal of Roe v. Wade. [Press release]. https://osteopathic.org/2022/06/26/statement-on-the-supreme-court-repealing-roe-v-wade/
10. American Osteopathic Association. (2022). *Interference laws – Amendment to American Osteopathic Association policy (H-325-A/22)* [Policy statement]. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H325-A-22_Interference_Laws-Amendment_to_American_Osteopathic_Association_Policy.pdf
11. American Osteopathic Association, American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, & American Psychiatric Association. (2025, February 6). Statement from leading physician groups on removal of data and guidance from federal websites. American Osteopathic Association. https://osteopathic.org/2025/02/06/statement-from-leading-physician-groups-on-removal-of-data-and-guidance-from-federal-websites/

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $150,000 Annually

The fiscal impact is due to staff resources to oversee the website content as information is consistently changing based on frequently changing laws, frequent guideline updates and monitoring of legal cases.

Staff resources to ensure the materials posted on the AOA website as up to date will consist of researching and vetting the information and making updates when appropriate.

ACTION TAKEN: Not Adopted

DATE: July 18, 2026

AMERICAN OSTEOPATHIC ASSOCIATION

500 Series Constitution and Bylaws Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (500 SERIES)
As of 07-18-26

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Constitution and Bylaws (500 series)
This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-500	Amendments to the American Osteopathic Association Constitution – Article VIII, Section 2 *(First Read)* (Dept. of Communications)	CAGOS	Constitution & Bylaws	First Read
H-501	Amendments to the American Osteopathic Association Constitution – Article VI *(First Read)* (HOD Structure)	CAGOS	Constitution & Bylaws	First Read
H-502	Amendments to the American Osteopathic Association Bylaws – Article IX (Dept. of Communications)	CAGOS	Constitution & Bylaws	Adopted in 2027 pending adoption of H500/A26 First Read
H-503	Amendments to the American Osteopathic Association Bylaws – Article V, Sections 1, 10 and 12 (HOD Structure)	CAGOS	Constitution & Bylaws	Adopted in 2027 pending adoption of H500/A26 First Read
H-504	Amendments to the American Osteopathic Association Bylaws – Article VIII, Section 3 (VP Duties)	CAGOS	Constitution & Bylaws	Adopted
H-505	Amendments to the American Osteopathic Association Constitution – Article III *(First Read)* (AOA Divisional Society Representation on the AOA Board of Trustees)	MAOPS-MOA-LOMA-VOMA-MOMA-SCOMS	Constitution & Bylaws	First Read

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION - ARTICLE VIII, SECTION 2 (FIRST READ)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, Goal 2 of the proposed 2026-2029 strategic plan is 'Communicating the value of osteopathic medicine'. Establishing a governance Department of Communications supports this strategic goal; and

WHEREAS, the addition of a governance Department of Communications would enhance the process of physician input into broad messaging strategies; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Constitution

Article VIII - Board of Trustees and Executive Committee

Section 2 - Executive Committee

The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Relations, **COMMUNICATIONS**, Education, Finance, Governmental Affairs, Membership, and Research and Public Health**.**

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: First Read

DATE: July 18, 2026

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE VI (FIRST READ)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, As the profession began growing exponentially, the increasing number of delegates created an unsustainable situation. The 2014 House of Delegates approved a Constitution and Bylaws modification to cap the divisional society delegate composition to 473, in addition to the specialty college affiliates and bureau of emerging leaders, exclusive of students; and

WHEREAS, per the Bylaws, one student delegate seat is provided for each College of Osteopathic Medicine (COM) branch campus. The significant growth in the number of COMs is causing the HOD to grow to impractical numbers; and

WHEREAS, the AOA Board of Trustees was directed to review the construct of the House of Delegates and provide a recommendation on the criteria for modification. The other aspects on operationalization are to be managed independently by the stakeholders; and

WHEREAS, the AOA Board of Trustees in collaboration with SOMA and COSGP leadership collaborated to construct the proposed House of Delegates structure modification as outlined in Exhibit A; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates approve the House of Delegates structure modification proposal; and

RESOLVED, that the AOA House of Delegates review the following amendments as a first read to:

AOA Constitution

Article VI - House of Delegates

B. ~~Student Council Representation in Divisional Societies Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by the Commission on Osteopathic College of Accreditation (COCA) and located in the state represented by that divisional society, such student delegate is to be elected according to the Bylaws of the American Osteopathic Association.~~

B. STUDENT REPRESENTATION. OSTEOPATHIC MEDICAL STUDENT DELEGATE POSITIONS SHALL BE ALLOCATED DELEGATES AS OUTLINED IN THE BYLAWS.

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: First Read

DATE: July 18, 2026

Exhibit A

DETAILED DELEGATE NUMBERS			
Category	**Proposed**	**Current**	**Variance**
Divisional Societies (52)*	473	473	No Change
Specialty Societies (21)	21	21	No Change
SOMA	0	1	-1
BEL	3	3	No Change
COMs	0	73**	-73
Student Delegates	SOMA: 20 COSGP (SGA): 20		+40
TOTAL	**537**	**571**	**-34**

*per 2014 Bylaws **1 student per COM

Delegate Composition Explanatory: The student delegate numbers (20 SOMA; 20 COSGP) would be equal to 8% of the total affiliate organization delegates of the House of Delegates. Annually the slated student delegates would need to stay engaged throughout the year with the state in which they resided. The aspects on operationalization are to be managed independently by the stakeholders.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS - ARTICLE IX PREVIEW

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, Goal 2 of the proposed 2026-2029 strategic plan is 'Communicating the value of osteopathic medicine'. Establishing a governance Department of Communications supports this strategic goal; and

WHEREAS, the addition of a governance Department of Communications would enhance the process of physician input into broad messaging strategies; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates approve the following amendments to the AOA Bylaws upon approval of the July 2027 second read of AOA's Constitution amendment:

AOA Bylaws

Article IX - Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association's departments shall include the Departments of Affiliate Relations, **COMMUNICATIONS**, Education, Finance, Governmental Affairs, Membership, and Research and Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted in 2027 pending adoption of H500/A26 First Read

DATE: July 18, 2026

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE V, SECTIONS 1, 10 AND 12

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, As the profession began growing exponentially, the increasing number of delegates created an unsustainable situation. The 2014 House of Delegates approved a Constitution and Bylaws modification to cap the divisional society delegate composition to 473, in addition to the specialty college affiliates and bureau of emerging leaders, exclusive of students; and

WHEREAS, per the Bylaws, one student delegate seat is provided for each College of Osteopathic Medicine (COM) each branch campus, and each additional location. The significant growth in the number of COMs is causing the HOD to grow to impractical numbers; and

WHEREAS, the AOA Board of Trustees was directed to review the construct of the House of Delegates and provide a recommendation on the criteria for modification. The other aspects on operationalization are to be managed independently by the stakeholders; and

WHEREAS, the AOA Board of Trustees in collaboration with SOMA and COSGP leadership collaborated to construct the proposed House of Delegates structure modification as outlined in Exhibit A; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the House of Delegates structure modification proposal; and

RESOLVED, that the AOA House of Delegates approve the following amendments to the AOA Bylaws upon approval of the July 2027 second read of AOA's Constitution amendment:

AOA Bylaws

Article V - House of Delegates
Section 10~~-Representation of Student Councils~~
~~The student council of each accredited college of osteopathic medicine, each branch campus and each additional location may be represented in the House of Delegates by its president (and such president's alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however,~~

~~the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the secretary of the appropriate divisional society.~~

SECTION 10 – STUDENT REPRESENTATION

A. SOMA DELEGATION

FOUR PERCENT (4%) OF THE TOTAL DELGATES AS STATED IN THE CONSTITUTION SECTIONS ARTICLE VI, SECTION 1(A), (C) AND (D) SHALL BE ALLOCATED TO THE STUDENT OSTEOPATHIC MEDICAL ASSOCIATION (SOMA). SOMA DELEGATES WILL BE SELECTED ACCORDING TO SOMA'S BYLAWS.

B: COSGP REPRESENTATION

FOUR PERCENT (4%) OF THE TOTAL DELGATES AS STATED IN THE CONSTITUTION SECTIONS ARTICLE VI, SECTION 1(A), (C) AND (D) SHALL BE ALLOCATED TO THE COUNCIL OF OSTEOPATHIC STUDENT GOVERNMENT PRESIDENTS (COSGP) OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE (AACOM). COSGP DELEGATES WILL BE SELECTED ACCORDING TO COSGP'S BYLAWS BUT SEATED WITH THE DIVISIONAL SOCIETY IN WHICH THEIR SCHOOL IS LOCATED.

DELEGATES OF BOTH SOMA AND COSGP MUST BE CURRENT STUDENTS, IN GOOD STANDING, ENROLLED IN A PROGRAM ACCREDITED BY THE COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION (COCA). SOMA AND COSGP SHALL PROVIDE TO THE CHIEF EXECUTIVE OFFICER, IN WRITING BY ELECTRONIC COMMUCATION, THE NAMES OF ITS DELEGATES AT LEAST 30 DAYS PRIOR TO THE FIRST DAY OF THE ANNUAL MEETING OF THE HOUSE OF DELEGATES. THE CHIEF EXECUTIVE OFFICER SHALL CERTIFY EACH MEMBER QUALIFIED AND SELECTED UNDER THIS SECTION. THE CALCULATION IDENTIFIED IN ARTICLE V, SECTION 10 OF THE BYLAWS SHALL BE ROUNDED TO THE CLOSEST DELEGATE NUMBER.

Article V - House of Delegates

~~Section 12-Representation of Student Osteopathic Medical Association~~

~~The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member's alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA delegate or alternate shall also be a member of a divisional society's delegation representing the state in which such SOMA Board member's osteopathic college is located. The SOMA delegate shall be accredited in the same manner and have the same privileges as~~

~~the other members of the divisional society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.~~

Article V - House of Delegates
Section 1-Certification of Delegates and Alternates

b. Specialty Colleges

Each AOA recognized specialty college shall select one delegate and at least one alternate **WHO ARE REGULAR MEMBERS OF THE AOA** to the AOA House of Delegates in a manner prescribed in its Constitution and Bylaws. No specialty college delegate or alternate shall concurrently serve as a delegate for a divisional society at the AOA's House of Delegates. The Secretary of each specialty college shall certify the name of its delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association and their specialty college.

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted in 2027 pending adoption of H500/A26 First Read

DATE: July 18, 2026

Exhibit A

DETAILED DELEGATE NUMBERS			
Category	**Proposed**	**Current**	**Variance**
Divisional Societies (52)*	473	473	No Change
Specialty Societies (21)	21	21	No Change
SOMA	0	1	-1
BEL	3	3	No Change
COMs	0	73**	-73
Student Delegates	SOMA: 20 COSGP (SGA): 20		+40
TOTAL	**537**	**571**	**-34**

*per 2014 Bylaws **1 student per COM

Delegate Composition Explanatory: The student delegate numbers (20 SOMA; 20 COSGP) are equivalent to 8% of the total affiliate organization delegates of the House of Delegates. Annually the slated student delegates would need to stay engaged throughout the year with the state in which they resided. The aspects on operationalization are to be managed independently by the stakeholders.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS - ARTICLE VIII, SECTION 3

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the Committee on AOA Governance and Organizational Structure (CAGOS) reviewed the Vice President position to align with current practice and provided a recommended Bylaws amendment to the AOA Board of Trustees; and

WHEREAS, the AOA Board of Trustees approved the recommended Bylaw amendment, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates approve the following amendments to the AOA Bylaws:

AOA Bylaws

Article VIII - Duties of Officers
Section 3 - Vice Presidents

The Vice Presidents~~, in the order of their designation and in the absence or at the request of the President and President-elect,~~ shall perform the duties **DELEGATED TO THEM BY** ~~of the office of~~ the President**.**

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ___July 18, 2026_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE III - AOA DIVISIONAL SOCIETY REPRESENTATION ON THE AOA BOARD OF TRUSTEES (FIRST READ)

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons; Maine Osteopathic Association; Louisiana Osteopathic Medical Association; Virginia Osteopathic Medical Association; Montana Osteopathic Medical Association; South Carolina Osteopathic Medical Society

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the American Osteopathic Association's (AOA) Constitution in Article III – Divisional Societies states, " the AOA shall be a federation of divisional societies…," and divisional societies constitute the grassroots foundation of AOA membership and the primary mechanism for physician engagement, recruitment and retention; and

WHEREAS, as the AOA seeks to strengthen and grow its membership, the expertise of divisional society leadership—derived from direct engagement with members and understanding of state and local needs—is essential to informed strategic planning and decision-making; and

WHEREAS, the AOA Board of Trustees, as currently structured, does not include designated divisional society representation and therefore lacks consistent access to this operational, "boots on the ground" perspective; and

WHEREAS, the Association of Osteopathic State Executive Directors (AOSED), composed of divisional society executive leaders, possesses substantial institutional knowledge and expertise in member engagement, organizational management, and implementation of AOA initiatives; and

WHEREAS, actions of the Board of Trustees directly impact divisional societies, and absent formal representation, the practical implications of such actions on membership growth, retention, and local engagement may not be fully considered; and

WHEREAS, inclusion of divisional society leadership on the Board of Trustees would ensure incorporation of diverse perspectives, including those grounded in frontline member engagement and program implementation, thereby strengthening the effectiveness of AOA governance; and

WHEREAS, enhanced divisional society representation would promote alignment, continuity, and shared strategic purpose between the AOA and its federated societies, supporting successful implementation of initiatives and the long-term sustainability of the organization; now, therefore, be it

RESOLVED, that the House of Delegates of the American Osteopathic Association, amend Article VIII of the Constitution in the following manner to ensure divisional society representation on the Board of Trustees; and

RESOLVED, that the AOA House of Delegates review the following amendments as a first read to:

AOA Constitution

Article VIII - Board of Trustees and Executive Committee

Section 1-Board of Trustees The Board of Trustees shall be the administrative and executive body of the Association and perform such other duties as are provided by the Bylaws. The Board of Trustees of this Association shall consist of ~~twenty-eight~~ **TWENTY-NINE** members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the House of Delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for a one year term. Candidates for the new physician in practice position shall be osteopathic physicians who have completed their postdoctoral training within the past five years and be nominated by the Bureau of Emerging Leaders. Candidates must be members in good standing of the AOA;

D. One postdoctoral trainee, to include intern, resident, or a fellow, member elected by the House of Delegates to serve for one year. Candidates for the postdoctoral trainee position shall be enrolled in an Accreditation Council for Graduate Medical Education (ACGME) internship, residency or fellowship. Candidates for the postdoctoral trainee position shall be nominated by the Bureau of Emerging Leaders. Candidates should be members in good standing of the AOA; and

E. One student member elected by the House of Delegates to serve for one year. Candidates for the student position shall be nominated, in alternating years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA).

F. ONE REPRESENTATIVE FROM DIVISIONAL AFFILIATES TO SERVE FOR TWO YEARS. THE DIVISIONAL AFFILIATE TRUSTEE MUST BE AN EXECUTIVE DIRECTOR/CHIEF EXECUTIVE OFFICER OF A STATE

67 **DIVISIONAL AFFILIATE AND BE NOMINATED BY THE ASSOCIATION OF**
68 **OSTEOPATHIC STATE EXECUTIVE DIRECTORS (AOSED).**

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $9,100 annually
One AOSED Advisor to attend the three in-person board meetings (OMED, Midyear, and Annual Business Meeting). *Housing cost fluctuates based on meeting location.

Meeting	Expense Description	Expense
OMED (September/ October)	Air Fair - $600 Housing - 4 nights x $368 = $1,472 Ground - $150 Per Diem - 5 days x $110 = $550	$2,772
Midyear (February)	Air Fair - $600 Housing - 3 nights x $459 = $1,377 Ground - $150 Per Diem - 4 days x $110 = $440	$2,567
Annual Business Meeting (July)	Air Fair - $600 Housing - 7 nights x $304 = $2,128 Ground - $150 Per Diem - 8 days x $110 = $880	$3,758
	Total:	**$9,097***

The AOA Finance Committee does not support the fiscal impact.

ACTION TAKEN: _____First Read_____

DATE: _____July 18, 2026_____

AMERICAN OSTEOPATHIC ASSOCIATION

600 Series Ad Hoc Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (600 SERIES)
As of 07-18-26

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-600	~~Advocating for~~ Coverage of Elemental Formula in State, Federal, and Private Insurance Programs (SR-Source: H601-A/21)	BFHP	Ad Hoc	Adopted as Amended
H-601	Mandatory Participation in Insurance Plans (SR-Source: H608-A/21)	BFHP	Ad Hoc	Adopted
H-602	Medicare Medical Necessity Certification Requirements (SR-Source: H618-A/21)	BFHP	Ad Hoc	Adopted
H-603	Telehealth (SR-Source: H603-A/21)	CERA	Ad Hoc	Adopted as Amended
H-604	Patient Access to Home Health Service (SR-Source: H604-A/2021)	CERA	Ad Hoc	Adopted
H-605	~~Electronic Medical/Health Record~~ **PROMOTING INTEROPERABILITY** Exemption Without Penalty (SR-Source:H606-A/21)	CERA	Ad Hoc	Adopted as Amended
H-606	Physician Administered OMT (SR-Source: H607-A/21)	CERA	Ad Hoc	Adopted
H-607	Medicare Claims Coding – Centers for Medicare and Medicaid Services Communications with Physicians (SR-Source: H609-A/21)	CERA	Ad Hoc	Adopted
H-608	Physician Negotiation Rights (SR-Source: H610-A/21)	CERA	Ad Hoc	Adopted as Amended
H-609	Opposition to use of **INAPPROPRIATE MEASURES USED** ~~Readmission Rates~~ by the Centers for Medicare and Medicaid Services as a Criterion for Ranking (SR-Source: H611-A/21)	CERA	Ad Hoc	Adopted as Amended
H-610	Current Procedural Terminology (CPT) Codes –Blending Rates (SR-Source: H612-A/21)	CERA	Ad Hoc	Adopted
H-611	Health Insurance Exchanges (SR-Source: H613-A/21)	CERA	Ad Hoc	Adopted as Amended
H-612	Access to Care – Network Adequacy and Coverage (SR-Source: H614-A/21)	CERA	Ad Hoc	Adopted

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As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-613	Third Party Payor Coverage Process Reform (SR-Source: H637-A/16)	CERA	Ad Hoc	Adopted as Amended
H-614	Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMS) (SR-Source: H616-A/21)	CERA	Ad Hoc	Adopted as Amended
H-615	Health Insurer Consolidation (SR-Source: H617-A/21)	CERA	Ad Hoc	Adopted as Amended
H-616	Disaster Relief Volunteers (SR-Source: H605-A/21)	CSHA	Ad Hoc	Adopted
H-617	Equity in Medicare and Medicaid Payments (H622-A/25)	CSHA	Ad Hoc	Sunset
H-618	Professional Liability Insurance Reform (SR-Source: H643-A/20)	CSHA	Ad Hoc	Adopted
H-619	Expanding Gender Identity options on Physician Intake Forms (SR-Source: H619-A/21)	BORPH	Ad Hoc	Adopted as Amended
H-620	Affirming Evidence Based Communication Standards for Osteopathic Physicians	BEL	Ad Hoc	Adopted as Amended
H-621	Physician Autonomy in Non-Physician Clinician Collaboration Agreements	BEL	Ad Hoc	Adopted as Amended
H-622	Physician Right to Collective Bargaining	BEL	Ad Hoc	Adopted as Amended
H-623	Artificial Intelligence Technologies and Osteopathic Medicine	BOT	Ad Hoc	Adopted as Amended
H-624	Artificial Intelligence as a Clinical Documentation Tool, not the Legal Medical Record	OOA (Ohio)	Ad Hoc	Adopted as Amended
H-625	Comprehensive Insurance Coverage for Testosterone Deficiency Treatments	OOA (Ohio)	Ad Hoc	Adopted as Amended
H-626	Enhanced Screening of Women for Obstructive Sleep Apnea (OSA)	OOA (Ohio)	Ad Hoc	Adopted as Amended
H-627	Expanding Equitable Access to Menopausal Hormone Therapy (MHT) through Medicaid and other Insurance Programs	OPSC (California)	Ad Hoc	Adopted as Amended
H-628	Collaboration for Reduction of Hospital Patient Length of Stay	SCOMS (South Carolina)	Ad Hoc	Adopted as Amended
H-629	AOA Statement on Expression of Hatred	BOT	Ad Hoc	Adopted as Amended
H-630	Addressing Antisemitism and Hate within the Osteopathic Community	MAOP (Maryland)	Ad Hoc	Adopted as Amended

SUBJECT: ~~ADVOCATING FOR~~ COVERAGE OF ELEMENTAL FORMULA IN STATE, FEDERAL, AND PRIVATE INSURANCE PROGRAMS - SOURCE: H601-A/21

SUBMITTED BY: Bureau Federal Health Programs

REFERRED TO: Ad Hoc Committee

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association supports ~~legislation which advocates for the~~
9 coverage of medically necessary elemental pediatric formula under Medicaid and
10 private insurance plans.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (600 SERIES)
As of 07-18-26

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-631	Defining Antisemitism	FOMA/MAOP/ KOAM (Florida) (Maryland) (Kansas)	Ad Hoc	Not Adopted

SUBJECT: MANDATORY PARTICIPATION IN INSURANCE PLANS - SOURCE: H608-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association opposes any public policy that requires
9 mandatory participation of physicians in any insurance plan, including Medicare or
10 Medicaid and private insurance plans.

Background Information: Provided by AOA Staff
Current AOA Policy: 1994; 1996 Reaffirmed an amended; 2001; 2006 Reaffirmed; 2011 Reaffirmed as amended; 2016 Reaffirmed as amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 18, 2026

SUBJECT: MEDICARE MEDICAL NECESSITY CERTIFICATION REQUIREMENTS - SOURCE: H618-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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

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

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

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

7 Policy Statement

8 The American Osteopathic Association (AOA) supports reasonable efforts to
9 prevent Medicare waste, fraud, and abuse, and there by calling on the Center for
10 Medicare and Medicaid Services (CMS) to evaluate its medical necessity
11 certification requirements including the amount of waste, fraud, and abuse detected
12 and prevented by such measures, the administrative burden imposed on physician
13 practices, and the rate of denial of legitimate medical supplies and equipment. The
14 AOA encourages CMS to develop a more efficient and less burdensome approach
15 to medical necessity certification.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed an amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: TELEHEALTH - SOURCE: H603-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

AOA Telehealth Policy

The COVID-19 public health emergency caused by the highly contagious sars-cov-2 virus has demonstrated the need to broaden and optimize the use and delivery of healthcare services through telehealth to prevent the spread of the outbreak. With the rapid pace of advancement in technology, telehealth is an evolving practice – both in the types of services furnished, and the tools used to expand access to medical care. Telehealth is a tool used not only to provide direct services to a patient via information technology, but also specialist and primary care consultations, the online storage and sharing of medical information, imaging services through digital transmissions and the interpretation of images, remote patient monitoring, and medical education.

The practice of medicine via electronic and technological means has been occurring for decades. As technology advances and the breadth of medical practice in this area expand, there is an increasing call to regulate patient care delivered through technological resources. Advocates for telehealth argue that it provides improved access to medical care and services to patients in rural or underserved areas. They also emphasize that it allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times, is also noted as a cause for increased patient demand for health care services through telehealth. Despite its advantages, opponents raise concerns over the lack of regulation and oversight to control this practice. The primary issues involving telehealth are: (1) geographical and site-of-service restrictions: (2) licensure of out-of-state practitioners who use technology to treat patients in a state where they are not licensed to practice; (3) technological problems and barriers; (4) reimbursement issues regarding payment for services rendered; and (5) quality of care.

Access, Efficiency and Quality

The U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have identified several benefits of telehealth. Virtual services limit physical contact and exposure to infectious diseases, shorten in-office wait times, eliminate commuting time and travel expenses, reduce time off from work and the need for childcare, and provide access to medical care in rural and underserved communities.

Despite the advances in telecommunication technology, some stakeholders are concerned that a lack of regulation and oversight may undermine the quality of care provided, or create an opportunity for fraud and abuse. Care deemed to be below the acceptable quality standard can be addressed either via the disciplinary action of a state medical board or via civil legal action (medical malpractice claims). Liability rules vary state by state and concerns exist over the determination of venue when a provider is utilizing telehealth across state lines. Additionally, standard of care must be established and may vary between face-to-face encounters and telehealth encounters; although, many providers argue against this variation.

Liability Concerns

One issue that arises under the discussion of advancing telehealth is the question of jurisdiction for liability cases. This includes cases of medical malpractice, where a physician licensed to practice in two or more states practices medicine over state lines through electronic means, and an adverse event occurs.

Current state and federal statutes and case law provide a remedy to overcome this barrier. Patients are provided a pathway to legal recourse in the state where the accident occurred, if there is a reasonable expectation for that harm to have occurred there. If the patient can provide evidence confirming that location, (IP address, for example) and did not attempt to deceive the physician as to their location. Under this established system, any time a physician is choosing to perform telehealth, they should have the expectation that they are choosing to be held liable under another state's laws if an adverse event occurs.

Licensure

Telehealth is a broad area and is not regulated by one specific board or oversight body. ~~There is no standard for~~ Telehealth education and ~~no~~ certification **STANDARDS CONTINUE TO EVOLVE** ~~in the provision of telehealth~~. Therefore, the burden of oversight currently falls on the state medical boards. Each board defines care that meets an acceptable quality somewhat differently. State licensure requirements also diverge with significant differences in testing, postgraduate education and continuing medical education requirements. Additionally, scopes of practice varies by state with no overall standard**S** in regards to prescription authority or practice rights. Finally, uniformity fails to exist in what constitutes a visit (establishment of the “physician-patient relationship”), with some states requiring a

face-to-face visit before a telehealth relationship can be established. Due to these differences, some advocates have promoted the concept of national licensure. They believe that a national license for the practice of medicine would eliminate barriers that prevent widespread use of telehealth.

The AOA supports state-based licensure and discipline oversight, believing that states should have the right to directly regulate and provide oversight for services being provided to their citizens. ~~Concerns have been expressed about who would assume responsibility for disciplinary action against providers if a national medical license was initiated~~. Currently, protection of the residents of the state is a top function and core value of the state licensing boards.

Conclusion

The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who may not have access to medical care. The AOA further recognizes the need to provide a broad framework that establishes payment and policy recommendations to effectively advocate for telehealth at the national level, while providing enough flexibility to allow each state to incorporate policies that meet the health care needs of their citizens.

The AOA supports that a physician is practicing medicine, in the absence of physical interaction, when medical services are being provided through ~~simultaneous two-way communication~~, **SYNCHRONOUS AND ASYNCHRONOUS** recognizing that some services may require appropriate and corresponding delays in said communication.

The AOA supports that the utilization of technology in patient care should be used to increase access to care, and must not be used in a way that would diminish patient centered comprehensive personal medical care or the quality of care being provided to the patient. To this end, the AOA supports the concept of telehealth and advocates that public and private payers adopt payment systems that are inclusive of telehealth, and payment parity for professional advice, consultation and development of patient treatment plans provided to patients, family members or designee via telehealth.

The AOA supports that the standard of care provided through the use of technology should be equivalent to that of care provided when the physician and patient are within close physical proximity.

The AOA supports that the technological network being used to deliver patient care must have protocols in place that ensure the stability and security of that network to comply with applicable state and federal laws regarding patient privacy protections.

The AOA supports that the scope of care being delivered by the physician and other health care providers through telehealth should not exceed education training and applicable state and federal law.

The AOA supports that the state-based licensure and ability of states to govern activities within their borders is paramount and would oppose any national licensure or efforts to preempt state statutes.

The AOA supports that malpractice claims that arise from care provided through technological means, when the physician and patient in separate jurisdictions, should be adjudicated under the process currently utilized by the judicial system; whereby, the plaintiff has the ability to determine the venue where the case is filed, within the constraints of that system.

The AOA supports physicians must provide complete transparency to their patients regarding their location, jurisdiction of licensure and any limitations of the technology used to deliver care.

The AOA supports that as physicians provide care in a variety of new ways, including telehealth, advanced technology can be used to improve patient care. The AOA further supports that telehealth policies directly tie into the Patient-Centered Medical Home (PCMH) model for care and other value-based care arrangements, and recognizes that we must simultaneously implement advancements in telehealth in order to be successful in new alternative payment models.

The AOA supports collaboration with the American Medical Association and other stakeholders to ~~advocate for~~ **SUPPORT** legislation or an executive order to mandate that all health insurance plans, including those issued by the centers for Medicare & Medicaid services and entities covered under Employee Retirement Income Security Act (ERISA) law continue to reimburse for telehealth services at a level that is commensurate with a face-to-face visit.

The AOA supports efforts to address educational and operational barriers that interfere with implementation of telehealth in physician offices, and believes that every effort should be made to allow telehealth services to be provided by the patient's attending physician, rather than by physicians or clinicians the patient is unaffiliated with or is not referred by the patient's primary care physician.

The AOA will monitor developments in telehealth on an ongoing basis and update this policy as needed.

Background Information: Provided by AOA Staff
Current AOA Policy: 2012; Revised 2017, Revised 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PATIENT ACCESS TO HOME HEALTH SERVICE
- SOURCE: H604-A/2021

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

6 Policy Statement

7 The American Osteopathic Association (AOA) supports policies that will improve
8 patient access and coverage to home healthcare services while prioritizing patient
9 safety and promoting quality of home health services.

Background Information: Provided by AOA Staff
Current AOA Policy: 2021

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: ~~ELECTRONIC MEDICAL/HEALTH RECORD~~ **PROMOTING INTEROPERABILITY** EXEMPTION WITHOUT PENALTY - SOURCE: H606-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and

4 WHEREAS, the Council on Economic and Regulatory Affairs determined that this
5 revision modernizes and broadens the policy to capture challenges of small
6 practices in complying, even if they have adopted EMRs; and now, therefore
7 be it

8 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
9 the following policy be REAFFIRMED AS AMENDED.

10 Policy Statement

11 The American Osteopathic Association supports an exemption to financial penalties
12 to solo and small group practices that ~~do not implement electronic medical records~~
13 **ARE UNABLE TO COMPLY WITH ELEMENTS OF THE PROMOTING**
14 **INTEROPERABILITY CATEGORY OF THE MERIT-BASED INCENTIVE**
15 **PAYMENT SYSTEM (MIPS) OR SIMILAR REQUIREMENTS UNDER OTHER**
16 **QUALITY REPORTING PROGRAMS.**

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PHYSICIAN ADMINISTERED OMT - SOURCE: H607-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

6 Policy Statement

7 The American Osteopathic Association actively opposes the use of Osteopathic
8 Manipulative Treatment (OMT)~~/~~ Current Procedural Terminology (CPT) codes by
9 groups other than fully-licensed osteopathic and allopathic physicians and will work
10 diligently to reverse such policies, wherever they exist, that allow non-physicians to
11 utilize OMT~~/~~ CPT codes for reimbursement.

Background Information: Provided by AOA Staff
Current AOA Policy: 1994; 1999 Reaffirmed as Amended; 2004 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: MEDICARE CLAIMS CODING – CENTERS FOR MEDICARE AND MEDICAID SERVICES COMMUNICATIONS WITH PHYSICIANS - SOURCE: H609-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

6 Policy Statement

7 The American Osteopathic Association urges the Centers for Medicare and
8 Medicaid Services officials to require its Medicare administrative contractors to
9 provide thorough, current, written information on the preparation and coding of
10 Medicare claims to all physicians prior to the implementation of any new policies or
11 programs.

Background Information: Provided by AOA Staff
Current AOA Policy: 1999; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: PHYSICIAN NEGOTIATION RIGHTS - SOURCE: H610-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; and

WHEREAS, the CERA developed revisions that seek to modernize policy, reflecting challenges faced following implementation of the No Surprises Act as well as practices by insurers that seek to limit physicians' negotiation leverage, thus limiting payment; now therefore be it

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

Policy Statement

The American Osteopathic Association ~~will~~ support**S** ~~public~~ policies that allow physicians to ~~jointly negotiate~~ **DIRECTLY NEGOTIATE WITH INSURERS AND OPPOSES ANTI-COMPETITIVE PRACTICES THAT SEEK TO LIMIT OR UNDERMINE PHYSICIANS' ABILITY TO NEGOTIATE EFFECTIVELY**. ~~with insurers thereby creating an equitable basis for negotiations between these parties~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: OPPOSITION TO USE OF **INAPPROPRIATE MEASURES USED** ~~READMISSION RATES~~ BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS A CRITERION FOR RANKING -SOURCE: H611-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and

4 WHEREAS, the Council on Economic and Regulatory Affairs has determined to
5 broaden the policy beyond solely readmission rates to generally oppose
6 holding physicians accountable to measures outside their; and now,
7 therefore be it

8 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
9 the following policy be REAFFIRMED AS AMENDED.

10 Policy Statement

11 The American Osteopathic Association **OPPOSES** ~~is opposed to the use of~~
12 ~~**QUALITY OR COST**~~ **MEASURES THAT HOLD PHYSICIANS ACCOUNTABLE**
13 **FOR FACTORS OUTSIDE OF THEIR CONTROL**. ~~readmission rates as a criterion~~
14 ~~for deciding payment for physicians and the use of readmission rates as a criterion~~
15 ~~for ranking the quality of care provided by physicians~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES BLENDING RATES - SOURCE: H612-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

6 Policy Statement

7 The American Osteopathic Association (AOA) is opposed to blending of payment
8 rates by insurers for CPT codes.

Background Information: Provided by AOA Staff
Current AOA Policy:2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: HEALTH INSURANCE EXCHANGES - SOURCE: H613-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and

WHEREAS, the Council on Economic and Regulatory Affairs has determined to amend the policy to better reflect the council's intentions; and now, therefore be it

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

Health Insurance

Exchanges

Policy Statement

The American Osteopathic Association adopts the following "Principles for State Health Insurance Exchanges" to assist states in the formation of health insurance exchanges and will communicate these principles to the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), governors and state legislatures.

Principles for State Health Insurance Exchanges

The "Patient Protection and Affordable Care Act" (ACA) (Public Law 111-148) authorized the establishment of state health insurance exchanges, or marketplaces. Exchanges provide a forum for individuals and small businesses to compare and purchase private health insurance plans. The ACA requires the U.S. Department of Health and Human Services establish initial guidance on the formation of the exchanges and what basic components a product must meet to qualify for participation in the new marketplace. The ACA depends on states to establish "exchanges," which are health coverage marketplaces intended to make it easier for individuals and small employers to shop, compare, and enroll in health insurance coverage.

States retain a great degree of flexibility in how exchanges operate, what benefits products can or should include beyond the federal floor, and how patients and physicians interact with insurers and their products within the exchanges. The AOA believes that states should adopt policies, as part of their health insurance exchanges that protect consumers, improve the quality of care provided, and decrease costs across the health care system. A critical element to achieving these goals is the establishment and implementation of policies that promote access to continuous and comprehensive primary care services.

States are the traditional regulators of the health insurance market and know their unique marketplace. However, states face many policy choices that will determine how successful exchanges will be in assuring that consumers and employers have a wide choice of attractive products. It is critical Exchanges be done right. To assist states in the formation of health insurance exchanges, the AOA proposes the following principles for state health insurance exchanges:

1. Structure of Health Insurance Exchanges
    a. All qualified plans should be permitted to offer coverage in an Exchange.
    b. Exchange coverage should be a choice, not a requirement. Individuals and employers should be able to purchase coverage inside and outside an Exchange.
    c. Consumers should have access to a broad range of innovative plan designs, and **THEY SHOULD BE PRESENTED AND/OR MARKETED**

IN A MANNER THAT EMPHASIZES TRANSPARENCY AND CLARITY IN THE SPECIFIC BENEFITS THAT CONSUMERS WILL RECEIVE, SUPPORTING WELL- INFORMED PLAN SELECTION. ~~their choices should not be limited to only a narrow set of standardized plan options~~

d. Exchanges should allow employers the option to keep their employees together and to continue to select qualified coverage among the health plans offered in the Exchanges.

e. State regulators (who are responsible for the entire market and assuring health plans have enough resources to pay claims) should continue to oversee premiums, network adequacy and transparency standards.

2. Governance Structure

a. The governing body of an exchange should include, by statute, consumer and physician representatives.

b. The governing body membership should be representative of all parties and should not be dominated by any one stakeholder, i.e. insurance companies.

3. Promote Enhanced Access and Quality

a. The benefit design should promote and incentivize primary care through a requirement that all plans ensure broad implementation of the patient- centered medical home as a condition of being recognized as a qualified plan.

b. Participating plans should demonstrate a commitment to providing enhanced payments to primary care physicians for care coordination and services provided outside the traditional face-to-face encounter.

C. States should assure adequate networks exist for each health insurance product sold on its exchange; to include primary and specialty care across all aspects of medical and behavioral health.

D. Health insurers should maintain free, publicly available network directories that are updated every 15 days.

E. Plans should not be allowed to discriminate against any patient population **THROUGH THEIR NETWORK DESIGNS** ~~including but not limited to tiering of participating providers.~~

F. PLANS SHOULD NOT BE ALLOWED TO DISCRIMINATE AGAINST OSTEOPATHIC PHYSICIANS BASED SOLELY ON THEIR DEGREE.

4. Uniform Administrative Functions

a. Enrollee applications should be standardized, readily available in a variety of culturally acceptable mediums, and easily understood.

b. Enrollees should receive presumptive eligibility—or provisional enrollment— to allow for delivery of essential preventive and primary care services upon submission of an application.

c. Consumer assistance and information offices, if not incorporated into the administrative framework of the exchange, should work closely with the state's exchange governing and administrative bodies.

d. Patients and physician practices should have access to consumer assistance programs.

e. Exchanges should adopt uniform standards for data requirements and definitions related to eligibility, enrollment and subsidy determinations.

f. Exchanges should focus on services and tools to help make it easier for consumers to compare and purchase health coverage and connect qualified individuals to subsidized coverage.

g. Exchanges should not add further layers of regulation or restrictions on market choice.

5. Standardized Contracting

a. Physician contracting should be standardized across all plans.

b. The inclusion of “all product clauses” should be strictly prohibited.

c. States opting to create multi-state exchanges, or enter into interstate compacts for the purchase of insurance, should harmonize contracting rules across all participating states.

6. Benefit Design

a. The essential benefit package should be inclusive of all services, whether explicitly or passively stated – including, but not limited to, coverage for osteopathic manipulative therapy/medicine.

b. The essential benefit package should promote continuous and comprehensive primary care services and should not place penalties or financial disincentives for primary care services provided outside the network.

7. Quality Improvement and Reporting

a. Quality measures should be uniform across plans participating in the exchange, state compacts, Medicaid, Children’s Health Insurance Plan, and state and local employee health benefits plans. Quality measures also should coordinate with Medicare, when possible.

b. Quality improvement programs should be inclusive of patient registry programs, such as the American Osteopathic Association’s (AOA) Clinical Assessment Program (CAP)

Background Information: Provided by AOA Staff
Current AOA Policy:2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE - SOURCE: H614-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

Policy Statement

The American Osteopathic Association (AOA) will advocate for public and private payors ensuring plan coverage for all medically necessary services, regardless of availability within the service area of its beneficiaries, and supporting state regulators as the primary enforcer of network adequacy requirements.

The AOA supports requiring provider terminations without cause be done prior to the enrollment period, allowing physicians to be added to the network at any time, and requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy.

The AOA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

The AOA will advocate for public policies to require out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.

The AOA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities; and, that physician and

patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

The AOA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities, and will advocate for laws that prohibit health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

The AOA will advocate that health plans be required to document to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: THIRD PARTY PAYOR COVERAGE PROCESS REFORM - SOURCE: H637-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and

WHEREAS, the Council on Economic and Regulatory Affairs determined to amend the policy to more accurately reflect the council's intentions; and now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) supports the development of model legislation and/or regulations to require that Medicare, commercial insurance companies, state Medicaid agencies, or other third party insurers utilize transparent and accountable processes for developing and implementing coverage decisions and policies.

The AOA will advocate that public and private insurers and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant physician organizations; **THAT SUCH PROTOCOLS OR CRITERIA ARE BASED ~~IN~~ ON PUBLICLY AVAILABLE LITERATURE AND EVIDENCE BASED CLINICAL GUIDELINES, ~~OR EVIDENCE~~**; and that such clinical coverage protocols should be easily and publicly accessible on their websites.

The AOA will advocate that when public and private insurers and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect; and, be it further

Through legislative and/or regulatory efforts the AOA will advocate that when Medicare Administrative Contractors (MAC) propose new or revised Local Coverage Determinations (LCD), said Contractors must: 1. Conduct Carrier Advisory Committee meetings in public, with minutes recorded and posted to the Contractor's website; and 2. Disclose the rationale for the LCD, including the

evidentiary standard upon which it is based when releasing an approved LCD. Through legislative and/or regulatory efforts**,** the AOA will advocate that CMS adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party empowered to make recommendations to affirm, withdraw or revise~~d~~ said policies to the Secretary of HHS; and **AOA WILL ALSO ADVOCATE** that MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) & ALTERNATIVE PAYMENT MODELS (APMS) - SOURCE: H616-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and

WHEREAS, the Council on Economic and Regulatory Affairs has determined to amend the policy to better reflect the councils intentions; and now, therefore be it

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

Policy Statement

The American Osteopathic Association (AOA) will ~~endeavor~~ ~~**CONTINUE**~~ ~~to~~ **ENCOURAGE THE EDUCATION OF** educate osteopathic physicians on the Medicare Access and Children's Health Insurance Program (CHIP) **R**~~r~~eauthorization **A**~~a~~ct of 2015 (MACRA),~~ and~~ the newly emerging **ALTERNATIVE** payment models **DEVELOPED BY THE CENTERS FOR MEDICARE AND MEDICAID INNOVATION,**~~ including~~ **AND CHANGES TO THE** Merit Based Incentive Payment System (MIPS). ~~AND Alternative Payment Models (APMS), resulting from the act and~~ **AOA WILL** ~~**DEVELOP RESOURCES ON**~~ **STAY INFORMED OF** how these **POLICIES AND** payment models might affect practicing physicians **AND SUPPORT PRACTICES BY** ~~**DISSEMINATING**~~ **KEEPING CURRENT WITH THESE MATERIALS.** ~~by developing and disseminating broadly available educational materials on MACRA and resulting payment models.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: HEALTH INSURER CONSOLIDATION - SOURCE: H617-A/21

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and

4 WHEREAS, the Council on Economic and Regulatory Affairs determined to amend
5 the policy to better reflect the intentions of the council; and now, therefore be
6 it

7 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
8 the following policy be REAFFIRMED AS AMENDED.

9 Policy Statement

10 The American Osteopathic Association (AOA) supports the application of strict and
11 necessary scrutiny by appropriate governmental agencies, including but not limited
12 to the Department of Justice, State Attorneys General, Federal Trade Commission,
13 and State Insurance Commissioners, to any consolidation of health insurers and
14 that each health insurer consolidation should be evaluated on protecting the
15 interests and needs of the health care consumer. **THIS ASSESSMENT SHOULD**
16 **CONSIDER IMPLICATIONS FOR**~~, including~~ patient access**,** and choice among
17 multiple insurers. The necessity of any merger within the health insurance industry
18 must demonstrate a benefit to patients by improving patient access and by meeting
19 the quadruple- aim of enhancing patient experience, improving population health,
20 reducing costs, and improving the work life of health care providers, including
21 clinicians and staff.

Background Information: Provided by AOA Staff
Current AOA Policy:2016; 2021 Reaffirmed with Amendments

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: DISASTER RELIEF VOLUNTEERS - SOURCE: H605-A/21

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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

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

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

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

7 Policy Statement

8 As part of volunteer service, the American Osteopathic Association recommends:
9 (1) encourage osteopathic physicians seek out appropriate training in disaster
10 response, (2) encourages all osteopathic physicians to enroll as a volunteer to
11 provide medical care during disasters before the next disaster strikes; (3)
12 encourages all DOs to consider joining the U.S. Surgeon General's Medical
13 Reserve Corps or registering with their state or local Emergency System for
14 Advanced Registration of Volunteer Health Profession Program (ESAR-VHP); (4)
15 encourages osteopathic physicians who wish to volunteer to provide domestic or
16 international emergency medical assistance to contact the humanitarian
17 organizations; and (5) encourages the federal and state governments to work with
18 the medical licensing boards to produce pathways and data resources that can
19 hasten licensed medical aid to disaster victims during public health emergencies.

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: EQUITY IN MEDICARE & MEDICAID PAYMENTS - SOURCE: H622-A/25

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy was to be reviewed for sunset in 2025; and

WHEREAS, the Council on State Health Affairs reviewed the policy and determined the subject matter of H622-A/25 and H321-A/22 to be substantially similar; and

WHEREAS, adding language from H622-A/25 to H321-A/22 and sunsetting H622-A/25 would provide a clear and comprehensive stance on the issue, eliminate redundancy, and streamline our policy compendium; and

WHEREAS, the Council on State Health Affairs provided the aforementioned recommendation to the 2025 House of Delegates, but H321-A/22 was inadvertently omitted, causing H622-A/25 to be referred back; and

WHEREAS, the Council on State Health Affairs has submitted both policies for review in 2026, with a recommendation to first reaffirm H321-A/22 as amended, and subsequently sunset H622-A/25; now, therefore be it

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

Policy Statement

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

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Adopted as Amended; 2020 Adopted as Amended; 2025 Referred

Prior HOD action on similar or same topic: H321-A/22

FISCAL IMPACT: $0

ACTION TAKEN: _____Sunset_____

DATE: ____July 18, 2026_____

SUBJECT: PROFESSIONAL LIABILITY INSURANCE REFORM
- SOURCE: H643-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy was due to be reviewed for sunset in 2025; and

WHEREAS, the policy was not assigned for review in 2025; and

WHEREAS, the policy was assigned to the Council on State Health Affairs for review in 2026; and

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

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

Policy Statement

The American Osteopathic Association continues support of professional liability insurance reform that includes the following principles:

1) limitations on non-economic damages - including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;

2) prohibiting “loss of chance” liability;

3) periodic payment of future expenses or losses;

4) offsets for collateral sources;

5) joint and several liability reform;

6) limitations on attorney contingency fees;

7) establishment of uniform statutes of limitations;

8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and “I’m sorry” clauses; and

9) reimbursement of all out-of-pocket expenses and lost income for physicians who are victims of frivolous lawsuits.

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

SUBJECT: EXPANDING GENDER IDENTITY OPTIONS ON PHYSICIAN INTAKE FORMS -SOURCE: H619-A/21

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy and determined that it is current; now, therefore be it

RESOLVED, that the BORPH recommends that the following policy be REAFFIRMED.

Policy Statement

The American Osteopathic Association (AOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their assigned sex at birth (male, female, intersex) and gender identity (male, female, transgender male, transgender female, nonbinary, additional category with blank for patient to complete.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2021 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: AFFIRMING EVIDENCE BASED COMMUNICATION STANDARDS FOR OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

WHEREAS, public trust in the medical profession depends on physicians communicating medical information that reflects the best available scientific evidence and current standards of care; and

~~WHEREAS, inconsistent or inaccurate public health messaging can contribute to patient confusion, reduced adherence to evidence-based recommendations, and preventable harm; and~~

WHEREAS, osteopathic physicians have an ethical responsibility under the AOA Code of Ethics to provide accurate, evidence-informed medical information while respecting patient autonomy and the evolving nature of scientific knowledge; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) affirms that osteopathic physicians have a professional ~~and ethical~~ obligation to communicate medical information grounded in the best available evidence and current standards of care.~~; and, be it further~~

~~RESOLVED, that the AOA utilizes existing communication strategies to reflect the best available scientific evidence and current standards of care~~.

Background Information: Provided by AOA Staff

Current AOA Policy:

- AOA Code of Ethics, Sec. 5 ("A physician should make a reasonable effort to partner with patients to promote their health and shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts. A physician shall maintain competence in such systematized and scientific knowledge through study and clinical applications.")

- AOA Code of Ethics, Sec. 7 (" Under the law a physician may advertise, but no physician shall advertise or solicit patients directly or indirectly through the use of matters or activities which are false or misleading".)

- Osteopathic Oath: ("I do hereby affirm…to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability…")

Prior HOD action on similar or same topic:

- H411-A/25: Support for Evidence-Based Vaccination Practices
- H450-A/25: Reaffirming Commitment to Evidence-Based Protection Against Vaccine-Preventable Illness

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PHYSICIAN AUTONOMY IN NON-PHYSICIAN CLINICIAN COLLABORATION AGREEMENTS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

WHEREAS, physicians hold ultimate responsibility for patient care and bear legal and ethical accountability for medical decisions made under their supervision or collaboration; and

WHEREAS, an increasing number of employed physicians are being expected to enter supervisory or collaborative agreements with non-physician clinicians, sometimes under conditions that may impede autonomy and negatively impact job security or contract renewal processes[~~1, 2~~]; and

WHEREAS, in environments where physicians lack adequate support, control, or resources to effectively supervise non-physician clinicians, both patient safety and the physician's professional standing can be jeopardized; and

WHEREAS, the decision to collaborate or supervise another clinician requires careful professional judgment, evaluation of the clinician's competencies, and consideration of patient safety; and

WHEREAS, several professional organizations have recognized this issue as a developing area of discussion[~~3, 4~~ 1,2]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports osteopathic physicians in their informed, voluntary participation in collaborative or supervisory agreements with non-physician clinicians, with compensation expectations clearly defined and commensurate with the physician's responsibilities, clinical judgment, and comfort level; and, be it further

RESOLVED, that the AOA ~~opposes the imposition of new or expanded collaborative or supervisory responsibilities on physicians, outside the terms of their original employment agreements, without transparent, mutually beneficial, and appropriately structured contract re-negotiation processes.~~ **SUPPORTS TRANSPARENT, MUTUALLY BENEFICIAL, AND APPROPRIATELY STRUCTURED CONTRACT RENEGOTIATION BEFORE PHYSICIANS ASSUME NEW OR EXPANDED COLLABORATIVE OR SUPERVISORY RESPONSIBILITIES BEYOND THE TERMS OF THEIR ORIGINAL EMPLOYMENT AGREEMENTS.**

Explanatory Statement:
This resolution aims to protect patient safety and physician autonomy by emphasizing the need for mutually beneficial supervisory agreements, while expanding access to safe, quality care. The proposition is geared towards contract development and renewal. Contract renewals may present barriers to negotiation such as restrictive covenants, compensation, and clawback provisions. Therefore, physicians may have limited negotiation capacity and find themselves in unfavorable collaboration agreements as a term of continued employment.

References:

1. Kane CK. *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties.* Policy Research Perspectives, American Medical Association; 2024. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.
2. Popover JL, Jones T, Kalathia C, et al. Physician Employment in America: Private Practices Dominate Despite Increased Hospital Employment. *JSLS*. 2025;29(2):e2025.00012. doi:10.4293/JSLS.2025.00012.
3. American Academy of Family Physicians. *Guidelines on the Supervision of Non-Physician Clinicians (NPCs).* AAFP. https://www.aafp.org/about/policies/all/guidelines-supervision.html
4. American College of Emergency Physicians. *Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department.* ACEP. https://www.acep.org/patient-care/policy-statements/guidelines-regarding-the-role-of-physician-assistants-and-nurse-practitioners-in-the-emergency-department

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: PHYSICIAN RIGHT TO COLLECTIVE BARGAINING

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

WHEREAS, physicians across the United States often face challenges related to excessive administrative burdens[1,2], inadequate compensation, rigid employment contracts, burnout, and limited control over their work environments; and

WHEREAS, the proportion of physicians employed by hospitals or corporate entities has risen over 15% since 2019, with over 77% currently falling into this category[3]; and

WHEREAS, physician compensation is increasing at a rate not commensurate with inflation or cost of living increases[1,4]; and

WHEREAS, collective bargaining and unionization can provide a way for physicians to negotiate for fair wages, reasonable working conditions, improved patient safety standards, and protections against exploitative practices; and

WHEREAS, the American Osteopathic Association (AOA) currently supports the rights of resident physicians to unionize and practice collective bargaining (H346-A/2024); and

WHEREAS, the AOA is committed to promoting the welfare, professional development, and autonomy of osteopathic physicians; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports physicians ~~lawfully~~ engaging in collective bargaining to protect professional and patient interests and encourages constructive dialogue between physicians and healthcare employers regarding working conditions, professional autonomy, and patient care.

Explanatory Statement:

Physicians lead multidisciplinary teams and are ultimately responsible for patient care. In modern healthcare settings, however, many physicians practice within large organizational structures and are subject to administrative and operational decisions that significantly influence clinical environments. These realities shape how care is delivered and affect physicians' ability to consistently meet professional and ethical standards.

Supporting physicians who choose to engage in collective bargaining can strengthen their ability to participate meaningfully in decisions that affect patient safety, workplace conditions, and the sustainability of medical practice. A unified physician voice can help

address unsafe or inefficient work environments, reduce factors contributing to professional burnout, and promote balanced collaboration between physicians and healthcare organizations. These efforts are intended to support high-quality patient care and a stable healthcare workforce.

Any physician organizing or participating in collective bargaining activities must conduct themselves in accordance with applicable laws and regulations, while maintaining a commitment to continuity of care. AOA support of physicians who choose to engage in lawful collective action affirms the organization's commitment to patient-centered care, professional responsibility, and the long-term health of the medical profession.

References:

1. Rao SK, Kimball AB, Lehrhoff SR, et al. The impact of administrative burden on academic physicians: results of a hospital-wide physician survey. *Acad Med.* 2017;92(2):237-243. doi:10.1097/ACM.0000000000001461
2. Woolhandler S, Himmelstein DU. Administrative work consumes one-sixth of U.S. physicians' working hours and lowers their career satisfaction. *Int J Health Serv.* 2014;44(4):635-642.
3. Physicians Advocacy Institute & Avalere Health. *Hospital and Corporate Acquisition of Physician Practices and Physician Employment, 2019–2023*. Physicians Advocacy Institute, Apr. 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf.
4. AMGA. "*New AMGA Survey Notes Significant Gains in Physician Compensation*." *AMGA*, June 2025, https://www.amga.org/about-amga/newsroom/press-releases/2025/june/new-amga-survey-notes-significant-gains-in-physician-compensation.

Background Information: Provided by AOA Staff

Current AOA Policy:

H346-A/24 Supporting the Rights of Residents to Unionize

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ARTIFICIAL INTELLIGENCE TECHNOLOGIES AND OSTEOPATHIC MEDICINE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Ad Hoc Committee

WHEREAS, advancements in artificial intelligence (AI)-driven technologies for use cases across the healthcare spectrum offer great promise for improving patient care through increasing efficiency, alleviating administrative burdens, augmenting physician decision-making, and enabling physicians to spend more time with patients; and

WHEREAS, a broad range of AI tools are being brought to market, including medical device software, health IT tools (e.g. products for billing and coding, prior authorization, scribing, etc.), medical reference tools relying on large language models, among numerous other technologies; and

WHEREAS, the pace of AI innovation continues to accelerate as there are now over 1,400 FDA approved AI software medical devices, 330 of which were approved in 2025 alone, and even more non-device AI products; and

WHEREAS, adoption of AI tools by physicians has risen rapidly, with 80% of physicians reporting that they use AI in a professional context, double the share reported in 2023, although many also express concerns about wider AI adoption, including concerns around liability, privacy and security, and skill loss; and

WHEREAS, incorporation of AI into clinical practice should be done in a patient-centered manner that aligns with osteopathic principles and whole-person care; and

WHEREAS, such incorporation of AI into clinical practice requires considerations around accountability, product safety and efficacy, privacy and security, transparency in products and data sets, methods for ensuring fairness, among other considerations; and

WHEREAS, in order to promote appropriate adoption of AI tools into clinical practice, the American Osteopathic Information Association (AOiA) has worked with DO leaders in digital health, including its Digital Health Steering Committee, to develop and publish its "OsteopathicAI Definition: A profession-level minimum practice standard for ethical clinician- and patient centered AI use in osteopathic medicine"; and

WHEREAS, the OsteopathicAI definition developed by the DHI Steering Committee is intended to be iterative to reflect the rapidly evolving practice environment and state of technology, evolved based on the guidance of its subject matter experts; and

WHEREAS, the AOA plays a leadership role in promoting the safe and effective adoption of AI in alignment with the distinct osteopathic approach to care; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~will~~ support**S** the adoption of safe and effective artificial intelligence tools in clinical practice, ~~and to ensure that state, federal, and private payer policies support use of artificial intelligence products in a manner that supports~~ **FOR** patient-centered, holistic care; and, be it further

RESOLVED, that the AOA endorses the American Osteopathic Information Association (AOiA) definition of OsteopathicAI as a minimum professional standard for patient-centered use of AI in osteopathic medicine. ; **AND BE IT FURTHER**

RESOLVED, THAT THE AOIA WILL REPORT BACK ANNUALLY TO THE HOUSE OF DELEGATES ANY CHANGES IN THE DEFINITION OF OSTEOPATHICAI.

Background Information: Provided by AOA Staff
Current AOA Policy:
H429-A/24 Artificial Intelligence in Healthcare Report and Action Plan

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ARTIFICIAL INTELLIGENCE AS A CLINICAL DOCUMENTATION TOOL, NOT THE LEGAL MEDICAL RECORD

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, Artificial Intelligence-assisted ambient listening and documentation tools are increasingly being utilized in clinical settings to improve physician efficiency, reduce administrative burden, and allow greater focus on patient care [1]; and

WHEREAS, Osteopathic physicians retain professional, ethical, and legal responsibility for the accuracy, completeness, and appropriateness of the medical record [2]; and

WHEREAS, Ambient audio recordings or AI-generated transcripts may contain inaccuracies, incomplete context, or non-clinical information and may pose significant medico-legal, privacy, data retention, and discoverability concerns [3]; and

WHEREAS, the progress note authored, reviewed, and authenticated by the physician has long served as the definitive legal medical record reflecting clinical judgment, decision making, and osteopathic principles and practice [4]; and

WHEREAS, clear guidance is necessary to ensure that emerging AI technologies enhance clinical efficiency without unintentionally creating additional legal liability or redefining the legal medical record [4]; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) supports the use of artificial intelligence technologies, including ambient listening tools as clinical efficiency aides to assist osteopathic physicians in documentation and workflow; and, be it further

RESOLVED, that the AOA supports the belief that ambient audio recordings, raw AI transcripts, or background data generated by AI tools shall not be considered part of the legal medical record unless explicitly incorporated into and verified within the physician's progress note; and, be it further

RESOLVED, that the AOA **SUPPORTS** ~~and~~ **THE** American Osteopathic Information Association'~~S~~ (AOiA) **COLLABORATIVE EFFORTS TO** ~~organizations~~ develop and disseminate guidance regarding the appropriate use of artificial intelligence-assisted listening technologies, with specific emphasis on maintaining the physician-authenticated progress note as the legal medical record and minimizing unintended medico-legal risk to physicians.

References:
1) "Artificial Intelligence (AI) in Health Care." *Congress.gov*, Library of Congress, 2 January 2026, https://www.congress.gov/crs-product/R48319.
2) “Code of Ethics.” Osteopathic.org, American Osteopathic Association, 24, July 2016, https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/
3) Topaz M, Peltonen LM, Zhang Z. Beyond human ears: navigating the uncharted risks of AI scribes in clinical practice. NPJ Digit Med. 2025 Sep 24;8(1):569. doi: 10.1038/s41746-025-01895-6. PMID: 40993221; PMCID: PMC12460601.
4) Floyd PT, Oates JC, Acker JW, Warren RW. Defining The Medical Record: Relationships Of The Legal Medical Record, The Designated Record Set, and the Electronic Health Record. Perspect Health Inf Manag. 2021 Oct 1;18(4):1h. PMID: 34975357; PMCID: PMC8649704.

Background Information: Provided by AOA Staff

Current AOA Policy:

H429-A24 Artificial Intelligence in Healthcare Report and Action Plan
H619-A/25 Health Information Technology and Clinical Software: Interoperability, Safety and Reliability
H622-A/24 Regulation of Health Information Technology Software

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: COMPREHENSIVE ~~INSURANCE~~ **THIRD PARTY PAYOR** COVERAGE FOR TESTOSTERONE DEFICIENCY TREATMENTS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, testosterone deficiency, also known as male hypogonadism, can lead to significant health issues such as fatigue, impaired sexual function, low bone density, reduced muscle mass, and depressed mood[1,2]; and

WHEREAS, in the United States, testosterone deficiency affects between four and five million men[2]; and

WHEREAS, effective treatment options for testosterone deficiency include not only injectable testosterone but also gels, patches, and other formulations that may better suit individual patient needs[1,2,3]; and

WHEREAS, equitable access to a variety of testosterone ~~replacement~~ therapies is essential for personalized patient care and optimal health outcomes [1,2,3]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate for comprehensive ~~insurance~~ **THIRD PARTY PAYOR** coverage of a range of testosterone ~~replacement~~ therapies to ensure patients have access to the most suitable treatment for their individual needs; and, be it further

RESOLVED, that the AOA ~~advocate for~~ **SUPPORTS THIRD PARTY PAYORS REGULARLY REVIEWING AND UPDATING** ~~insurance providers to regularly review and update~~ their coverage policies for testosterone ~~replacement~~ therapies to align with clinical guidelines.

References:

1. Testosterone Replacement Therapy for Male Hypogonadism https://www.aafp.org/pubs/afp/issues/2024/0600/testosterone-replacement-therapy-male-hypogonadism.html
2. Current Hypogonadism Treatment Options https://www.acofp.org/news-and-publications/journal/article-detail/vol-11-no-2-(2019)-march-april-2019/current-hypogonadism-treatment-options
3. Testosterone Therapy in Men with Androgen Deficiency Syndromes: An Endocrine Society Clinical Practice Guideline

https://academic.oup.com/jcem/article/95/6/2536/2597900?login=false#google_vignette

Background Information: Provided by AOA Staff
Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: ENHANCED SCREENING OF ~~WOMEN~~ **FEMALES** FOR OBSTRUCTIVE SLEEP APNEA (OSA)

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, Obstructive Sleep Apnea (OSA) is associated with a 2- to 3-fold increased risk of cardiovascular and metabolic disease[1], and

WHEREAS, OSA affects ~~approximately 17-23%~~ **A SIGNIFICANT PERCENTAGE** of ~~women~~**FEMALES**, with prevalence varying by age, menopausal status, and diagnostic criteria used[2] , such that among ~~women~~ **FEMALES** aged 30-49 years, OSA prevalence is approximately 8.7%, increasing to **ABOUT** 27.8% in those aged 50-70 years[1]; and

WHEREAS, the prevalence of OSA **MORE THAN** doubles postmenopausally, approaching rates comparable to ~~men~~**MALES**, with postmenopausal ~~women~~ **FEMALES MORE THAN** 3 times more likely to have OSA compared to premenopausal ~~women~~**FEMALES**[4]; and

WHEREAS, ~~the condition is~~ **OSA HAS BEEN SHOWN TO BE** substantially underdiagnosed in ~~women~~**FEMALES**, with estimates suggesting over 80% of cases remain undetected[3]; likely ~~exacerbated by the fact that women with OSA presenting differently than men, more commonly reporting insomnia, fatigue, mood disturbances, and depression rather than the classic symptoms of loud snoring and witnessed apneas[2]~~; **DUE TO THE DIFFERENCES IN PRESENTING SYMPTOMATOLOGY;** and

WHEREAS, traditional diagnostic criteria and clinical assessments often prioritize symptoms more common in ~~men~~**MALES**[1], - **LOUD SNORING AND WITNESSED APNEAS – RATHER THAN THE "NON-CLASSIC" SYMPTOMS, SUCH AS INSOMNIA, FATIGUE, MOOD DISTURBANCES, AND DEPRESSION, WHICH OFTEN MAY BE MORE INDICATIVE OF OSA IN FEMALES, THUS** exacerbating **SEX-BASED** inequities in OSA screening and treatment; therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) ~~advocate for~~ **SUPPORTS** education on the importance of screening and treating ~~both men and women~~ **MALES AND FEMALES** for Obstructive Sleep Apnea (OSA), ~~regarding overall reduction of cardiovascular health and quality of life, paying particular attention to the sex differences in presentation and prevalence in women after menopause~~; and **BE IT FURTHER**,

RESOLVED, that the AOA ~~encourage education regarding the inequities in OSA screening, through advocating for~~ **SUPPORTS CRITERIA FOR INITIATING OSA SCREENING BASED ON SYMPTOMATOLGY THAT INCLUDES NON-TRADITIONAL PRESENTATIONS MORE LIKELY IN FEMALES** ~~lower thresholds for screening and challenging the need for documentation of traditionally male-dominant symptoms~~; and, be it further

RESOLVED, that the AOA ~~advocate for~~ **SUPPORTS** ~~insurance companies to~~ **THAT THIRD PARTY PAYORS** ~~to~~ approve ~~women~~ **FEMALES** for **OSA DIAGNOSTIC STUDIES WHEN** ~~sleep studies when clinical suspicion and comorbidities are strong, despite not fitting the criteria set based on studies that were male-dominant.~~ **APPROPRIATE SYMPTOMATOLOGY, COMORBIDITIES, AND CLINICAL SUSPICION ARE DOCUMENTED.**

References:

1. Gottlieb DJ, Punjabi NM. Diagnosis and Management of Obstructive Sleep Apnea: A Review. *JAMA.* 2020;323(14):1389–1400. doi:10.1001/jama.2020.3514.
2. Dunietz GL, Chervin RD, Tauman R, Shaklai S, Sankari A. OSA in Women: Associations With Reproductive Aging and Screening Challenges. Chest. 2025 Aug 28:S0012-3692(25)05125-6. doi: 10.1016/j.chest.2025.08.001. Epub ahead of print. PMID: 40885537.
3. Mukherjee S, Patel SR, Kales SN, Ayas NT, Strohl KP, Gozal D, Malhotra A; American Thoracic Society ad hoc Committee on Healthy Sleep. An Official American Thoracic Society Statement: The Importance of Healthy Sleep. Recommendations and Future Priorities. Am J Respir Crit Care Med. 2015 Jun 15;191(12):1450-8. doi: 10.1164/rccm.201504-0767ST. PMID: 26075423; PMCID: PMC5442970.
4. Schwarz EI, Schiza S. Sex differences in sleep and sleep-disordered breathing. Curr Opin Pulm Med. 2024 Nov 1;30(6):593-599. doi: 10.1097/MCP.0000000000001116. Epub 2024 Aug 26. PMID: 39189037; PMCID: PMC11451933.

Background Information: Provided by AOA Staff

Current AOA Policy:

H313-A/24 Testosterone Therapy: Long Term Effect on Health

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: EXPANDING EQUITABLE ACCESS TO MENOPAUSAL HORMONE THERAPY (MHT) **ACROSS THIRD-PARTY PAYORS** ~~THROUGH MEDICAID AND OTHER INSURANCE PROGRAMS~~

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Ad Hoc Committee

WHEREAS, menopausal hormone therapy (MHT) is a well-established, evidence-based treatment that improves quality of life for individuals experiencing menopause and perimenopause[1]; and

WHEREAS, MHT significantly reduces vasomotor symptoms, genitourinary syndrome of menopause, and bone loss, and improves sleep, mood, and sexual health in menopausal and perimenopausal individuals[2]; and

WHEREAS, untreated menopausal symptoms are associated with reduced workplace productivity[3], increased healthcare utilization[4], higher risks of osteoporosis and fractures[5], and worsened cardiovascular outcomes[6]; ~~underscoring the importance of equitable coverage;~~ and,

WHEREAS, precedent exists for hormone therapy to be recognized as medically necessary and consistently covered under Medicaid and private insurance, as demonstrated by the coverage of testosterone therapy for hypogonadism in ~~cisgender men~~**MALES**[7-10], while coverage for estrogen and progesterone therapy for menopausal and perimenopausal individuals is variable across states and plans, reflecting systemic inequities in access to medically indicated hormone therapy; and,

WHEREAS, no comprehensive national study currently exists examining Medicaid or private insurance coverage of menopause hormone therapy (MHT), creating a gap in understanding of access disparities for low-income and marginalized populations; now, therefore, be it,

RESOLVED, that the American Osteopathic Association (AOA) support the adoption of policies advocating for equitable, medically indicated coverage of Menopausal Hormone Therapy (MHT) across ~~Medicaid and other insurance programs.~~ **THIRD-PARTY PAYORS**.

References:

1. Agency for Healthcare Research and Quality. (2015). Management of menopausal symptoms (Comparative Effectiveness Review No. 147). Rockville, MD: U.S. Department of Health and Human Services. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK285463/
2. ACOG, 2014. Management of Menopausal Symptoms. (n.d.). Retrieved July 29, 2025, from https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2014/01/managemen t-of-menopausal-symptoms
3. Faubion, S. S., et al. (2023). Impact of menopause symptoms on women in the workplace. Mayo Clinic Proceedings. [Estimated $1.8 billion in lost work time; $26.6 billion including medical expenses]
4. Shiozawa, A., Mancuso, S., Young, C., Friderici, J., Tran, S., & Trenz, H. M. (2024). Comparison of healthcare costs for women with treated versus untreated vasomotor symptoms due to menopause. Advances in Therapy, 41(5), 1885–1895. https://doi.org/10.1007/s12325-024-02821-0
5. Minaković, I., et al. (2023). Early menopause and risk of fractures—a preventable gap. Journal of Menopausal Medicine, 29(2), 89–96. https://doi.org/10.6118/jmm.2023.29.2.89
6. El Khoudary, S. R., et al. (2023, February 20). The connection between menopause and cardiovascular disease risks. American Heart Association News. https://www.heart.org/en/news/2023/02/20/the-connection-between-menopause-and-cardiov ascular-disease-risks
7. Centers for Medicare & Medicaid Services. (2024). Local coverage determination (LCD) for testosterone injection and Testopel® (L39086). CMS. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39086&ver=10
8. UnitedHealthcare. (2023). Testosterone replacement/supplementation therapy (injectable, Testopel®). UnitedHealthcare Provider. https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-p lan/testosterone-replacement-supplementation-therapy-cs.pdf
9. Aetna. (2023). Clinical policy bulletin: Testosterone replacement therapy. Aetna. https://www.aetna.com/cpb/medical/data/1000_1099/1014.html
10. Arkansas Blue Cross and Blue Shield. (2023). Testosterone replacement therapy coverage policy. Arkansas Blue Cross and Blue Shield. https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2015028&viewInt r o=yes

Background Information: Provided by AOA Staff

AOA was invited and participated in the White House Menopause Task Force – Inaugural Meeting in March of 2026. Public Policy continues to work with the White House in establishing strategic direction in academic & workforce reform, research acceleration, and workplace & public health strategy as it relates to menopause.

Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: COLLABORATION FOR REDUCTION OF **SYSTEMS LEVEL BARRIERS CONTRIBUTING TO PROLONGED** HOSPITAL PATIENT LENGTH OF STAY

SUBMITTED BY: South Carolina Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, extended hospital length of stay exposes patients to increased mortality and morbidity risks from inpatient care. These include but are not limited to hospital acquired infections, deep venous thromboembolism, falls, excessive testing, and medication errors; and

WHEREAS, extended hospital length of stay leads to system costs **AND** ~~including~~ hospital physician, resident and staff burnout; and

WHEREAS, extended hospital length of stay reduces hospital bed availability and **WHICH MAY** contribute~~s~~ to emergency room overcrowding; and

WHEREAS, extended hospital length of stay contributes to higher healthcare costs ~~from provider date of service billing~~; and

WHEREAS, work with policymakers to identify best approaches for reducing hospital length of stay in U.S. healthcare delivery systems has been an ongoing focus of research and improvement; and

WHEREAS, public and private ~~insurers~~ **THIRD-PARTY PAYORS** typically take ~~3~~ **THREE OR MORE** business days to make coverage determinations regarding rehabilitation or skilled nursing facility placement following hospitalization; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~advocate for~~ **SUPPORTS** expedited coverage for post-acute placement of hospitalized patients; and

RESOLVED, that the AOA support efforts to **IDENTIFY AND** address system-level barriers contributing to prolonged hospital length of stay; and be it further

RESOLVED, that the AOA ~~advocate for~~ **SUPPORTS** timely post-acute placement services with continued goals of excellence in patient safety, healthcare and hospital quality.

References:

1) Technical Brief Number 40 Interventions To Decrease Hospital Length of Stay Prepared for: Agency for Healthcare Research and Quality U.S. Department of Health and Human Services 5600 Fishers Lane Rockville, MD 20857 www.ahrq.gov Sept 2021
2) Strategies to Reduce Hospital Length of Stay: Evidence and Challenges by Rahim Hirani 1,2,*,†,Dhruba Podder 1,†,Olivia Stala 1,Ryan Mohebpour 1,Raj K. Tiwari 1,2 andMill Etienne 1,3,* Medicina 2025, 61(5), 922; https://doi.org/10.3390/medicina61050922 20 May 2025
3) Reducing Hospital Length of Stay: A Multimodal Prospective Quality Improvement Intervention by Joseph Walker Keach, MD · Mara Prandi-Abrams · Allison S. Sabel, MD, PhD, MPH · Romana Hasnain-Wynia, PhD · Jonathan M. Mroch · Thomas D. MacKenzie, MD, MSPH January 30, 2025 DOI: 10.1016/j.jcjq.2025.01.012
4) Interventions to Reduce Hospital Length of Stay in High-risk Populations A Systematic Review Shazia Mehmood Siddique, MD, MSHP; Kelley Tipton, MPH; Brian Leas, MS; S. Ryan Greysen, MD, MS; Nikhil K. Mull, MD; Meghan Lane-Fall, MD, MSHP; Kristina McShea, MSLIS; Amy Y. Tsou, MD, MSc JAMA Network Open. 2021;4(9):e2125846. doi:10.1001/jamanetworkopen.2021.25846 (Reprinted) September 20, 2021
5) Institute of Medicine Committee on Quality of Health Care in America. In: Kohn LT, Corrigan JM, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Washington (DC): National Academies Press (US); 2000. 10.17226/9728. [PubMed]

Background Information: Provided by AOA Staff

Current AOA Policy:

H604-A/21 Patient Access to Home Health Services

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: AOA STATEMENT ON EXPRESSION OF HATRED

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Ad Hoc Committee

WHEREAS, there has been a rise in the expression of hatred based on race, ethnicity, sex, religion (for example, antisemitism); and

WHEREAS, there has been a significant rise in violence in many sectors; and

WHEREAS, the AOA Board of Trustees approved the anti-hate statement as board policy pending ratification by the AOA House of Delegates. As an additional step to combat expressions of hate, the AOA is developing a CME webinar that will be made available to a variety of audiences; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) unequivocally denounces hatred and discrimination based on race, religion, **AGE,** sex (including pregnancy, sexual orientation, or transgender status), **DISABILITY, NATIONAL ORIGIN, GENETIC INFORMATION** and other federally protected classes; and be it further

RESOLVED, the AOA declares that the perpetration of hate and/or discrimination, and expressions of support for violence by our members have no place in healthcare, will not be tolerated, and are uniformly condemned whether in word, action, or deed, including social media or other electronic posts; and be it further

RESOLVED, the AOA takes all allegations seriously and will serve as the arbiter for all formal complaints of violations of the AOA Code of Ethics or Guidelines on Professional Conduct. Upon completion of the due process, members with substantiated claims may face penalties, up to and including suspension from and/or expulsion from AOA membership.

Background Information: Provided by AOA Staff
The last resolve should be a whereas statements as there is existing policy: H433-A/25 Gender Identity Non-Discrimination, H406-A/24 Discrimination in Healthcare, and H511-A/24 AOA Rules and Guidelines on Physicians' Professional Conduct)

Current AOA Policy:

AOA Code of Ethics
AOA Guidelines on Professional Conduct
H433-A/25 Gender Identity Non-Discrimination
H406-A/24 Discrimination in Healthcare

Prior HOD action on similar or same topic: None

FISCAL IMPACT:
The AOA Board of Trustees approved funding to construct the CME webinar in the amount of $29,780.

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

Exhibit A: Glossary of Terms

Term	Definition
Antisemitism	Hostility, prejudice, or discriminatory conduct directed toward Jewish individuals, institutions, or communities, including rhetoric or actions that dehumanize, threaten, or marginalize Jewish people or deny the legitimacy of their identity and including, but not limited to the full definition of antisemitism by the International Holocaust Remembrance Alliance (IHRA).
Discrimination	Any act, conduct, or practice, intentional or unintentional, that results in disparate treatment, exclusion, or disadvantage of an individual or group due to a protected characteristic, contrary to applicable federal, state, or organizational nondiscrimination standards.
Electronic Posts / Social Media	Any content or communication disseminated through digital platforms, including but not limited to social networking sites, online forums, messaging applications, blogs, or public comment systems, regardless of audience size or privacy settings.
Expressions of Hatred / Hate	Any verbal, written, symbolic, or behavioral communication that demeans, vilifies, threatens, or incites hostility toward an individual or class of individuals on the basis of a protected characteristic. This term encompasses both explicit and implicit expressions, whether communicated directly or through digital or electronic means.
Expressions of Support for Violence	Any verbal, symbolic, written endorsement, encouragement, or glorification of harm directed toward an individual or group.
Federally Protected Classes	Those categories of individuals explicitly identified under federal law as protected from discrimination, including but not limited to race, color, religion, sex (inclusive of pregnancy, sexual orientation, and gender identity), national origin, age, disability, and genetic information.
Healthcare Setting	Any physical or virtual environment in which an osteopathic physician or member engages in professional, educational, administrative, or organizational activity subject to ethical and conduct standards of the American Osteopathic Association.
Sex (Including Pregnancy, Sexual Orientation, or Transgender Status)	A legally recognized protected characteristic encompassing biological sex, pregnancy or related medical conditions, sexual orientation, gender identity, and transgender status, as interpreted under relevant federal nondiscrimination statutes and judicial precedent.

SUBJECT: ADDRESSING ANTISEMITISM AND HATE WITHIN THE OSTEOPATHIC COMMUNITY

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Ad Hoc Committee

WHEREAS, the osteopathic medical profession is committed to upholding the principles of human dignity, respect, and compassionate care for all people; and

WHEREAS, incidents of antisemitism have risen nationally in recent years, affecting Jewish patients, students, physicians, and communities; and

~~WHEREAS, concerns have been raised within the osteopathic community regarding instances of antisemitism occurring at or involving osteopathic medical schools and affiliated institutions;~~

WHEREAS, in the summer of 2025 ~~2023~~, an employee of the American Osteopathic Information Association (AOiA) was **CHARGED WITH** ~~arrested after~~ committing a violent attack targeting a Jewish institution ~~that occurred during an osteopathic meeting~~, an act that federal authorities described as terrorism; and

~~WHEREAS, members of the osteopathic profession expressed concern that the AOA did not issue a direct acknowledgment of antisemitism in connection with this incident, did not name the victims, and instead released a general "Live/Love/DO" message that did not address the nature of the attack or the specific harm to the Jewish community; and~~

~~WHEREAS, the absence of a clear response to antisemitism following this event left many osteopathic physicians, students, and community members feeling unseen, unsupported, and unsafe; and~~

WHEREAS, THE UNITED STATES, THE CITY OF CHICAGO, (HOME OF THE AOA), AND MANY OTHER ORGANIZATIONS INCLUDING PRIVATE COMPANIES, PUBLIC COMPANIES AND UNIVERSITIES HAVE FORMALLY ADOPTED THE INTERNATIONAL HOLOCAUST REMEMBRANCE ALLIANCE'S (IHRA) DEFINITION OF ANTISEMITISM TO ENSURE THAT A CLEAR STANDARD OF BEHAVIOR IS ESTABLISHED, AND

~~WHEREAS, an additional concern has been raised regarding the selection of speakers for AOA-sponsored events, including OMED, where an invited~~

~~presenter has been publicly associated with rhetoric or positions perceived by many as anti-Israel or antisemitic; and~~

~~WHEREAS, the use of inflammatory, dehumanizing, or hateful language—such as labeling individuals or groups as "baby-killers," "genociders," or similar terms—has been reported within professional and educational settings, contributing to a hostile environment and undermining the values of the osteopathic profession; and~~

WHEREAS, the AOA has an ethical responsibility to foster a safe, inclusive, and respectful environment for all members, including Jewish physicians, students, and patients; and

WHEREAS, training and education from qualified experts can help the profession better identify, understand, and respond to antisemitism and all forms of hate, bias, and discrimination now, therefore be it

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIAITON (AOA) ADOPTS THE CURRENT INTERNATIONAL HOLOCAUST REMEMBERANCE ALLIANCE (IHRA) DEFINITION OF ANTI-SEMITISM[1], AND

~~RESOLVED, that that the American Osteopathic Association (AOA) formally acknowledge the concerns raised by members regarding antisemitism within the profession and the impact of the lack of a direct response to the 2023 attack targeting a Jewish institution; and, be it further~~

~~RESOLVED, that the AOA commit to addressing antisemitism explicitly and directly as part of its broader efforts to combat hate, discrimination, and harassment in all forms; and, be it further~~

~~RESOLVED, that the AOA partner with a nationally recognized Jewish organization with expertise in antisemitism education—such as one specializing in hate prevention, bias training, and community safety—to develop and provide optional training for AOA leadership, osteopathic medical schools, and the broader osteopathic community; and, be it further~~

RESOLVED, that the AOA ~~review its speaker selection processes for OMED and other official events to~~ ensure that invited presenters uphold the profession's standards of respect, inclusivity, and avoidance of hate-based rhetoric; and, be it further

~~RESOLVED, that such training include guidance on identifying antisemitism, understanding its contemporary manifestations, responding appropriately to incidents, and fostering environments where all individuals feel safe and respected; and, be it further~~

68 ~~RESOLVED, that the AOA review its speaker selection processes for OMED and~~
69 ~~other official events to ensure that invited presenters uphold the profession's~~
70 ~~standards of respect, inclusivity, and avoidance of hate-based rhetoric; and,~~
71 ~~be it further~~

72 ~~RESOLVED, that the AOA develop and disseminate clear guidelines discouraging~~
73 ~~the use of dehumanizing or hateful language—including terms such as~~
74 ~~"baby-killers," "genociders," or similar rhetoric—within professional,~~
75 ~~educational, and organizational settings; and, be it further~~

76 RESOLVED, that the AOA reaffirm its commitment to creating a professional
77 environment in which Jewish members, and all members, feel valued,
78 protected, and supported.

REFERENCES

1. INTERNATIONAL HOLOCAUST REMEMBRANCE ALLIANCE. "IHRA NON LEGALLY BINDING WORKING DEFINITION OF ANTISEMITISM." MAY 26, 2016. AVAILABLE HERE.

Background Information: Provided by AOA Staff

Current AOA Policy: H433-A/25 Gender Identity Non-Discrimination, H406-A/24 Discrimination in Healthcare, and H511-A/24 AOA Rules and Guidelines on Physicians' Professional Conduct

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

FISCAL IMPACT: ~~$25,000~~
~~The expense is to develop a webinar for training and education from a price quote received from a Jewish organization.~~

~~The AOA Finance Committee does not support the fiscal impact.~~

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 18, 2026_____

SUBJECT: DEFINING ANTISEMITISM

SUBMITTED BY: Florida Osteopathic Medical Association, Maryland Association of Osteopathic Physicians and Kansas Association of Osteopathic Medicine

REFERRED TO: Committee on Constitution & Bylaws

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1 WHEREAS, based on 2020 Pew Research data, Jewish people represented
2 approximately 2.5% of the United States population, yet, according to the
3 Federal Bureau of Investigation's (FBI) Uniform Crime Reporting (UCR)
4 Program, in 2024, 16% of all hate crimes were anti-Jewish[1]; and

5 WHEREAS, according to the FBI's UCR Program, 69% of hate crimes motivated by
6 a religious bias in 2024 were anti-Jewish, more than seven times higher than
7 any other group[1]; and

8 WHEREAS, when healthcare providers or their institutions publicly make antisemitic
9 remarks, promote acts or displays of antisemitism, or commit antisemitic
10 violence it disparages their respective professions in the eyes of the public
11 and may lead to greater distrust of their professions as a whole; and

12 WHEREAS, persons making antisemitic statements often seek to justify their
13 behavior by challenging the definition of antisemitism[2]; and

14 WHEREAS, the American Osteopathic Association embodies a philosophy of non
15 discrimination as promulgated in the Osteopathic Oath, the Osteopathic
16 Pledge of Commitment, The AOA Code of Ethics and current AOA policy
17 (see H511-A/24 as an example); and

18 WHEREAS, the AOA does not have a working definition of antisemitism to
19 standardize the evaluation of ethics complaints, or to establish an expected
20 standard of behavior; and

21 WHEREAS, the United States, the City of Chicago, home of the AOA, and many
22 other organizations including private companies, public companies and
23 universities have formally adopted the International Holocaust Remembrance
24 Alliance's (IHRA) definition of antisemitism to ensure that a clear standard of
25 behavior is established; now, therefore be it

26 RESOLVED, that the American Osteopathic Association (AOA) adopts the
27 International Holocaust Remembrance Alliance's (IHRA) definition of
28 antisemitism (see Appendix I); and, be it further

29 RESOLVED, that the AOA encourages all Osteopathic organizations to adopt the
30 IHRA definition of antisemitism.

References:

1. UCR Summary of Reported Crimes in the Nation: 2024; Federal Bureau of Investigation; https://cde.ucr.cjis.gov/LATEST/webapp/#. Accessed April 5, 2026.
2. Understanding The Origins of Antisemitism; https://www.ajc.org/OriginsOfAntisemitism#:~:text=Why%20is%20antisemitism%20called%20the,the%20world's%20most%20ancient%20hatred Accessed April 8, 2026.
3. Adoptions and Endorsements of the IHRA Working Definition of Antisemitism; https://ihra.combatantisemitism.org/#:~:text=In%20the%20United%20Kingdom%2C%20271,Spain%2C%20and%20three%20in%20Venezuela Accessed April 8, 2026.

Background Information: Provided by AOA Staff

Current AOA Policy: The Osteopathic Oath, The Osteopathic Pledge of Commitment, The AOA Code of Ethics and H511-A/24-AOA Rules and Guidelines on Physicians' Professional Conduct

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Not Adopted_____

DATE: ____July 18, 2026_____

APPENDIX I:
International Holocaust Remembrance Alliance definition of antisemitism:
Contemporary examples of antisemitism in public life, the media, schools, the workplace, and in the religious sphere could, taking into account the overall context, include, but are not limited to:

1. Calling for, aiding, or justifying the killing or harming of Jews in the name of a radical ideology or an extremist view of religion.
2. Making mendacious, dehumanizing, demonizing, or stereotypical allegations about Jews as such or the power of Jews as collective — such as, especially but not exclusively, the myth about a world Jewish conspiracy or of Jews controlling the media, economy, government or other societal institutions.
3. Accusing Jews as a people of being responsible for real or imagined wrongdoing committed by a single Jewish person or group, or even for acts committed by non-Jews.
4. Denying the fact, scope, mechanisms (e.g. gas chambers) or intentionality of the genocide of the Jewish people at the hands of National Socialist Germany and its supporters and accomplices during World War II (the Holocaust).
5. Accusing the Jews as a people, or Israel as a state, of inventing or exaggerating the Holocaust.
6. Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations.
7. Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavor.
8. Applying double standards by requiring of it [Israel] a behavior not expected or demanded of any other democratic nation.
9. Using the symbols and images associated with classic antisemitism (e.g., claims of Jews killing Jesus or blood libel) to characterize Israel or Israelis.
10. Drawing comparisons of contemporary Israeli policy to that of the Nazis.
11. Holding Jews collectively responsible for actions of the state of Israel.

AMERICAN OSTEOPATHIC ASSOCIATION

700 Series Joint Budget Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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106th ANNUAL AOA HOUSE OF DELEGATES MEETING
2026 RESOLUTION ROSTER (700 SERIES)
As of 07-18-26

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTION:
Joint Board/House Budget Review Committee (700 series)
This committee reviews the AOA Strategic Plan and Budget.

Res. No.	Resolution Title	Submitted By	Reference Committee	With Action
H-700	Approval to Concur with the AOA FY 2027 Expenditures	Finance Committee	Joint Board House Budget Review Committee	Adopted
H-701	2026-2029 AOA Strategic Plan, Vision and Mission Statements	Strategic Planning Committee	Joint Board House Budget Review Committee	Adopted

SUBJECT: Approval to Concur with the AOA FY 2027 Annual Budget

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board of Trustees "have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, with the annual budget for the fiscal year"; and

WHEREAS, the Joint Board/House Budget Review Committee has convened, reviewed, and approved the AOA FY 2027 Operating Budget, the AOA FY 2027 Capital Expenditures Budget and the AOA FY 2027 142 E. Ontario Building Budget reports as submitted; now therefore be it

RESOLVED, the American Osteopathic Association House of Delegates concurs with the AOA FY 2027 Annual Budget as provided.

EXPLANATORY STATEMENT: FY28 JOINT BOARD/HOUSE BUDGET REVIEW — TWO-YEAR LOOK BACK

AS PART OF THE FY28 JOINT BOARD AND HOUSE BUDGET REVIEW, THE PRESENTATION WILL INCORPORATE A TWO-YEAR LOOK BACK PERIOD COVERING FY26 AND FY27 ACTUAL PERFORMANCE ALONGSIDE THE FY28 PROPOSED BUDGET. THIS RETROSPECTIVE WINDOW IS INTENDED TO PROVIDE THE BOARD AND HOUSE WITH HISTORICAL CONTEXT FOR EVALUATING CURRENT-YEAR ASSUMPTIONS, VARIANCE TRENDS, AND THE TRAJECTORY OF KEY FINANCIAL AND OPERATIONAL METRICS.

THIS LOOK-BACK PERIOD IS INTENDED TO PROMOTE TRANSPARENCY IN THE BUDGET REVIEW PROCESS WHILE RESPECTING THE APPROPRIATE BALANCE BETWEEN GOVERNANCE OVERSIGHT AND OPERATIONAL MANAGEMENT — PROVIDING SUFFICIENT CONTEXT FOR INFORMED BOARD AND HOUSE REVIEW WITHOUT EXTENDING INTO THE DAY-TO-DAY OPERATIONAL DECISION-MAKING THAT REMAINS WITHIN MANAGEMENT'S PURVIEW.

BEGINNING WITH THE FY28 REVIEW, THIS TWO-YEAR LOOK-BACK FORMAT WILL SERVE AS THE STANDARD STRUCTURE FOR FUTURE JOINT BOARD/HOUSE BUDGET PRESENTATIONS, ENSURING CONSISTENCY AND COMPARABILITY ACROSS REVIEW CYCLES GOING FORWARD.

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

Prior HOD action on similar or same topic: None

ACTION TAKEN: __Adopted_____

DATE: _____July 18, 2026_____

SUBJECT: 2026-2029 AOA STRATEGIC PLAN, VISION AND MISSION STATEMENTS

SUBMITTED BY: Strategic Planning Committee

REFERRED TO: Joint Board House Budget Committee

WHEREAS, the American Osteopathic Association's (AOA) Strategic Plan is revised and updated approximately every three years; and

WHEREAS, the Strategic Planning Committee developed the 2026-2029 AOA Strategic Plan with input from the AOA Board of Trustees, members, staff, osteopathic affiliate leaders, and leaders from stakeholder organizations, and the plan is provided as Exhibit A; and

WHEREAS, the AOA Board of Trustees approved the 2026-2029 AOA Strategic Plan and the Vision and Mission statements during the February 2026 Midyear Meeting; ~~now, therefore be it~~ **AND**

WHEREAS, THE JOINT BOARD/HOUSE BUDGET REVIEW COMMITTEE HAS CONVENED, REVIEWED, AND APPROVED THE 2026-2029 AOA STRATEGIC PLAN, AND THE VISION AND MISSION STATEMENTS; NOW, THEREFORE BE IT

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates concurs with the 2026-2029 AOA Strategic Plan, Vision and Mission statements.

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

Prior HOD action on similar or same topic: None

Fiscal Impact: Determined annually

ACTION TAKEN: _____Adopted_____

DATE: ____July 18, 2026_____

Exhibit A

STRATEGIC PLAN 2026-2029

Your Journey. Our Shared Commitment.

1

Support the Career Journey of Osteopathic Physicians and Students Around the World

2

Communicate the Value of Osteopathic Medicine

3

Strengthen the osteopathic body of knowledge through education and research

4

Invest in physician leadership development

AMERICAN OSTEOPATHIC ASSOCIATION

Proposed 2026-2029 Strategic Plan

★ Goal 1	Statement of Success
Support the Career Journey of Osteopathic Physicians and Students Around the World	Osteopathic physicians and students utilize AOA programs and services that support the education and practice continuum through lifelong learning. (UME, GME, CME, Certification). Osteopathic physicians choose to validate competency through board certification, and maintain competency through easily accessible high-quality, relevant, robust CME experiences (Lifelong Learning) and osteopathic continuous certification.

Goal 1 Strategy	Statement of Success
1. Support future DOs through the medical education continuum of UME, GME, and CME, collaborating with various stakeholders when appropriate, by providing services, information, and support relevant to all stages of education and training.	Engage future DOs early in their journey by serving as a trusted resource throughout the medical education continuum. Educate and promote financial stewardship and overall health and well-being for AOA members. Strengthen the partnership with AACOM and COCA to continue to successfully build a stronger education pathway for future osteopathic physicians (DOs).
2. Educate students, residents and program directors to recognize the relevance of AOA board certification and osteopathic distinctiveness.	Increase the number of osteopathic residents who maintain AOA membership and take AOA board certification. Effectively market to all ACGME programs, focusing on the distinct communication needed to reach program directors and residents, advocating for osteopathic recognition in GME programs. Offer programs that create greater student and resident pride in the osteopathic profession.
3. Continue to grow the OMED conference.	Implement the OMED divisional society (state) participation program focusing on small to mid-sized states. Enhance the Resident and New Physicians in Practice tracks. Increase the number of Specialty Colleges participating in-person.
4. Collaborate with specialties and divisional societies to continue to offer quality, cost-effective osteopathic CME that does not hinder or burden the affiliates.	Engage with specialties and divisional societies to develop mutually beneficial CME offerings. Highlight all specialties and divisional societies in CME programming.
5. Strengthen the osteopathic continuum from Student through the New Physician in Practice.	Support a stronger and smoother transition experience from osteopathic medical student to resident to attending. Increase engagement with osteopathic medical students, residents, fellows and new physicians in practice to make AOA membership invaluable.

AMERICAN OSTEOPATHIC ASSOCIATION

Proposed 2026-2029 Strategic Plan

★ Goal 2	Statement of Success
Communicate the Value of Osteopathic Medicine	The AOA demonstrates, bolsters, and advances the distinctiveness of osteopathic medicine globally and its role in optimizing public health.

Goal 2 Strategy	Statement of Success
1. Expand public awareness of the value of osteopathic medicine.	Increase 'Find a DO' search metrics. Increase patient testimonials.
2. Protect and advocate for expanded international practice rights and the distinct value of DO licensing boards.	Increase the international recognition of the equivalence of AOA board certification and AOA accredited GME. Maintain current number of separate osteopathic state licensing boards.
3. Highlight excellence and accomplishments by osteopathic physicians and those supporting the osteopathic journey.	Create an increased feeling of pride and loyalty by those within the osteopathic profession and a greater sense of trust by the public. Amplify the visibility of osteopathic physicians and students in national media outlets.

AMERICAN OSTEOPATHIC ASSOCIATION

Proposed 2026-2029 Strategic Plan

★ Goal 3	Statement of Success
Strengthen the osteopathic body of knowledge through education and research	The AOA develops, cultivates, and disseminates empirical evidence that demonstrates the efficacy of osteopathic medicine on patient outcomes. The knowledge base of osteopathic medicine increases and positively impacts evidence-based outcomes.

Goal 3 Strategy	Statement of Success
1. Strengthen osteopathic education and competency standards	Support consistent integration of osteopathic philosophy, principles, and practice (OPP/OMM) across UME, GME, certification and CME so all physicians graduate and train with a strong, shared foundation in whole-person, osteopathic care.
2. Advance and expand osteopathic research infrastructure	Build sustainable pathways for high-quality osteopathic research Grow the impact and visibility of osteopathic evidence in peer-reviewed journals and clinical practice.
3. Promote innovation in osteopathic training models and partnerships	Expand access to osteopathic education and strengthen the pipeline of osteopathically trained physicians, and demonstrate the value of osteopathic medicine in diverse healthcare settings.
4. Strengthen osteopathic research and research opportunities	Increase NIH funding for DOs, COMs and COM faculty. Increase the number of DO and COM scientists represented on NIH Study Sections and Advisory Panels.

AMERICAN OSTEOPATHIC ASSOCIATION

Proposed 2026-2029 Strategic Plan

★ Goal 4	Statement of Success
Invest in physician leadership development	The AOA establishes and curates timely leadership experiences throughout an osteopathic physician's career lifecycle.

Goal 4 Strategy	Statement of Success
1. Advocate for greater leadership opportunities for osteopathic students and physicians.	Increase the number of osteopathic representatives serving in leadership roles in partner organizations and external entities.
2. Expand leadership opportunities for early career osteopathic physicians.	Expand the leadership experiences within the Bureau of Emerging Leaders (BEL). Increase AOA and specialties and divisional societies engagement with Residents, Fellows, and New Physicians in Practice.
3. Increase the engagement of osteopathic medical students in the AOA.	Encourage COMs to support SOMA chapters. Increase the number of osteopathic medical student members that participate in in-person AOA activities.

Vision and Mission Statements

Approved by the AOA BOT 9/25/25

Vision Statement

To be the global leader and unifying home for the osteopathic profession.

Mission Statement

To advance the distinctive philosophy and practice of osteopathic medicine by supporting physicians and students through advocacy, leadership, education, certification, research and innovation; promoting wellness, whole person care, and improved health outcomes.

AMERICAN OSTEOPATHIC ASSOCIATION

House of Delegates ▪ July 17 – 19, 2026

AMERICAN OSTEOPATHIC ASSOCIATION

2025 House of Delegates Resolutions

Actions

July 2025

200 Series Educational Affairs Resolutions

Actions

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

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

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Rural Sites – Osteopathic Education in (SR-Source-H201-A/20)	BOE	Educational Affairs	Adopted
H-201	Graduate Medical Education – Training of U.S. Medical School Graduates (SR-Source-H200-A/20)	BOE	Educational Affairs	Adopted
H-202	Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs (SR-Source-H202-A/20)	BOE	Educational Affairs	Adopted
H-203	Blue Ribbon Commission (SR-Source-H205-A/20)	BOE	Educational Affairs	Sunset
H-204	Autopsies (SR-Source-H203-A/20)	BOE	Educational Affairs	Adopted
H-205	Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities (SR-Source-H209-A/20)	BOE	Educational Affairs	Adopted as Amended
H-206	Audition Rotations for Osteopathic Medical Students (SR-Source-H214-A/20)	BOE	Educational Affairs	Adopted as Amended
H-207	Classification of Osteopathic Medical Graduates as U.S. Medical Graduates in Eras (SR-Source-H230-A/19; Referred-H210-A/24)	BOE	Educational Affairs	Adopted as Amended
H-208	Interdisciplinary Education and High Value Care (Source-Referred-H216-A/24)	BOE	Educational Affairs	Adopted as Amended
H-209	Osteopathic Medical School Education (Source-Referred-H224-A/24)	BOE	Educational Affairs	Adopted as Amended
H-210	Osteopathic Primary Care in Small Communities	POMA (Pennsylvania)		Withdrawn
H-211	Addressing COMLEX-USA Discrimination in Family Medicine Residency Programs and Promote Transparency for Osteopathic Medical Students	ACOFP	Educational Affairs	Adopted as Amended
H-212	Inclusion of Osteopathic Manipulative Treatment OMT) Procedures in ACGME Case Logs	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-213	Support of Osteopathic Recognition and the Integrity of Osteopathic Training	OOA (Ohio)	Educational Affairs	Referred to OOA

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

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

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_ _____

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: Sunset_____

DATE: ____July 19, 2025_____

SUBJECT: AUTOPSIES - SOURCE: H203-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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

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

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

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

Osteopathic Medical School Education

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

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

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

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

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

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

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

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

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References:

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

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

Background Information: Provided by AOA Staff

Current AOA Policy:

H345-A/23 AOA Support for GME Equity

H348-A/24 GME Equity Annual Report 2024

Prior HOD action on similar or same topic:

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

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

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

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

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

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

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

References:

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

Background Information: Provided by AOA Staff

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

Report of specialties that use Case Logs

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, Osteopathic Recognition (OR) is an accreditation status with the Accreditation Council for Graduate Medical Education (ACGME) that distinctly acknowledges programs that provide structured training on osteopathic principles and practice and the tenets of osteopathic medicine in graduate medical education (GME) [1]; and

WHEREAS, the OR-Review Committee with the ACGME outlines specific standards for achieving OR status [1]; and

WHEREAS, to date, the number of programs that have achieved OR is far smaller than the number of programs previously accredited by the American Osteopathic Association before the establishment of the Single Accreditation System (SAS) with the ACGME [2,3]; and

WHEREAS, the American Association of Colleges of Osteopathic Medicine (AACOM) published in August of 2024 the results of a study on the barriers to achieving Osteopathic Recognition, with hopes that the results would drive ideas/methods to overcome these barriers [4]; and

WHEREAS, some successful OR programs have already demonstrated viable models of maintaining and expanding high-quality osteopathic training [5]; and

WHEREAS, the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) have the responsibility to safeguard and promote the integrity of osteopathic training and education; ~~and,~~ now therefore be it~~:~~

RESOLVED, the American Osteopathic Association (AOA) encourages ~~all~~ osteopathic training in graduate medical education and strongly supports Accreditation Council for Graduate Medical Education (ACGME) Osteopathic Recognition as the gold standard for graduate medical education programs seeking to provide comprehensive osteopathic training; and be it further

RESOLVED, the AOA works collaboratively with the **AMERICAN** Association of Colleges of Osteopathic Medicine (AACOM) to identify and promote successful models of Osteopathic Recognition, provide guidance and resources to programs seeking recognition to ensure the continued strength and growth of osteopathic education and training in graduate medical education; and be it further

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

References:

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

Background Information: Provided by AOA Staff

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

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

DATE: ____July 19, 2025_____

SUBJECT: OSTEOPATHIC MEDICAL STUDENT ~~AUDITION~~ ROTATIONS

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Educational Affairs

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

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

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

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

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

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

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

Background Information: Provided by AOA Staff

Current AOA Policy:

H214-A/20 Audition Rotations for Osteopathic Medical Students
H345-A/23 AOA Support for GME Equity
H348-A/24 GME Equity Annual Report 2024

Prior HOD action on similar or same topic:

H231-A/19 Recognition of COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

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

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Educational Affairs

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

WHEREAS, Policy H345-A/23 – AOA Support for GME Equity requires the AOA Board of Trustees to provide a report to the House of Delegates; now therefore be it

RESOLVED, that the 2025 House of Delegates accept the AOA Board of Trustees GME Equity 2025 Annual Report as outlined.

2025 GME Equity Annual Report

As the professional home for over 38,000 osteopathic medical students and 31,000 osteopathic residents and fellows, the American Osteopathic Association (AOA) remains steadfast in its commitment to identifying and addressing systemic barriers that hinder equitable access to graduate medical education opportunities for the osteopathic medical profession. Throughout the year, the AOA continued its collaborative efforts with the American Association of Colleges of Osteopathic Medicine (AACOM) and the National Board of Osteopathic Medical Examiners (NBOME) to promote universal acceptance of the COMLEX-USA licensing exam, advocate for equitable evaluation of DO applicants, reduce systemic biases in medical training environments, and advance recognition of osteopathic credentials across all levels of medical education. AOA leaders remain active participants in the Joint Osteopathic Organization Leadership coalition, which meets regularly to address shared priorities including student parity, professional advocacy, and the future of osteopathic medical education.

In March 2025, the AOA, in continued partnership with the AACOM, convened a second annual Student Parity Summit. AOA President Teresa A. Hubka, DO, and CEO Kathleen S. Creason, MBA, led the meeting alongside leaders from national organizations including the American Medical Association, the Association of American Medical Colleges, the National Resident Matching Program, and for the first time, the Accreditation Council for Graduate Medical Education. The summit focused on the ongoing perception of bias against the DO degree in residency selection, the need for comprehensive data to better understand and address disparities, the development of immediate non-legislative strategies to improve parity, and the pursuit of long-term sustainable solutions to ensure equal opportunity for all medical students.

Following the Student Parity Summit, the AOA and AACOM submitted a letter to the ACGME recommending specific modifications to the Common Program Requirements and Sponsoring Institution Requirements aimed at addressing parity challenges faced by osteopathic medical students during the transition to residency. Additionally, the AOA, AACOM, and AAMC jointly sent a letter to the ACGME proposing the formation of a working group comprised of stakeholder organizations to celebrate successes, describe challenges, and identify opportunities to realize the true value of single GME accreditation.

Increased data transparency from stakeholders has been a key request from the AOA and the AACOM. This year, there has been an increase in available data on osteopathic medical students' applications, interview, ranking, and matching trends. From this data, the AOA has identified program directors' associations to increase engagement in the coming months facilitated through our strong partnership with the Council on Medical Specialty Societies (CMSS).

AOA staff and leadership also engaged directly with graduate medical education stakeholders to address inequities reported by osteopathic medical students. Through the dedicated do-discrimination@osteopathic.org inbox, the AOA responded to dozens of student concerns related to access to audition rotations, program acceptance of COMLEX-USA scores, and discriminatory language in program materials or communications. The extent to which inequities against DOs run afoul of the law is a state law issue and, as such, varies state by state. For this reason, in November 2024, AOA presented to osteopathic state and specialty affiliates on model state legislation the AOA has developed to support DO parity and provided guidance to state affiliates on how to advocate for stronger regulatory frameworks that protect and promote equitable treatment of osteopathic medical students and physicians. These resources are available on the AOA's affiliate workspace for easy access and the AOA remains ready to assist any state affiliates through this process.

The AOA remains unwavering in its mission to eliminate barriers to graduate medical education access and to ensure that all osteopathic medical students and residents are evaluated fairly and equitably. Through continued collaboration, advocacy, and education, the AOA is advancing a future where osteopathic medical students and physicians have equal opportunities to thrive in medical training and practice.

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

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted__
DATE: ___July 19, 2025

AMERICAN OSTEOPATHIC ASSOCIATION

300 Series Professional Affairs Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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

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

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Site Neutral Reimbursement (SR-Source-H306-A/20)	BFHP	Professional Affairs	Adopted
H-301	Physician Office Laboratories (SR-Source-H312-A/20)	BFHP	Professional Affairs	Adopted
H-302	Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services (SR-Source-H315-A/20)	BFHP	Professional Affairs	Adopted as Amended
H-303	Emergency Medical Services for Children – Support of (SR-Source-H316-A/20)	BFHP	Professional Affairs	Adopted
H-304	Medicare Balance Billing (SR-Source-H319-A/20)	BFHP	Professional Affairs	Adopted
H-305	Adverse Childhood Experiences Screening (SR-Source-H327-A/20)	BFHP	Professional Affairs	Adopted
H-306	Inequalities in Medicaid Funding Affecting U.S. Territories (SR-Source-H329-A/20)	BFHP	Professional Affairs	Adopted
H-307	Protecting American Students from Profit-Driven Foreign Medical Schools (SR-Source-H302-A/20)	BFHP	Professional Affairs	Adopted as Amended
H-308	Osteopath and Osteopathy - Use of the term (SR-Source-H310-A/20)	BIOM	Professional Affairs	Adopted as Amended
H-309	Postgraduate Compensation (SR-Source-H313-A/20)	BOE	Professional Affairs	Adopted as Amended
H-310	Low Back Pain Clinical Practice Guidelines, Revision of (SR-Source-H325-A/20)	BORPH	Professional Affairs	Referred to BORPH
H-311	Intentionally Blank			
H-312	Retail-Based Health Clinics and Urgent Care Centers (SR-Source-H301-A/20)	BORPH	Professional Affairs	Adopted as Amended
H-313	Second Opinion, Surgical Cases (SR-Source-H314-A/20)	CERA	Professional Affairs	Adopted as Amended
H-314	Buprenorphine Maintenance Treatment Insurance Coverage (SR-Source-H323-A/20)	CERA	Professional Affairs	Adopted as Amended

AMERICAN OSTEOPATHIC ASSOCIATION

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

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

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

Policy Statement

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 19, 2025_____

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

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

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

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

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended__

DATE: ____July 19, 2025_____

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

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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

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

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

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

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

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

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

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

Executive Summary:
The American Osteopathic Association (AOA) recommends that osteopathic physicians use Osteopathic manipulative treatment (OMT) in the care of patients with low back pain. Evidence from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a) supports this recommendation.
1. Overview material: Provide a structured abstract that includes the guideline's release date, status (original, revised, updated), and print and electronic sources.

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

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

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

ABSTRACT

Background

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

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

Methods

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

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

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

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

Results

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

OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP. Franke et al found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95%CI: -0.58 to -0.14). More specifically, in chronic nonspecific LBP, evidence suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95%CI:-25.18 to - 4.68) and functional status (SMD:-0.32, CI:-0.58 to -0.07). When examining nonspecific LBP in pregnancy, low-quality evidence suggested a significant difference in favor of OMT for pain (MD, -23.01; 95% CI, -44.13 to -1.88) and functional status (SMD, -0.80; 95% CI, - 1.36 to - 0.23). Conversely for nonspecific LBP postpartum, Franke et al found that moderate-quality evidence suggested a significant difference in favor of OMT for pain (MD, -41.85; 95% CI, - 49.43 to -34.27) and functional status (SMD, -1.78; 95% CI, -2.21 to -1.35).[2]

Conclusions

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

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

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

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

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

BACKGROUND

Historically, low back pain has been the most common reason for visits to osteopathic physicians.[3] More recent data from the Osteopathic Survey of Health Care in America has confirmed that a majority of patients visiting osteopathic physicians continue to seek treatment

for musculoskeletal conditions.[4, 5] A distinctive element of low back care provided by osteopathic physicians is osteopathic manipulative treatment (OMT). A comprehensive evaluation of spinal manipulation for low back pain undertaken by the Agency for Health Care Policy and Research in the United States concluded that spinal manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms.[6]Nevertheless, because most studies of spinal manipulation involve chiropractic or physical therapy,[7]it is unclear if such studies adequately reflect the efficacy of OMT for low back pain. Although the professional bodies that represent osteopaths, chiropractors, and physiotherapists in the United Kingdom developed a spinal manipulation package consisting of three common manual elements for the UK Back pain Exercise and Manipulation (UK BEAM) trial,[8] there are no data on the comparability of profession specific outcomes.[9,10] It is well known that OMT comprises a diversity of techniques.[11] These OMT techniques are not adequately represented by the UK BEAM trial package. Professional differences in spinal manipulation are more pronounced in research studies, in which chiropractors have focused almost exclusively on high-velocity-low amplitude techniques.[12] For example, a major trial of chiropractic manipulation as adjunctive treatment for childhood asthma used a high-velocity-low amplitude thrust as the active treatment.[13] The simulated treatment provided in the sham manipulation arm of this chiropractic trial, which ostensibly was used to provide no therapeutic effect, bore a marked similarity to OMT.[12, 14] Because differences in professional background and training lend themselves to diverse manipulation approaches, clinicians have been warned about generalizing the findings of systematic reviews to practice.[15] In additional to professional differences in the manual techniques themselves, osteopathic physicians in the United States, unlike allopathic physicians or chiropractors, can treat this condition simultaneously using both conventional primary care approaches and complementary spinal manipulation. This represents a unique philosophical approach in the treatment of low back pain. Consequently, there is a need for empirical data that specifically address the efficacy of OMT for conditions such as low back pain.[16]

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

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

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

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

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

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

Patients with nonspecific low back pain of musculoskeletal origin are eligible for guideline recommendations. Patients with visceral disease conditions that refer pain to the low back are excluded from these guidelines. Other conditions of exclusion are when the following are the identified source of the low back pain: vertebral fracture; vertebral joint dislocation; muscle

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OMT versus untreated for nonspecific low back pain in postpartum women

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

DISCUSSION

Efficacy of OMT

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

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

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

psychological outcomes at little extra cost.[26]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

391

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

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

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Appendix 1

DEFINITION OF TERMS USED

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

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

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

active method, technique in which the person voluntarily performs an osteopathic practitioner-directed motion.

articulatory treatment, (Archaic). See *osteopathic manipulative treatment, articulatory treatment system.*

articulatory (ART), a low velocity/ moderate to high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased range of movement. The activating force is either a repetitive springing motion or repetitive concentric movement of the joint through the restrictive barrier.

balanced ligamentous tension (BLT), 1. According to Sutherland's model, all the joints in the body are balanced ligamentous articular mechanisms. The ligaments provide

proprioceptive information that guides the muscle response for positioning the joint, and the ligaments themselves guide the motion of the articular components. (*Foundations* **Chapman reflex,** See *Chapman reflex.*

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

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

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

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

Positioning," later termed "strain-counterstrain").

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

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

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

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

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

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

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

facilitated positional release (FPR), a system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue and joint tension in all planes, and an activating force (compression or torsion) is added.

2. A technique developed by Stanley Schiowitz, DO.

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

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

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

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

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

high velocity/low amplitude technique (HVLA), an osteopathic technique

employing a rapid, therapeutic force of brief duration that travels a short distance within the anatomic range of motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction. Also known as thrust technique.

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

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

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

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

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

ligamentous articular strain technique (LAS), 1. A manipulative technique in which the goal of treatment is to balance the tension in opposing ligaments where there is abnormal tension present. 2. A set of myofascial release techniques described by Howard Lippincott, DO, and Rebecca Lippincott, DO. 3. Title of reference work by Conrad Speece, DO, and William Thomas Crow, DO.

liver pump, See *hepatic pump.*

lymphatic pump, 1. A term used to describe the impact of intrathoracic pressure changes on lymphatic flow. This was the name originally given to the thoracic pump technique before the more extensive physiologic effects of the technique were recognized. 2. A term coined by C. Earl Miller, DO.

mandibular drainage technique, soft tissue manipulative technique using passively induced jaw motion to effect increased drainage of middle ear structures via the eustachian tube and lymphatics.

mesenteric release technique (mesenteric lift), technique in which tension is taken off the attachment of the root of the mesentery to the posterior body wall. Simultaneously, the abdominal contents are compressed to enhance venous and lymphatic drainage from the bowel.

muscle energy, a form of osteopathic manipulative diagnosis and treatment in which the patient's muscles are actively used on request, from a precisely controlled position, in a specific direction, and against a distinctly executed physician counterforce. First described in 1948 by Fred Mitchell, Sr, DO.

myofascial release (MFR), a system of diagnosis and treatment first described by Andrew Taylor Still and his early students, which engages continual palpatory feedback to achieve release of myofascial tissues.

> **direct MFR,** a myofascial tissue restrictive barrier is engaged for the myofascial tissues and the tissue is loaded with a constant force until tissue release occurs.
>
> **indirect MFR**, the dysfunctional tissues are guided along the path of least

resistance until free movement is achieved.

myofascial technique, any technique directed at the muscles and fascia. See also *osteopathic manipulative treatment, myofascial release.* See also *osteopathic manipulative treatment, soft tissue technique.*

myotension, a system of diagnosis and treatment that uses muscular contractions and relaxations under resistance of the osteopathic practitioner to relax, strengthen or stretch muscles, or mobilize joints.

Osteopathy in the Cranial Field (OCF), 1. A system of diagnosis and treatment by an osteopathic practitioner using the primary respiratory mechanism and balanced membranous tension. See also *primary respiratory mechanism.* 2. Refers to the system of diagnosis and treatment first described by William G. Sutherland, DO. 3. Title of reference work by Harold Magoun, Sr, DO.

passive method, based on techniques in which the patient refrains from voluntary muscle contraction.

pedal pump, a venous and lymphatic drainage technique applied through the lower extremities; also called the pedal fascial pump or Dalrymple treatment.

percussion vibrator technique, 1. A manipulative technique involving the specific application of mechanical vibratory force to treat somatic dysfunction. 2. An osteopathic manipulative technique developed by Robert Fulford, DO.

positional technique, a direct segmental technique in which a combination of leverage, patient ventilatory movements and a fulcrum are used to achieve mobilization of the dysfunctional segment. May be combined with springing or thrust technique.

progressive inhibition of neuromuscular structures (PINS), 1. A system of diagnosis and treatment in which the osteopathic practitioner locates two related points and sequentially applies inhibitory pressure along a series of related points. 2. Developed by Dennis Dowling, DO.

range of motion technique, active or passive movement of a body part to its physiologic or anatomic limit in any or all planes of motion.

soft tissue (ST), A system of diagnosis and treatment directed toward tissues other than skeletal or arthrodial elements.

soft tissue technique, a direct technique that usually involves lateral stretching, linear stretching, deep pressure, traction and/or separation of muscle origin and insertion while monitoring tissue response and motion changes by palpation. Also called myofascial treatment.

Spencer technique, a series of direct manipulative procedures to prevent or decrease soft tissue restrictions about the shoulder. See also *osteopathic manipulative treatment (OMT), articulatory treatment (ART).*

splenic pump technique, rhythmic compression applied over the spleen for the purpose of enhancing the patient's immune response. See also *osteopathic manipulative treatment (OMT), lymphatic pump.*

spontaneous release by positioning, See *osteopathic manipulative treatment, counterstrain.*

springing technique, a low velocity/ moderate amplitude technique where the

restrictive barrier is engaged repeatedly to produce an increased freedom of motion. See also *osteopathic manipulative treatment, articulatory treatment system.*

Still Technique, 1. Characterized as a specific, non-repetitive articulatory method that is indirect, then direct. 2. Attributed to A.T. Still. 3. A term coined by Richard Van Buskirk, DO, PhD.

Strain-Counterstrain,® 1. An osteopathic system of diagnosis and indirect treatment in which the patient's somatic dysfunction, diagnosed by (an) associated myofascial tenderpoint(s), is treated by using a passive position, resulting in spontaneous tissue release and at least 70 percent decrease in tenderness. 2. Developed by Lawrence H. Jones, DO, in 1955. See *osteopathic treatments, counterstrain.*

thoracic pump, 1. A technique that consists of intermittent compression of the thoracic cage. 2. Developed by C. Earl Miller, DO.

thrust technique (HVLA), See *osteopathic manipulative treatment, high velocity/low amplitude technique (HVLA).*

toggle technique, short lever technique using compression and shearing forces.

traction technique, a procedure of high or low amplitude in which the parts are stretched or separated along a longitudinal axis with continuous or intermittent force.

v-spread, technique using forces transmitted across the diameter of the skull to accomplish sutural gapping.

ventral techniques, See *osteopathic manipulative treatment, visceral manipulation.*

visceral manipulation (VIS), a system of diagnosis and treatment directed to the viscera to improve physiologic function. Typically, the viscera are moved toward their fascial attachments to a point of fascial balance. Also called ventral techniques.

somatic dysfunction: Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

Appendix 2

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Source: H325-A/20

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: none

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Bureau of Osteopathic Research & Public Health*

DATE: July 19, 2025

Copied from AOA Task Force on the Low Back Pain Clinical Practice Guidelines. *American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients With Low Back Pain.* J Am Osteopath Assoc. 2016;116(8):536-549. doi:10.7556/jaoa.2016.107

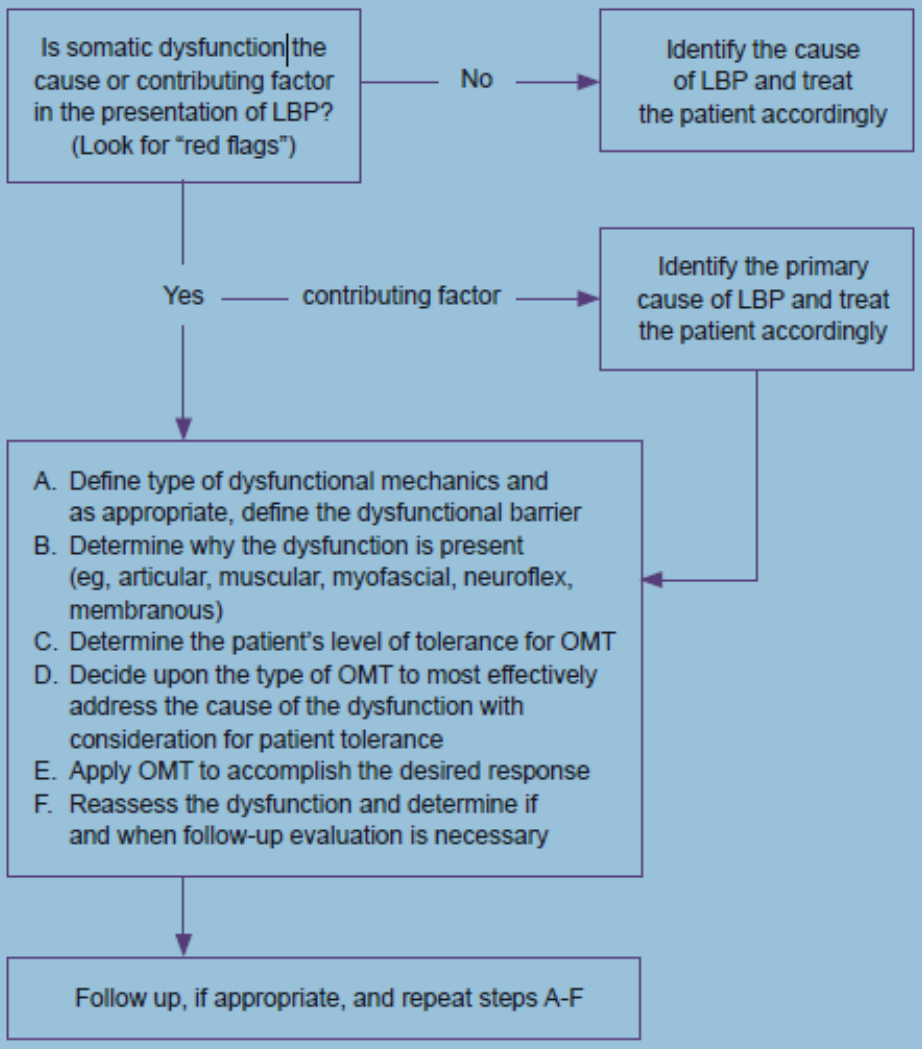

Figure.
Algorithm for osteopathic manipulative treatment (OMT) for low back pain (LBP) decision making.
Source: Adapted from: Nelson KE. The manipulative prescription. In: Nelson KE, Glonek T, eds. *Somatic Dysfunction in Osteopathic Family Medicine*. Baltimore, MD: Lippincott, Williams & Wilkins; 2007:27-32.

SUBJECT: RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS - SOURCE: H-301/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be Reaffirmed as Amended.

The American Osteopathic Association (AOA) recommends that retail-based health clinics and urgent care centers adhere to the following principles and standards to guide their establishment and operation.

1. Retail-based health clinics and urgent care centers must establish arrangements by which their health care practitioners have direct access to and supervision by physicians at levels that meet or exceed respective state laws.
2. Retail-based health clinics and urgent care centers must encourage patients to establish care with a primary care physician to ensure continuity of care. If a patient's conditions or symptoms are beyond the scope of services provided by the clinic, that patient must immediately be referred to an appropriate physician or emergency facility. Also, retail-based health clinics **AND** urgent care centers should be encouraged to use electronic health records as a means of communicating information with the patient's primary physician and facilitating continuity of care.
3. Whether by electronic communication, or some other acceptable means, retail-based health clinics **AND** urgent care centers must send detailed information on services provided to the patient's primary care physician in a timely manner to ensure continuity of care.
4. The clinic must have a well-defined and limited scope of clinical services. These services must not exceed the on-site health provider's scope of practice, as determined by state law. **IF A LISCENSED PHYSICIAN IS NOT ONSITE, IT MUST BE CLEARLY POSTED.**
5. Retail-based health clinics **AND** urgent care centers must use standardized medical protocols developed from evidence-based practice guidelines for non-physician practitioners.

6. Retail-based healthcare clinics **AND** urgent care centers must comply with all applicable standards of state and federal regulations expected of physician offices.
7. Retail-based healthcare clinics and urgent care centers must not expand into programs offering patient care for the management of chronic and complex conditions.
8. Retail-based healthcare clinics located in or affiliated with a pharmacy must inform patients that any medication prescribed or recommended may be purchased at the patient's pharmacy of choice.

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2015 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 19, 2025_____

SUBJECT: SECOND OPINION, SURGICAL CASES – SOURCE: H314-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED

6 The American Osteopathic Association (AOA) believes that ~~AOA members~~
7 **OSTEOPATHIC PHYSICIANS** who are board certified, or board eligible and
8 qualified by their training and experience to render a second surgical opinion in any
9 given case, be recognized and utilized as qualified and reimbursed by entities
10 underwriting such opinions and that this policy statement in no way advocates the
11 institution of any mandatory second surgical opinion programs, by any entity.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE – SOURCE: H323-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) recommends that ~~state Medicaid administrators~~ **PUBLIC AND PRIVATE PAYORS (1)** remove any arbitrary and restrictive limits for buprenorphine coverage; ~~and that state Medicaid administrators and third party payers~~ **(2)** recognize that **~~USING~~** ~~chronic disease management~~ **~~MEDICATION FOR~~ TREATMENT OF OPIOID USE DISORDER** includes a combination of psychotherapeutic and pharmacological interventions that will yield the best outcomes for ~~patients with opioid use disorder~~ **SUCH PATIENTS, WHEN POSSIBLE.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: TAX CREDIT FOR PRECEPTING - SOURCE: H305-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) will support legislation to implement
8 precepting tax credits.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS - SOURCE: H308-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED**.**

The American Osteopathic Association (AOA) and its component societies are encouraged to support osteopathic physicians and their practices by:

(1) working with the American Osteopathic Information Association to educate physicians as to the importance of compliance, risk management, and risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues.

(2). Identifying supportive state and federal agencies, professional liability insurance companies, and physicians with expertise on these issues.

(3) encouraging government agencies and insurance companies to utilize only expert witnesses who are osteopathic physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic physicians and boards with “like osteopathic specialty”.

(4) ~~AOA and state society leadership of~~ **IDENTIFYING** any needs, trends, or issues of concern related to the above, which will enhance the rights and practices of our fellow osteopathic physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

SUBJECT: PHYSICIAN INCENTIVES TO **PRACTICE IN** UNDERSERVED AREAS - SOURCE: H317-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) will support federal and state
8 legislation to increase physician loan repayment programs and tax
9 deductions/credits for individuals who practice in underserved rural and urban
10 areas.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: VIOLENCE AGAINST HEALTHCARE STAFF
- SOURCE: H324-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports legislation to hold patients
8 and their associates (that includes friends, family, and anyone who accompanies
9 them) accountable for physical assault and verbal threats to health care staff by
10 upgrading penalties under federal and relevant state law and legislation from
11 misdemeanors to felonies where applicable.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR ~~CHRONIC~~ PAIN - UNITED STATES - SOURCE: H337-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant but requires updating to reflect recent changes; now, therefore be it

5 RESOLVED, the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED AS AMENDED.

7 The American Osteopathic Association (AOA) opposes the misuse and inflexible
8 application of the United States Centers for Disease Control and Prevention (CDC)
9 "Guideline for Prescribing Opioids for ~~Chronic~~ Pain — ~~United States, 2016,~~
10 ~~(Guideline)"~~ by law makers and regulators; and the AOA opposes the codification of
11 the Guidelines into law or regulation and their use as a measure of the
12 appropriateness of physicians prescribing.~~; and the AOA recommends physicians~~
13 ~~read and consider the use of the **2019 RECOMMENDATIONS OF THE AMERICAN**~~
14 ~~**MEDICAL ASSOCIATION OPIOID TASK FORCE AND THE CDC "CLINICAL**~~
15 ~~**PRACTICE GUIDELINE FOR PRESCRIBING OPIOIDS FOR PAIN — UNITED**~~
16 ~~**STATES, 2022"** 2019 AMA Opioid Task Force 2019 Guidelines in patients being~~
17 ~~treated for non-malignant chronic pain conditions.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2020 Adopted as Amended

Prior HOD action on similar or same topic: H322-A/20 Prescription Drug Diversion and Abuse – Education, Research, and Advocacy; H326-A/21 Pain Related Education Requirements; H345-A/24 Opioid Crisis, Causes; H431-A/22 AOA Policies on Opioids and Substance Use

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: USE OF THE TERM “PHYSICIAN” “DOCTOR” AND “PROVIDER”- SOURCE: H336-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED**.**

Use of the Term “Physician” “Doctor” and “Provider”

The American Osteopathic Association (AOA) adopts as policy:

(1) that ~~AOA members~~ **OSTEOPATHIC PHYSICIANS** are encouraged to use the terms “physician” or “doctor” to describe themselves, leaving other terms such as “practitioner,” “clinician,” or “provider” to be used by non-physician clinicians or to categorize health care professionals as a whole;

(2) THAT AOA ADVOCATES FOR THE USE OF THE TERM “STUDENT PHYSICIAN” WHEN INTRODUCING OSTEOPATHIC MEDICAL STUDENTS IN CLINICAL SETTINGS, TO CLEARLY DISTINGUISH THEM FROM OTHER TYPES OF LEARNERS WITHIN THE HEALTHCARE ENVIRONMENT.

~~(2)~~ **(3) THAT AOA** supports the appropriate use of credentials and professional degrees in advertisements;

~~(3)~~ **(4) THAT AOA** supports providing a mechanism for physicians to report advertisements related to medical care that are false or deceptive;

~~(4)~~ **(5) THAT AOA** opposes non-physician clinicians’ use of the title “physician,” as well as use of the title “doctor” without specifying the type of doctorate received, because such communication is likely to confuse the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine;

~~(5)~~ **(6) THAT AOA** opposes legislation that would expand the use of the term “physician” to persons other than US-trained DOs, and MDs; and

34 ~~(6)~~ **(7) THAT AOA** supports a policy that physicians and non-physician clinicians
35 should identify themselves to their patients using their degree in both a verbal
36 introduction as well as by other identification clearly visible during patient
37 encounters.

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: __July 19, 2025_____

SUBJECT: SUPPORT FOR **OSTEOPATHIC MANIPULATIVE TREATMENT (**OMT**)** PRIVILEGES – SOURCE: H349-A/19

SUBMITTED BY: Bureau of Osteopathic Education / AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Bureau of Osteopathic Education (BOE) submitted H335 A/24 Support for OMT Privileges (Source H349 A/19) to the 2024 House of Delegates and recommended that it be reaffirmed as amended; and

WHEREAS, the 2024 House of Delegates referred this policy back to BOE to include guidelines for credentialing if appropriate; and

WHEREAS, the BOE and President Hubka's CME Workgroup has reviewed the policy and sample credentialing guidelines; and

WHEREAS, the BOE has had significant discussions regarding this resolution at its November 2023, January 2024, April 2024, June 2024, September 2024, January 2025, and March 2025 meetings. The revisions to the policy are based on the 2015 credentialing document from the Department of the Navy Bureau of Medicine and Surgery; and

WHEREAS, consensus within the BOE could not be reached on the creation of separate guidelines "that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT." There was significant concern that the development of credentialing guidelines would have unintended consequences and create a mechanism for non-DOs to regulate OMT practice within medical systems and hospitals; and

WHEREAS, the BOE believes that their revisions to the policy provides guidance for **THE AMERICAN OSTEOPATHIC ASSOCIATION (**AOA**)** to advocate for all osteopathic physicians who desire to practice OMT within medical systems and hospitals. This is also consistent with current AOA **Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance** Source: H635 - A/20 "To perform OMT a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine or a medical doctor must have completed a board-approved postgraduate osteopathic training program that encompasses osteopathic principles and practices, including hands-on demonstration and competency testing in OMT"; and

WHEREAS, THE DEFINITION OF ~~OSTEOPATHIC MANIPULATIVE TREATMENT IS: OSTEOPATHIC MANIPULATIVE TREATMENT (~~OMT~~)~~ IS THE THERAPEUTIC APPLICATION OF MANUALLY GUIDED FORCES BY APPROPRIATELY TRAINED, FULLY LICENSED PHYSICIANS TO

IMPROVE PHYSIOLOGIC FUNCTION AND/OR SUPPORT HOMEOSTASIS THAT HAS BEEN ALTERED BY SOMATIC DYSFUNCTION.(1) SOMATIC DYSFUNCTION IS DEFINED AS "IMPAIRED OR ALTERED FUNCTION OF RELATED COMPONENTS OF THE BODY FRAMEWORK SYSTEM: SKELETAL, ARTHRODIAL AND MYOFASCIAL STRUCTURES, AND THEIR RELATED VASCULAR, LYMPHATIC AND NEURAL ELEMENTS." (1) OMT IS CONSIDERED SAFE WITH LOW RATES OF ADVERSE EVENTS (2); AND

WHEREAS, Osteopathic Manipulative Treatment is required curriculum for all Colleges of Osteopathic Medicine and assessed by the Comprehensive Osteopathic Medical Licensing Examination of the United States, ~~and~~ **NOW THEREFORE BE IT**;

~~WHEREAS, this guidance only refers to osteopathic physicians; a separate resolution should be developed if there is a desire to have policy for allopathic physicians; now, therefore be it~~

RESOLVED, that the BOE recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **WILL** support and advocate for all **OSTEOPATHIC** physicians who desire to practice osteopathic manipulative treatment (OMT) within medical systems and hospitals; ~~and, that The AOA create guidelines, that can be distributed upon request to hospitals, medical systems, and other interested entities, that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT~~.

DELINEATION OF CLINICAL PRIVILEGES

THE AOA HOLDS THAT GRADUATION FROM A COCA-ACCREDITED OSTEOPATHIC MEDICAL SCHOOL OR AN OSTEOPATHICALLY RECOGNIZED RESIDENCY PROGRAM PROVIDES SUFFICIENT FOUNDATIONAL COMPETENCY IN OMT. NEVERTHELESS, IT RECOGNIZES THAT CERTAIN HOSPITAL MEDICAL STAFF COMMITTEES OR PRIVILEGING BODIES MAY REQUIRE FURTHER EVIDENCE OR DOCUMENTATION TO DEMONSTRATE ONGOING COMPETENCY IN OMT, PARTICULARLY IN DIVERSE CLINICAL CONTEXTS.

THESE GUIDELINES, THEREFORE, SERVE AS AN ADVISORY RESOURCE, ASSISTING PRIVILEGING BODIES IN VERIFYING AND VALIDATING OMT PRIVILEGES WHILE RESPECTING THE UNIQUE AUTHORITY AND EXPERTISE OF OSTEOPATHIC PHYSICIANS TO GUIDE AND OVERSEE OMT CREDENTIALING.

THIS DOCUMENT SERVES TO PROVIDE EXAMPLE GUIDELINES AND IS NOT INTENDED TO SET A STANDARD FOR ANY INSTITUTION OR TO BE ALL-INCLUSIVE. IT REFLECTS THE AMERICAN OSTEOPATHIC ASSOCIATION

(AOA) POLICY AND EMPHASIZES THE EXCLUSIVE AUTHORITY OF OSTEOPATHIC PHYSICIANS IN GUIDING PRIVILEGING FOR OMT.

TRAINING OR EXPERIENCE CRITERIA FOR OMT PRIVILEGES:

1. **GRADUATED FROM OSTEOPATHICALLY RECOGNIZED ACGME RESIDENCY PROGRAM, OR GRADUATED FROM AN AOA OR ACGME RESIDENCY PROGRAM AND PERFORMED OMT DURING RESIDENCY, AND**
2. **PARTICIPATES IN AOA-ACCREDITED, OMT-SPECIFIC CONTINUING MEDICAL EDUCATION COURSES, OR**
3. **DEMONSTRATES CONSISTENT AND ACTIVE PRACTICE OF OMT (DOCUMENTED OR ATTESTED TO)**

REFERENCES:

1. **GIUSTI, REBECCA, EDITOR *THE GLOSSARY OF OSTEOPATHIC TERMINOLOGY*, 3RD EDITION. AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE, 2017.**
2. **DEGENHARDT, B. F., JOHNSON, J. C., BROOKS, W. J., & NORMAN, L. (2018). CHARACTERIZING ADVERSE EVENTS REPORTED IMMEDIATELY AFTER OSTEOPATHIC MANIPULATIVE TREATMENT. *THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION, 118*(3), 141–149. HTTPS://DOI.ORG/10.7556/JAOA.2018.033**

Background Information: Provided by AOA Staff
Current AOA Policy: 2019; 2024 Referred

Prior HOD action on similar or same topic: H635-A/20- AOA Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance
H335-A/24- Referred to Bureau of Education

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: END-OF-LIFE CARE – USE OF PLACEBOS IN – SOURCE: H322-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H310-A/2024 SR END-OF-LIFE CARE – USE OF PLACEBOS IN-H322-A/19 to the 2024 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2024 House of Delegates referred this policy back to BORPH and requested that BORPH update the language to use current terminology for substance use disorders; and

WHEREAS, the policy was sent to the American Osteopathic Academy on Addiction Medicine to review and update the language, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Use of Placebos in End-of-Life Care

Position Paper

The AOA approves the attached position paper on Use of Placebos for Pain Management in End-of-Life Care and will be updated according to the current literature.

USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE

The placebo effect of medication can be a significant resultant action of any prescription. However, the substitution of a placebo in place of effective pain medication has been widely recognized as unethical, ineffective and potentially harmful. ([1-9]) A number of organizations have advised against the use of placebo substitution, including the American Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical Association), American Nursing Association, and the American Society of Pain Management Nurses.

This white paper describes the literature and rationale in support of the AOA's position on the controversial subject of the use of placebos for pain management in terminally ill patients.

I. Definition of Terms

A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution means the substitution of a physiologically inactive substance for a comparison with the physiologically active substance. Placebo effect is the positive psychosomatic response of an individual to a treatment; in contrast, the nocebo response is a negative psychosomatic response to a treatment. ([10]) The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician's treatment plan and/or prescription for the symptom relief are more likely to obtain relief. ([4] [2])

Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a "nocebo response". A pleasant effect is called a "positive placebo response". It has been noted that, "a positive placebo response simply speaks to the strength of an individual's central control processes (i.e., mind) to recruit their descending inhibitory system to block pain. The trained osteopathic physician knows that pain relief occurs both in the mind and in the body." ([4]) The basis of the placebo effect in a therapeutic physician-patient relationship also involves good communication skills as well as listening to the patient. ([4, 11, 12])

To summarize, a placebo is a type of treatment, necessarily used in controlled clinical trials, that has no inherent physiological action yet is designed to mimic a therapy with a known active physiologic effect. Positive changes resulting from placebo administration would be due to expectations of success by the patient. Thus, the use of placebo effect is based on the patient's perception of the role of the placebo agent with symptom relief. The placebo response may be enhanced with a positive patient-physician relationship.

B. Addiction, substance **USE DISORDER**, ~~abuse and dependence,~~ tolerance, withdrawal, and pseudo-addiction.

Some physicians inappropriately justify using **A** placebo in pain management to avoid **GENERATING A SUBSTANCE USE DISORDER** ~~"addicting" the patient~~. Addiction, as defined by the American Academy of Pain Medicine,([13]) "is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving."

Substance **USE DISORDER** ~~abuse~~ is defined as **THE HARMFUL USE OF SUBSTANCES DESPITE NEGATIVE CONSEQUENCES**. ~~psychological and physical dependence on substances.~~ Some physicians are concerned that prescribing narcotics may lead to substance **USE DISORDER** ~~abuse~~ and therefore may attempt to use a placebo to assess whether the patient truly requires narcotics for pain relief. However, there is no scientific basis for using placebo in the assessment of the patient in pain who has or may have the potential for a substance **USE DISORDER** ~~abuse~~. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) ([14]), lists definitive criteria for diagnosis of psychological and physical dependence on substances. This text categorizes "Substance-Related Disorders" but does not utilize the term addiction; further, nowhere in the DSM-V is placebo administration utilized with criteria for diagnosing various forms of substance **USE DISORDERS.** ~~abuse.~~ Substance **USE DISORDER** ~~dependence~~ **ENCOMPASSES** ~~is defined as~~ a cluster of cognitive, behavioral, and physiological symptoms. The essential feature of a substance **USE DISORDER** ~~dependent individual~~ is continuous use of the substance despite significant substance-related problems, such as deleterious effects on occupation, relationships, health, and others.

Physicians may become uncomfortable with requests for increased dosages of pain medications, fearing that a patient is manifesting a substance-related disorder. A better understanding of the concepts of tolerance, physical dependence, physiological dependence withdrawal symptoms and pseudo-addiction, may help physicians understand and more effectively treat these patients.

Tolerance represents a markedly diminished effect that can occur with continued use of most medications; the degree depends upon the daily dose and length of use. The need for medication titration, either due to development of tolerance or to incomplete responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory changes in receptors and/or increased clearance resulting from induction of various metabolic pathways. The problem of tolerance should therefore be anticipated as a possible outcome in prescription pain medications.

Withdrawal is defined by the DSM-V ([14]) as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such "drug seeking behavior" has been deemed as "proof" of "addiction." The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a **SUBSTANCE USE DISORDER** ~~substance-abusing patient~~ according to the DSM-V. ([14])

126 II. Legal Considerations in the Use of Placebos in Pain Management
127 While there are no specific laws governing the use of placebos in any circumstance, there
128 is a considerable amount of legislation regarding a patient's right to pain management.
129 There are several state statutes that address this issue, some of which are based on the
130 Federation of State Medical Boards' Model Guidelines for the Use of Controlled
131 Substances for the Treatment of Pain.([15]) This document clarifies that legislative statutes
132 accepting these guidelines understand the ongoing increased scientific knowledge of pain
133 management, and thus have no need to modify legislation as the science of pain
134 management changes. This document does not mention placebo usage.
135
136 The American Bar Association (ABA) ([16]) adopted a resolution concerning the promotion of
137 pain management in all patients with chronic pain. This resolution states, "…that the
138 American Bar Association urges federal, state, and territorial governments to support fully
139 the rights of individuals suffering from pain to be informed of, choose, and receive effective
140 pain and symptom evaluation, management and ongoing monitoring as part of basic
141 medical care, even if such pain and symptom management may result in analgesic
142 tolerance, physical dependence or as an unintended consequence shorten the individual's
143 life." Placebo substitution for active pain medicine without informed consent on the part of
144 the patients clearly violates the nature and substance of the ABA's position. Additionally, in
145 two Supreme Court decisions regarding the right to assisted suicide, the court promoted
146 the right of individuals to appropriate palliative care and pain management. ([17, 18])
147
148 While there is little case law concerning tort or administrative findings against physicians
149 for inadequate pain management, this is likely to change in the near future. The main
150 barrier to malpractice claims for inadequate pain management is use of the customary
151 local standard to determine what constitutes ordinary care. The courts are steadily moving
152 away from this standard to a national standard which uses clinical guidelines as the
153 determinant of ordinary care. This is seen in the decision in the case of Nowatske v.
154 Oserloh, where the court stated, "should customary medical practice fail to keep pace with
155 development and advances in medical science, adherence to custom might constitute a
156 failure to exercise ordinary care…" ([19])
157
158 Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency
159 for Healthcare Research and Quality ([1]), the American Pain Society, ([7]) the Healthcare
160 Facilities Accreditation Program ([20]) as well as the Joint Commission on Accreditation of
161 Healthcare Organizations ([21]) are good examples of sources the courts are using to
162 determine ordinary practice. These guidelines do not support the use of placebo in any
163 fashion except in approved research studies when the appropriate patient informed
164 consent has been obtained. Therefore, the physician thus cannot justify the use of placebo
165 for pain management by attempting to diagnose "addiction" or with support from any of the
166 above regulatory agencies. ([5])
167 Furthermore, under California's elder abuse statute, ([22]) a physician was successfully sued
168 by the deceased's family for inadequate pain management at the end of life. ([23])
169
170 III. Adverse Effects of Placebo Use
171

Pain is a universal experience and is subjective by nature. Despite the common colloquialism, “I feel your pain,” no individual can truly experience another’s pain. There are no laboratory tests or consistently reliable physical findings for assessment of pain. Patient self-report remains the gold standard for pain assessment. ([24]) Use of a placebo in place of an effective pain medication for attempting to determine whether the patient at end-of life is really in pain is under no circumstances appropriate.

There is a concern if a physician deceives the patient and substitutes a placebo treatment in the place of a known effective treatment without informing the patient. Deception has no place within the therapeutic relationship and is counter-productive. A physician may counsel a patient that “this treatment may be effective in treating your condition,” but evidence-based medicine cannot guarantee a treatment outcome.

In this era of informed consent, deception of the patient poses many problems, including erosion of the trust individuals and society as a whole have for physicians. There are methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a highly specialized procedure performed by a few skilled pain management physicians with appropriate informed consent.

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association’s 2000 report, is an ongoing problem. ([25]) While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. ([7, 26]) It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a “suicidogen,” whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death. ([6]) In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects ([3]) and potentially precipitate hyperalgesia ([27]) or withdrawal in patients previously treated with pain medications.

IV. Summary

Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of known effective pain medication for determining whether the patient is really in pain is under no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose substance **USE DISORDER** ~~abuse,~~ commonly referred to by some physicians as “addiction.” There is no medical justification for the use of placebos to assess or treat pain at end of life.

The only appropriate use of a placebo is in approved clinical research with informed consent.

References:

1. Agency for Health Care Policy and Research. Management of Cancer Pain, Clinical Practice Guideline, Number 9, AHCPR Publication Number 94-0592. Sept10, 2002 <http://www.ahcpr.gov/gils/00000176.HTM
2. Barsky AJ et al . Nonspecific medication side effects and the nocebo phenomenon. JAMA. 2002 Feb 6; 287 (5):622-7.
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4. Brody H. Commentary of placebos. Hastings Center Report. 1975 Apr 5; (2):17-8.
5. Brody H. The lie that heals: the ethics of giving placebos. Annals of Internal Medicine. 1982 July 97(1):112-8.
6. Brody H. The placebo response. Recent research and implications for family medicine. J Family Practice 2000 July 49(7):649-54.
7. Brody H. Placebo Response, Sustained Partnership and Emotional Resilience in Practice. Journal of the American Board of Family Practice. 1997 Jan-Feb 10(1): 72-73.
8. Emmanuel L et al . Foundations for Physicians on End-of-Life Care Curriculum. The EPEC Project, The Robert Wood Johnson Foundation. 1999. M4-4.
9. Ward et al. Foundations of Osteopathic Medicine, Second Edition. Philadelphia: Lippincott, Williams and Wilkins; 2003 p. 221.
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13. Helsinki Declaration. World Medical Association. 1989 available at http://ohsr.od.nih.gov/helsinki.php3
14. National Pharmaceutical Council and Joint Commission on Accreditation of Healthcare Organizations. Pain: Current Understanding of Assessment, Management and Treatments. December 2001. http://www.jcaho.org/news+room/health+care+issues/pain+mono_npc
15. Portenoy R.K. Contemporary Diagnosis and Management of Pain in Oncologic and AIDS Patients. Handbooks in Health Care Co., 1998.
16. Porter J., Jick H. Addiction rare in patients treated with narcotics. New England Journal Of Medicine 302 (2):123, 10 Jan 1980.
17. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. Fifth Edition. American Society of Pain. 2003. p 37-39.
18. "Proposed ABA Policy on Legal Obstacles To Effective Pain Management," American Bar Association 11 July 2000 http://www.abanet.org/aging/policyfinal.doc
19. Withdrawal Hyperalgesia after Acute Opioid Physical Dependence in Non-addict Humans: A Preliminary Study. Journal of Pain 4 (9):511-19 Nov 2003.
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23. Sullivan M, Terman Gw, Peck B, Correll Dj, Rich B, Clark Wc, Latta K, Lebovits A, Gebhart G; American Pain Society Ethics Committee. Aps Position Statement On The Use Of Placebos In Pain Management. J Pain 2005 Apr 6(4):215-217.
24. Arnstein P, Broglio K, Wuhrman E, Kean M B. The use of Placebos In Pain Management. Pain Management Nursing 2011 Dec 12 (4): 225-229.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Referred)

Prior HOD action on similar or same topic:
H310-A/24 Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: __*Referred to Bureau of Osteopathic Public Health and Research*

DATE: _July 19, 2025_____

SUBJECT: ~~MARIJUANA & THC – UNINTENTIONAL PEDIATRIC INGESTION PREVENTION~~ **PREVENTION OF PEDIATRIC CONSUMPTION OF CANNABIS, ITS DERIVATIVES, AND SYNTHETIC CANNABINOIDS**

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2025 thirty-nine states, three territories and the District of Columbia allow the medical use of cannabis products; and twenty-four states, three territories and the District of Columbia allow or regulate cannabis for non-medical adult (recreational) use[1], and

WHEREAS, there had been a consistent increase in pediatric edible cannabis exposures during the previous five years, with the most common site for exposure being residential settings (97.1%) and most of those exposures occurring in the patient's own residence (90.7%)[2], and

WHEREAS, since cannabis is illegal at the federal level, the Poison Prevention Packaging Act requirements are not binding, and states are responsible for regulating labeling and packaging of cannabis products[3], and

WHEREAS, the American College of Medical Toxicology has published guidelines for packaging of cannabis to prevent pediatric ~~ingestion~~ **CONSUMPTION** and poisoning which include 1) requiring child-resistant packaging consistent with the Poison Prevention Packaging Act, and 2) prohibition of labeling and advertising that might appeal to children[4], therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports ~~state~~ legislation and regulation that ensures 1) ~~marijuana and tetrahydrocannabinol (THC)~~ **CANNABIS, ITS DERIVATIVES, AND SYNTHETIC CANNABINOIDS** containing products are not manufactured, labeled, or marketed in a manner that could potentially be appealing to minors, and 2) they are packaged in a manner to prevent pediatric ~~ingestion~~ **CONSUMPTION**.

References:
[1]National Council of State Legislatures. (2020). www.ncsl.org/civil-and-criminal-justice/cannabis-overview.

[2]Shenouda, J., et al. (2023) Pediatric Edible Cannabis Exposures and Acute Toxicity: 2017 – 2021. *Pediatrics*. 151(2), February 2023.

[3]Lisi, D.M., Pharm D. (2022). Cannabis Edibles and Pediatric Toxicity Risk. *U.S. Pharmacist.* 47(8)HS-2-11.

[4]Amirshahi, M.M., Moss, M.J., Smith, S.W. *et al.* ACMT Position Statement: Addressing Pediatric Cannabis Exposure. *J. Med. Toxicol.* **15**, 212–214 (2019). https://doi.org/10.1007/s13181-019-00708-z.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: ~~MARIJUANA~~ **CANNABIS** CESSATION COUNSELING REIMBURSEMENT

SUBMITTED BY: American College of Osteopathic Family Physicians (ACOFP)

REFERRED TO: Committee on Professional Affairs

WHEREAS, marijuana is the second most commonly used mind-altering substance in the United States, widely legalized for medicinal *and* recreational use [(1)]; and

WHEREAS, 19 million people met the criteria for marijuana use disorder in 2022 [(1)]; and

WHEREAS, the National Institute on Drug Abuse identifies marijuana as an addictive drug and marijuana products have been shown to cause dependence, including the potential for withdrawal effects [(1)]; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) will cover 2 tobacco cessation attempts per year, with each attempt including a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions in a 12-month period with the codes 99406 and 99407 [(2)]; and

WHEREAS, Medicare covers these services in both inpatient and outpatient settings and now waves the deductible or copayment for patients, with net zero cost to patients [(2)]; and

WHEREAS, tobacco cessation has significant health risk reduction benefits warranting the incentive for providers to counsel on cessation; and

WHEREAS, marijuana, although not yet as heavily researched as tobacco, has still been shown to also have long term negative health consequences including impacts on lung health, mental health (psychosis, schizophrenia, depression), cardiovascular effects (stroke, heart attack, arrhythmia), gastrointestinal issues (cannabinoid hyperemesis syndrome, PUD), concentration, memory, fetal complications in pregnancy, and cancer risk (throat, head and neck) [(3)] now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourages further research on ~~marijuana~~ **CANNABIS AND ITS DERIVATIVES** and its potential health benefits and risks; and, be it further

RESOLVED, that the AOA advocate for legislation requiring insurance companies to reimburse ~~providers~~ **PHYSICIANS AND NON-PHYSICIAN CLINICIANS** for ~~marijuana~~ **CANNABIS** cessation counseling; and, be it further

29 RESOLVED, that the AOA advocate that CMS reimburse physicians for ~~marijuana~~
30 **CANNABIS** cessation counseling in a similar way to tobacco cessation
31 counseling.

References:

1. Sharp, Amelia. *How to Quit Smoking Marijuana.* Nov. 15, 2024. American Addiction Centers. https://americanaddictioncenters.org/marijuana-rehab/quit-marijuana.
2. *Smoking & Tobacco Use Cessation Counseling.* Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=130#:~:text=Minimal%20counseling%20is%20already%20covered,in%20a%2012%20month%20period.
3. *Cannabis (Marijuana).* Sept 2024. National Institute of Drug Abuse. https://nida.nih.gov/research-topics/cannabis-marijuana#short-term-health-cannabis.

Background Information: Provided by AOA Staff

Current AOA Policy:

H424-A/21 Medical Cannabis – Research on

H428-A/22 Recreational Cannabis Use by Physicians, Students and Patients – White Paper

No direct duplicate on payment, but AOA supports payment for substance use disorder counseling:

H608-A/20 Health Plan Coverage of Tobacco Cessation Treatment

H325-A/23 Physician Payment for Electronic Advice, Counseling and Treatment Plans

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: RURAL HOSPITAL FUNDING

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, 60 million people in the United States (20% of the population) live in rural areas [1]; and

WHEREAS, Section 1820 of the Social Security Act established Medicare Rural Hospital Flexibility Programs (MRHFPs) that allow individual states to designate certain facilities as critical access hospitals (CAHs) [2]; and

WHEREAS, CAHs provide vital healthcare services to patients in rural areas; and

WHEREAS, over the past two decades, nearly 200 rural hospitals have closed [3]; and

WHEREAS, more than 700 rural hospitals– one-third of all rural hospitals in the country– are at risk of closing because of the serious financial problems they are experiencing [3]; and

WHEREAS, the Medicare and Medicaid programs are major funding sources for services provided by CAHs, and

WHEREAS, a significant number of osteopathic physicians practice in rural areas including in CAHs [4] ; and

WHEREAS, Congress **HAS PASSED LEGISLATION THAT AMOUNTS** ~~is considering proposals that would amount~~ to the largest Medicaid cut in the program's history [~~4~~**5**]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA), ~~through its Washington office~~ advocate for adequate funding for critical access hospitals.

References:
1. https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html accessed May 1, 2025
2. https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf accessed May 1, 2025
3. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf accessed May 1, 2025
4. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2024-OMP-Report.pdf accessed May 1, 2025

5. https://www.congress.gov/bill/119th-congress/house-bill/1/text

Background Information: Provided by AOA Staff
Current AOA Policy:
H439-A/24 Physician Supply in Rural, Underserved United States – Recommendations for Improving
H314-A/23 Rural Healthcare Payment Equity
H201-A/24 Health Care Shortage in Rural America
H216-A/21 Rural Healthcare Provided by Current GME Programs – Preservation of

H439-A/24 is the only policy that mentions "critical access hospitals" directly, but all policies listed above directs the AOA to advocate for rural funding.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: PHARMACY BENEFIT MANAGERS (PBMS)

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, nearly one in three retail pharmacies have closed since 2010[1]; and

WHEREAS, rural, black, and Latin X communities have been disproportionately been impacted by these closures worsening pre-existing health disparities [1]; and

WHEREAS, independent pharmacies have been twice as likely to close as chain pharmacy stores [1]; and

WHEREAS, Pharmacy Benefits Managers (PBMs) now control nearly 90% of all pharmacy benefits with just three companies being responsible for 80% of those prescription drug claims [2]; and

WHEREAS, PBMs not only manage pharmacy benefits but also own major pharmacy chains or mail order pharmacies or are owned by major insurers [3]; and

WHEREAS, these relationships have led PBMs to develop preferred pharmacy networks that exclude or reduce payments to independent pharmacies [3]; and

WHEREAS, these practices have led to the creation of pharmacy deserts, increased consumer costs, and created restrictive formularies, thereby reducing access to healthcare goods and services; now, therefore be it

~~RESOLVED, that the American Osteopathic Association (AOA) supports legislation/regulation which addresses the healthcare access challenges created by current Pharmacy Benefit Managers (PBMs); and, be it further~~

~~RESOLVED~~, **WHEREAS**, that possible solutions include but are not limited to:

1. Increased PBM pricing transparency
2. Prohibiting PBMs from providing preferred payments to pharmacies owned by the PBM
3. Prohibiting PBMs from requiring use of pharmacies owned by the PBM
4. Passing the full amount of manufacturer rebates on to ~~insurers~~ **PATIENTS**
5. Prohibiting spread pricing

28 6. Encouraging anti-trust investigations into PBMs

29 **RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA)**
30 **SUPPORTS LEGISLATION OR REGULATION WHICH ADDRESSES THE**
31 **HEALTHCARE ACCESS CHALLENGES CREATED BY CURRENT**
32 **PHARMACY BENEFIT MANAGERS (PBMS**).

References:

1. Guadamuz, etal., More US Pharmacies Closed Than Opened In 2018–21; Independent Pharmacies, Those In Black, Latinx Communities Most At Risk, Journal of Health Affairs, December 2024, https://doi.org/10.1377/hlthaff.2024.00192

2. https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html accessed April 11, 2025

3. https://www.americanprogress.org/article/5-things-to-know-about-pharmacy-benefit-managers accessed April 11, 2025

Background Information: Provided by AOA Staff

Current AOA Policy:

H334-A/24 Pharmacy Benefit Managers-Increased Regulation of – White Paper

Prior HOD action on similar or same topic:

H334-A/24 Pharmacy Benefit Managers-Increased Regulation of – White Paper

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Iowa Osteopathic Medical Association*

DATE: July 19, 2025

SUBJECT: SUPPORT FOR METHODS TO INCREASE THE COMPENSATION FOR PEDIATRICIANS TO ADDRESS FUTURE WORKFORCE CHALLENGES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, pediatrics is a critical specialty in the American Healthcare system, providing essential care to infants, children, and adolescents and contributing to the long-term health of the population [1]; and

WHEREAS, the number of graduating medical students matching into pediatric residency programs has declined in recent years, leading to concerns about the adequacy of the future pediatric workforce [2]; and

WHEREAS, pediatricians face unique financial challenges, including lower average compensation compared to many other medical specialties, despite the high demands of their work and the complex care required by pediatric patients [2,3]; and

WHEREAS, pediatricians often care for a disproportionately high percentage of Medicaid populations, which are subject to lower reimbursement rates and increased administrative burdens, further impacting their financial viability [2,3]; and

WHEREAS, addressing the compensation disparities faced by pediatricians is necessary to increase the attractiveness of the specialty to graduating medical students who face a heavy medical school debt load, to ensure adequate access to pediatric care nationwide [4]; and, now therefore be it:

RESOLVED, that the American Osteopathic Association (AOA) advocate for the exploration and implementation of creative methods to increase the compensation of pediatricians, including but not limited to:

- ~~Advocacy for increased Medicaid and Medicare reimbursement rates for pediatric services~~
- ~~Development of loan repayment programs, scholarships, or financial incentives targeted specifically at medical students and residents pursuing primary care pediatrics~~
- ~~Establishing public and private grants or subsidies to support pediatric practices in underserved or high-need areas~~
- ~~Promoting value-based care models that reward pediatricians for improving health outcomes in vulnerable populations, and be it further~~

35 RESOLVED, that the AOA ~~advocate for~~ **SUPPORT** collaboration with federal and state
36 policymakers, healthcare organizations, and medical education stakeholders to
37 advocate for policy reforms that address financial barriers to entering the pediatric
38 specialty; and be it further
39
40 RESOLVED**,** that the AOA ~~advocate for~~ **SUPPORT** research into innovative payment
41 models and compensation structures for pediatricians to ensure long-term sustainability
42 of the pediatric workforce for the future~~., and be it further~~
43
44 ~~RESOLVED, that a copy of this resolution be submitted to the AOA for consideration at the~~
45 ~~2025 AOA House of Delegates~~.

References:

1) Pediatricians. 27 Jan 2025. Cleveland Clinic. Doi: https://my.clevelandclinic.org/health/articles/21716-what-is-a-pediatrician
2) Carroll, A. Why Doctors aren't going into pediatrics. New York Times. 1, July, 2024. Doi: https://www.nytimes.com/2024/07/01/opinion/pediatrician-shortage.html
3) Rascoe, A. Fewer Doctors are going into Pediatrics: That's leaving a huge gap in hospitals. NPR. 14, April 2024. Doi: https://www.npr.org/2024/04/14/1244683914/fewer-doctors-are-going-into-pediatrics-thats-leaving-a-huge-gap-in-hospitals
4) Permar, S and RJ Vinci. A nation with too few pediatricians could see health care costs soar. STAT: Reporting from the frontiers of health and medicine. 2 April 2024. Doi: https://www.statnews.com/2024/04/02/too-few-pediatricians-health-care-costs/%6

Background Information: Provided by AOA Staff
Current AOA Policy: None

Overarching Policies but not specific to pediatrics:
H612-A/20 Medicaid Payment
H317-A/20 Physician Incentives to Underserved Areas
H341-A/21 Appropriate Payment Mechanisms for Physician-Led Team-Based Health Care
H321-A/22 Equity in Medicare & Medicaid Payments

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: DEFINITION OF OSTEOPATHIC PHYSICIAN

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

WHEREAS, osteopathic medicine has struggled to define itself in a way that represents all U.S. trained osteopathic physicians, regardless of specialty or use of Osteopathic Manipulative Treatment (OMT); and

WHEREAS, American Osteopathic Association (AOA) policy H317/A23 defines osteopathic medicine as follows:

The American Osteopathic Association (AOA) defines osteopathic medicine as a complete system of medical care with a philosophy that combines the needs of the patient with the current practice of medicine, surgery and obstetrics; that emphasizes the concept of body unity, the interrelationship between structure and function; and that has an appreciation of the body's ability to heal itself; and

WHEREAS, there is a need for the profession to align around a common, contemporary definition that enables research, grant funding, physician reimbursement, and public education and marketing; and

WHEREAS, adoption of a unified, modern definition of a U.S. trained osteopathic physician will strengthen internal cohesion and promote clearer external understanding and communication of the role and philosophy of the osteopathic physician; and

WHEREAS, the upcoming *Educational Council on Osteopathic Principles (ECOP) Glossary of Osteopathic Terminology* includes the following definition:

Doctor of Osteopathic Medicine (DO), United States: an osteopathic physician who has graduated from a COCA-accredited institution and is a fully qualified physician, educated within the context of a distinct patient-centered, health-oriented philosophy, trained to combine specialized diagnostic and therapeutic hands-on skills (Osteopathic Manipulative Treatment) with the latest advances in the science and practice of medicine to offer comprehensive healthcare to patients; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopt the Educational Council on Osteopathic Principles (ECOP) definition of "Doctor of Osteopathic Medicine, United States" for profession-wide use; and be it further

32 RESOLVED, that the AOA encourage all affiliated entities to utilize this definition in
33 all activities involving the definition and representation of a U.S. trained
34 osteopathic physician.

Background Information: Provided by AOA Staff
Current AOA Policy:
H317-A/23-Osteopathic Medicine Definition
H626-A/24-Osteopathic Terminology - Glossary of
H340-A/24-Clarification on the Terms "Osteopathy, and "Osteopath" in the United States

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: AOA PROGRAM PARTICIPANTS AND AWARDS CRITERIA POLICY

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2024 the AOA President constructed an AOA Program and Award Recipients Workgroup; and

WHEREAS, the charge of the workgroup was to confirm guidelines for participants and recipients for the following AOA programs: AOA Awards Recipients; AOA Program Participants (i.e., Leadership Academy, TIPS Program); BEL Scholarship Recipients; Bureaus, Committees, and Councils Appointments; Task Force and Liaison Appointments; Research Grant Recipients; A.T. Still Lecturers; Presidential Citation Recipients; Speakers and Presenters During AOA Events; and Media Recognition Outlets (i.e., The DO, DOs to Know); and

WHEREAS, the workgroup also was charged to determine if recipients and participants who are eligible for AOA membership be required to maintain current AOA membership and if recipients and participants who are DOs eligible for board certification maintain current AOA board certification status for each of the programs; and

WHEREAS, the AOA's Constitution and Bylaws contain requirements for AOA membership but there are no requirements for AOA board certification; and

WHEREAS, the workgroup completed a report that was reviewed and approved by the AOA Board of Trustees in July 2024; and now, therefore be it

RESOLVED, that the AOA House of Delegates accept the AOA Program Participants and Awards Criteria Policy provided with this resolution~~; and be it further~~

~~RESOLVED, that the AOA Board of Trustees will establish a task force that will further study AOA board certification as a requirement for specific AOA positions~~.

Background Information: Provided by AOA Staff

Current AOA Policy: Approved by the AOA Board of Trustees July 2024.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended__

DATE: ___July 19, 2025_____

AOA Program Participants and Awards Criteria Policy

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Bureaus, Committees, and Council	** Except where positions are designated for public members (i.e., non-physicians serving on a bureau or committee who are intended to represent and speak for the interests of the public and consumers of osteopathic medical services), membership in both the AOA and a divisional society shall be a requisite for qualification for service on a bureau, council, or committee of the Association. (AOA Bylaws, Article IX) – AOA board certification is preferred.	Required (with exceptions)	Preferred (with exceptions)
BEL DO Day Scholarship Program	Scholarships to attend DO Day are awarded to osteopathic physicians in training and new physicians in practice who want to become more involved in medical advocacy. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred
BEL OMED Scholarship Program	Osteopathic residents, fellows, and new physicians in practice who are enrolled in an ACGME-accredited postdoctoral training program (if you are a resident/fellow) within five years of completing postdoctoral training (if you are a new physician in practice), and a first-time OMED attendee. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred (with exceptions) Exceptions will include postdoctoral trainees
Leadership Academy Program	This academy is designed for osteopathic medical students, residents, fellows, and new physicians in practice who want to enhance their leadership skills. Candidates preferably have some leadership experience within the profession prior to participating in the program. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred (with exceptions) Exceptions will include postdoctoral trainees and osteopathic medical students

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Liaison Appointments	Recommendations for appointments are submitted to the President, President-Elect, and CEO for review and approval. The Board of Trustees will approve all appointments. AOA membership is required. AOA board certification is preferred. Exceptions will be made for those who represent other fields of public service.	Required (with exceptions)	Preferred (with exceptions)
Task Force Appointments	Recommendations for appointments are submitted to the President, President-Elect, and CEO for review and approval. The Board of Trustees will approve all appointments. AOA membership is required. AOA board certification is preferred. Exceptions will be made for those who represent other fields of public service.	Required (with exceptions)	Preferred (with exceptions)
Training In Public Studies (TIPS) Program	The TIPS program is open to all osteopathic physicians who are in an active AOA- or ACGME-accredited residency or fellowship training program to apply. In addition, our letter of acceptance to the program requires fellows to become members of the AOA at the resident physicians and fellows level, at minimum. AOA board certification is not required.	Required	Not Required

Awards and Recognition

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Awards: Advocacy Awards	AOA advocacy awards are intended to recognize excellence in public policy advocacy and support for the osteopathic profession through various media/communication platforms. Award categories will include individual AOA members (including students and residents), osteopathic affiliates, media advocates, and members of Congress. Except for categories recognizing public service individuals, recipients are required to be AOA members. AOA board certification is not required. *The Bureau on Federal Health Programs recommends final recipients to the BOT.*	Required (with exceptions)	Not Required

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Awards: Bob E. Jones CAE Award	The Bob E. Jones, CAE Award recognizes outstanding executive directors/CEOs who continually contribute to the AOA and the osteopathic profession. All executive directors/CEOs from state affiliates, specialty affiliates, and osteopathic stakeholder organizations are eligible for nomination for the award. Nominations may be self-nominated, peer-nominated from other AOA affiliate EDs/CEOs, or from national AOA or affiliate volunteer leadership. Recipient(s) will be encouraged to become AOA Associate members. AOA board certification is not required. *The Bureau of Affiliate Relations recommends final recipients to the BOT.*	Preferred	Not Required
Awards: Distinguished Service Award	The Distinguished Service Award is the American Osteopathic Association's (AOA) highest honor. It is awarded annually to deserving physicians or lay individuals for outstanding accomplishments in advancing the science and art of osteopathic medicine, education, philanthropy, or other fields of public service. Preferential consideration will be given to those individuals whose service has been to or through the osteopathic medical profession. AOA board certification is not required. This award recognizes contributions to the overall profession rather than regional or local efforts. *The Committee on Awards recommends final recipients to the BOT.*	Preferred (with exceptions)	Not Required
Awards: DEI Award	The DEI Award will be presented to one individual and one organization that has proven exemplary leadership and commitment to promoting and advancing DEI initiatives in the osteopathic community. AOA membership is preferred with exception. AOA board certification is preferred. *The Committee on Awards recommends final recipients to the BOT.*	Preferred (with exceptions)	Preferred
Awards: *Journal of Osteopathic Medicine (JOM)* Awards	Each year, the *Journal of Osteopathic Medicine* will recognize an article with significant contributions to Social Determinants of Health Research, Innovations Research, Health Policy Research, Quality Improvement in Education Research, Junior Faculty / Young Investigators Research, and Clinical Research. AOA board certification is preferred. *The JOM Editorial Board recommends final recipients to the BOT.*	Preferred	Preferred

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Awards: Mentor of the Year	The AOA Mentor of the Year Award was developed to honor DOs who help shape the future of the osteopathic profession through their involvement with osteopathic medical students and new physicians in practice. Students, DOs, AOA affiliates, or any other member of the osteopathic professional family are welcome to submit nominations. The nominee must be a member, in good standing, of the AOA. AOA board certification is preferred with exception. *The Bureau of Emerging Leaders recommends final recipients to the BOT.*	Required	Preferred (with exceptions)
Awards: Outstanding Affiliate Awards	This award recognizes the tremendous contributions that affiliates make to the success of the osteopathic profession. All state and specialty college affiliates are eligible for nomination for the Outstanding Affiliate Awards. Affiliates can self-nominate or be nominated by others for this award. Previous award recipients are ineligible for Outstanding Affiliate Award nomination until three years have elapsed. *The Bureau of Affiliate Relations recommends final recipients to the BOT.*	Not Required	Not Required
Awards: Media Recognition Outlets	Osteopathic physicians recognized in this arena are encouraged to become AOA members. AOA board certification is preferred if the individual is eligible for board certification and if AOA board certification is available. Exceptions will be made for those who represent other fields of public service.	Preferred (with exceptions)	Preferred (with exceptions)
Awards: Presidential Citations	Recipients are osteopathic medical profession leaders or groups who are honored by the current AOA President for their accomplishments and contributions to the osteopathic profession. The president is given full latitude on who will receive this award.	Not Required	Not Required

Additional Opportunities

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
A.T. Still Memorial Lecturer	An individual is selected and formally invited to deliver the Andrew Taylor Still Memorial address during the House of Delegates meeting annually. AOA membership is preferred. AOA board certification is preferred,	Preferred	Preferred (with exceptions)
Journal of Osteopathic Medicine (JOM) Editorial Board	AOA membership is required with exceptions. AOA board certification is preferred. This process is currently under review. The final criteria will be updated upon approval from the AOA Board of Trustees.	Required (with exceptions)	Preferred (with exceptions)

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Research Grant Recipients	**Physicians and PhD Researchers**: Osteopathic Physician (DO); or MD, PhD, or other individuals holding an equivalent doctoral degree (applicants not affiliated with an osteopathic institution or osteopathic recognized programs must have a DO as key personnel on the Research Team). **New Investigators**: Osteopathic Physician (DO); or MD, PhD or other individuals holding an equivalent doctoral degree (applicants not affiliated with an osteopathic institution or osteopathic recognized programs must have a DO as key personnel on the Research Team). Must have completed their terminal research degree (e.g., PhD or equivalent doctoral degree) or post-graduate clinical training (e.g., residency, fellowship), whichever date is later, within the past 10 years of the date of the expected award. **Osteopathic Medical Students**: Applicants must be an osteopathic medical student fulfilling his/her coursework requirements at an AOA accredited College of Osteopathic Medicine at the time of the award. Must have a Preceptor/Mentor with qualifying criteria. Grant recipients are encouraged to become AOA members. AOA board certification is preferred.	Preferred	Preferred (with exceptions)
Speakers and Presenters During AOA Events (Non-CME Events)	Osteopathic physicians speaking and presenting at AOA events are encouraged to become members. An exception is made for professional speakers who speak for the interests of the public. AOA board certification is preferred.	Preferred	Preferred (with exceptions)
"The DO" Editorial Board	Interested parties submit information through the communication and marketing application process. All editorial advisory board members are to be members of the AOA. *The DO* Editor and communications staff review the applications and provide recommendations to the CEO and President. The CEO and President review and approve the recommendations to be provided to the Board. AOA board certification is preferred.	Required	Preferred (with exceptions)

AMERICAN OSTEOPATHIC ASSOCIATION

400 Series Public Affairs Resolutions

Actions

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (400 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Protection of Safe Water Supply (SR-Source-H405-A/20)	BFHP	Public Affairs	Adopted
H-401	Aircraft Emergency Medical Supplies (SR-Source-H411-A/20)	BFHP	Public Affairs	Referred to BFHP
H-402	Firearms and Non-Powdered Guns – Education for Users (SR-Source-H418-A/20)	BFHP	Public Affairs	Adopted as Amended
H-403	Drugs, Curbing Counterfeit (SR-Source-H426-A/20)	BFHP	Public Affairs	Adopted
H-404	Continued Support of Combating Bio-Terrorism Activities (SR-Source-H432-A/20)	BFHP	Public Affairs	Adopted
H-405	National Institutes of Health Grants (SR-Source-H437-A/20)	BFHP	Public Affairs	Adopted as Amended
H-406	Firearm Violence (SR-Source-H442-A/20)	BFHP	Public Affairs	Adopted as Amended
H-407	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase (SR-Source-H446-A/20)	BFHP	Public Affairs	Adopted
H-408	Epidemic Terrorist Attack Victims, Government Responsibility Of Health Care (SR-Source-H453-A/20)	BFHP	Public Affairs	Adopted
H-409	Silver Alert System (SR-Source-H436-A/20)	BFHP	Public Affairs	Sunset
H-410	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (SR-Source-H402-A/20)	BORPH	Public Affairs	Referred to BORPH
H-411	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (SR-Source-H403-A/20)	BORPH	Public Affairs	Referred to BORPH
H-412	Antibiotic Stewardship (SR-Source-H406-A/20)	BORPH	Public Affairs	Adopted as Amended
H-413	Vaccines for Children Program (SR-Source-H407-A/20)	BORPH	Public Affairs	Referred to BORPH

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-414	Intrauterine Fetal Demise Awareness (SR-Source-H409-A/20)	BORPH	Public Affairs	Adopted
H-415	Animals in Medical Research (SR-Source-H412-A/20)	BORPH	Public Affairs	Adopted
H-416	Cancer (SR-Source-H413-A/20)	BORPH	Public Affairs	Adopted as Amended
H-417	Cardiopulmonary Resuscitation, Training (SR-Source-H414-A/20)	BORPH	Public Affairs	Adopted as Amended
H-418	Children's Safety Seats (SR-Source-H415-A/20)	BORPH	Public Affairs	Sunset
H-419	Environmental Responsibility--Waste Materials (SR-Source-H417-A/20)	BORPH	Public Affairs	Adopted
H-420	Genetic Manipulation of Food Products – Consumers Right to Know (SR-Source-H419-A/20)	BORPH	Public Affairs	Adopted
H-421	Condom Usage – Health Education (SR-Source-H420-A/20)	BORPH	Public Affairs	Adopted
H-422	Support of Literacy Programs (SR-Source-H421-A/20)	BORPH	Public Affairs	Adopted
H-423	Healthy Family, Support of (SR-Source-H424-A/20)	BORPH	Public Affairs	Adopted as Amended
H-424	Immunization of 9 to ~~26~~ **45** Year Old Male and Females with Human Papilloma Virus Vaccine (SR-Source-H425-A/20)	BORPH	Public Affairs	Adopted as Amended
H-425	Sleep Disorders - Promoting the Understanding and Prevention of (SR-Source-H427-A/20)	BORPH	Public Affairs	Adopted
H-426	Minority Health Disparities (SR-Source-H428-A/20)	BORPH	Public Affairs	Referred to BORPH
H-427	Infant Walker (Mobile) – Ban on the Manufacture, Sale and Use of (SR-Source-H429-A/20)	BORPH	Public Affairs	Adopted
H-428	Develop In-Vitro Fertilization Standards of Care (SR-Source-H430-A/20)	BORPH	Public Affairs	Not Adopted
H-429	Childhood Obesity – Worsening Epidemic in the American Society (SR-Source-H433-A/20)	BORPH	Public Affairs	Adopted
H-430	Texting While Driving (SR-Source-H435-A/20)	BORPH	Public Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-431	Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents (SR-Source-H400-A/20)	BORPH	Public Affairs	Adopted as Amended
H-432	Screening for Breast Cancer (SR-Source-H438-A/20)	BORPH	Public Affairs	Adopted
H-433	Gender Identity Non-Discrimination (SR-Source-H439-A/20)	BORPH	Public Affairs	Adopted as Amended
H-434	Traumatic Brain Injury Awareness (SR-Source-H440-A/20)	BORPH	Public Affairs	Adopted as Amended
H-435	Support for Family Caregivers (SR-Source-H441-A/20)	BORPH	Public Affairs	Adopted as Amended
H-436	Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders (SR-Source-H444-A/20)	BORPH	Public Affairs	Adopted
H-437	AOA Response to Novel Public Health Threats (SR-Source-H445-A/20)	BORPH	Public Affairs	Adopted as Amended
H-438	Homeless Support (SR-Source-H449-A/20)	BORPH	Public Affairs	Adopted as Amended
H-439	Breastfeeding While on Medication Assisted Treatment (MAT) (SR-Source-H452-A/20)	BORPH	Public Affairs	Adopted as Amended
H-440	Minorities, Underrepresented (URM) – Increasing Numbers of Applicants (SR-Source-H454-A/20)	BORPH	Public Affairs	Adopted as Amended
H-441	Regulation of E-Cigarettes and Nicotine Vaping (SR-Source-H455-A/20)	BORPH	Public Affairs	Adopted as Amended
H-442	Seat Belt Laws – Primary Enforcement (SR-Source-H408-A/20)	CSHA	Public Affairs	Adopted
H-443	Death - Right to Die (SR-Source-H416-A/20)	CSHA	Public Affairs	Adopted
H-444	Tanning Devices (SR-Source-H422-A/20)	CSHA	Public Affairs	Adopted as Amended
H-445	Tobacco Settlement Funds (SR-Source-H423-A/20)	CSHA	Public Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-446	Vaccination Rates – Daycare Notification to Parents (SR-Source-H404-A/20)	CSHA	Public Affairs	Adopted
H-447	Protecting Patients with Private Insurance from Balance Billing (SR-Source H426-A/19; Referred H402-A/24)	BFHP	Public Affairs	Adopted
H-448	Raw Milk-Health Risks (SR-Source H416-A/19; Referred H413-A/24)	BORPH	Public Affairs	Adopted as Amended
H-449	Recognizing Breast Implant Illness (BII) (Source-Referred H434-A/24)	BORPH	Public Affairs	Adopted as Amended
H-450	Reaffirming Commitment to Evidence-Based Protection Against Vaccine-Preventable Illnesses	ACOP	Public Affairs	Adopted as Amended
H-451	Continued Support of Access to and Research on National Newborn Metabolic Screening Protocols	ACOP	Public Affairs	Adopted as Amended
H-452	Equitable Use and Coverage of Anti-Obesity Incretin Mimetic Medications	BEL	Public Affairs	Adopted as Amended
H-453	Advocate for Access to Overweight and Obesity Care	OOA (Ohio)	Public Affairs	Adopted as Amended
H-454	Against the Use of Food Dyes and Preservatives	OOA (Ohio)	Public Affairs	Adopted as Amended
H-455	Recognizing Period Poverty as a Policy Concern	SOMA	Public Affairs	Adopted as Amended
H-456	Sharing Centralized Resources on State-Specific Reproductive Health Policies	SOMA	Public Affairs	Referred to Finance
H-457	Family Planning and Fertility Preservation Resources for Medical Trainees	SOMA	Public Affairs	Adopted as Amended
H-458	Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products	BORPH	Public Affairs	Not Adopted

SUBJECT: PROTECTION OF SAFE WATER SUPPLY - SOURCE: H405-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) encourages the oil industry and the
8 Environmental Protection Agency (EPA) to seek out new technologies for safer
9 disposal of waste well water and the protection of our water supply.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: AIRCRAFT EMERGENCY MEDICAL SUPPLIES
- SOURCE: H411-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the concept that airlines,
8 under the control of the Federal Aviation Administration, maintain a policy for
9 adequately equipping commercial aircraft of greater than 19 seats with at least
10 minimal diagnostic and emergency medical supplies and supports legislation and
11 regulation that any physician providing emergency service while on board aircraft be
12 immune from any liability or legal action.

Background Information: Provided by AOA Staff
Current AOA Policy: 1984; 1989 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __*Referred to Bureau on Federal Health Programs*_____

DATE: ___July 19, 2025_____

SUBJECT: FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS - SOURCE: H418-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports **COMPREHENSIVE** education involving firearm and non-powdered guns safety ~~and the inherent risk, benefits and responsibility of ownership~~. [Editor's Note: Non-Powdered Guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of compressed air or gas, electricity, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: DRUGS, CURBING COUNTERFEIT - SOURCE: H426-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the Food and Drug
8 Administration's (FDA) efforts to educate osteopathic physicians on how to identify
9 counterfeit drugs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: CONTINUED SUPPORT OF COMBATING BIO-TERRORISM ACTIVITIES - SOURCE: H432-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association supports any and all constitutionally legal
8 efforts to prevent and respond to future acts of bio-terrorism in the United States.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: NATIONAL INSTITUTES OF HEALTH GRANTS
- SOURCE: H437-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) encourages osteopathic physicians,
8 osteopathic medical schools, and their affiliated institutions to pursue **NATIONAL**
9 **INSTITUTES OF HEALTH (**NIH**)** funding for biomedical research; and requests that
10 the NIH include osteopathic medical schools in the overall United States medical
11 school funding reports and also to include a category specific to Osteopathic
12 Manipulative Treatment (OMT) in the estimates of funding for various Research,
13 Condition, and Disease Categories (RCDC) reported each year to Congress and
14 the American public.

15 **THE AOA ADVOCATES FOR THE NIH TO REQUEST GRANT SUPPORT AND**
16 **ADEQUATE FUNDING FROM CONGRESS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: FIREARM VIOLENCE - SOURCE: H442-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends the following policy be REAFFIRMED.

Policy Statement

~~The American Osteopathic Association (AOA):~~

~~(1) Supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;"~~

~~(2) Supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence;~~

~~(3) Supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and~~

~~(4) Encourages enhanced education of gun safety and safe handling of firearms; and~~

~~(5) Approves the attached Policy Statement on Firearm Violence.~~

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have

the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms**,** is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. ~~The AOA supports the Administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety."~~ We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

Background Information: Provided by AOA Staff

Current AOA Policy: 2013; 2015 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE - SOURCE: H446-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) recognizes public health data
8 demonstrating the impact of firearms on mortality and wellness in the United States
9 and will support federal legislation requiring comprehensive background checks for
10 all firearm purchases, including sales by gun dealers, sales at gun shows, and
11 online sales for purchase, which does not extend to firearms transfers between
12 family members or firearms attained through inheritance. The AOA will support
13 efforts to require firearms safety training, including military or law enforcement
14 training, as a condition to purchase any class of firearms.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE - SOURCE: H453-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports all healthcare personnel
8 and first responders and victims of domestic or foreign terrorist attacks in the United
9 States being eligible for healthcare treatment stemming from the act to be covered
10 by the United States Government.

Background Information: Provided by AOA Staff
Current AOA Policy: 2004; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: SILVER ALERT SYSTEM - SOURCE: H436-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 the American Osteopathic Association (AOA) supports the wide-spread
4 state adoption of emergency response systems for missing mentally
5 impaired adults throughout the United States, via "Silver Alert" and "Gold (or
6 golden) Alert" networks which are also known as "Endangered Person
7 Advisory Networks"; and

8 WHEREAS, the Bureau on Federal Health Programs believes that this policy is
9 duplicative of H416-A/24 Alert Network – Silver and Gold now, therefore be it

10 RESOLVED, that the Bureau on Federal Health Programs recommends the
11 following policy be SUNSET.

12 The American Osteopathic Association (AOA) supports the formation of a "Silver
13 Alert" System on a national level to notify communities of missing persons with
14 mental disabilities, particularly seniors with cognitive or developmental impairments.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H416-A/24 – Alert Network-Silver and Gold

FISCAL IMPACT: $0

ACTION TAKEN: ____Sunset_____

DATE: ____July 19, 2025_____

SUBJECT: PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS - SOURCE: H-402/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the widespread use and
7 high compliance rate of the Health and Human Services National Vaccine
8 Implementation Plan for infants, children, and adults through education of the public
9 using media and marketing tools available to its organization.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___*Referred to Bureau of Osteopathic Research and Public Health*__

DATE: ___July 19, 2025_____

SUBJECT: SUPPORT FOR THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS - SOURCE: H-403/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages osteopathic physicians
7 consider the vaccination history as an integral part of their patient's health record
8 and should counsel their patients on appropriate vaccinations for their age and
9 health conditions. Osteopathic physicians should take all reasonable steps to
10 ensure their patients of all ages are fully immunized against vaccine preventable
11 illnesses and make vaccine recommendations to their patients according to the
12 recommendations of the Advisory Committee on Immunization Practices (ACIP) and
13 published in the Morbidity and Mortality Weekly Report (MMWR) and should not
14 advocate alternative schedules.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __*Referred to Bureau of Osteopathic Research and Public Health*___

DATE: ___July 19, 2025_____

SUBJECT: ANTIBIOTIC STEWARDSHIP - SOURCE: H-406/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports the five core actions outlined **BELOW BY** ~~in~~ the National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic physicians **AND THEIR COLLABORATING CARE EXTENDERS (NP/PA ETC)** to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which is a commitment to use antibiotics only when they are medically necessary.

1. **SLOW THE EMERGENCE OF RESISTANT BACTERIA AND PREVENT THE SPREAD OF RESISTANT INFECTIONS;**

2. **STRENGTHEN NATIONAL ONE-HEALTH SURVEILLANCE EFFORTS TO COMBAT RESISTANCE;**

3. **ADVANCE DEVELOPMENT AND USE OF RAPID AND INNOVATIVE DIAGNOSTIC TESTS FOR IDENTIFICATION AND CHARACTERIZATION OF RESISTANT BACTERIA;**

4. **ACCELERATE BASIC AND APPLIED RESEARCH AND DEVELOPMENT FOR NEW ANTIBIOTICS, OTHER THERAPEUTICS, AND VACCINES; AND**

5. **IMPROVE INTERNATIONAL COLLABORATION AND CAPACITIES FOR ANTIBIOTIC RESISTANCE PREVENTION, SURVEILLANCE, CONTROL, AND ANTIBIOTIC RESEARCH AND DEVELOPMENT.**

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 19, 2025_____

SUBJECT: VACCINES FOR CHILDREN PROGRAM
- SOURCE: H-407/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) supports ~~the expansion of~~ the
9 Vaccines for Children (VFC) Program to include all Advisory Committee on
10 Immunizations Practices (ACIP) age-appropriate vaccines for all underinsured
11 children, in keeping with the original goals of the program.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _*Referred to Bureau of Osteopathic Research and Public Health*____

DATE: ___July 19, 2025_____

SUBJECT: INTRAUTERINE FETAL DEMISE AWARENESS
- SOURCE: H-409/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports increasing public
7 awareness of the risk for intrauterine fetal demise and encourages the director of
8 the National Institutes of Health to allocate more resources to intrauterine fetal
9 demise research.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: ANIMALS IN MEDICAL RESEARCH - SOURCE: H-412/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the use of animals for valid
7 medical research projects and the humane handling and treatment of such animals,
8 and their ready availability from legitimate sources. The AOA supports eventual
9 elimination of the use of animals in medical research as better techniques become
10 available.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: CANCER - SOURCE: H-413/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) recognizes, endorses, and approves the continuing efforts of the National Cancer Institute to develop means to significantly reduce the incidence of cancer and the suffering and death resulting from cancer. ~~THE AOA will disseminate to the medical community and the public information gained from osteopathic and other research activities on the applications of the latest advances in cancer prevention, detection, early diagnosis and treatment.~~

Background Information: Provided by AOA Staff

Current AOA Policy: Status: 1974; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1995, 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended

DATE: _____July 19, 2025_____

SUBJECT: CARDIOPULMONARY RESUSCITATION, TRAINING - SOURCE: H-414/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) strongly supports instruction in Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) training to the general public; and encourages member physicians to qualify as instructors in basic life support so as to enable them to teach ~~Cardiopulmonary Resuscitation~~ **CPR** and AED courses on a voluntary basis.

Background Information: Provided by AOA Staff

Current AOA Policy: 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: CHILDREN'S SAFETY SEATS - SOURCE: H-415/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that this policy is covered under resolution H419-
4 A/24 Occupant Protection in Passenger Vehicles (SR-Source-H427-A/19),
5 now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that this policy be SUNSET.

8 The American Osteopathic Association (AOA) supports the adoption and
9 enforcement of child safety seat statutes in accordance with the National Highway
10 Traffic Safety Administration Guidelines.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H419-A/24 Occupant Protection in Passenger Vehicles

FISCAL IMPACT: $0

ACTION TAKEN: _Sunset_____

DATE: ___July 19, 2025_____

SUBJECT: ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS - SOURCE: H-417/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports recycling

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: GENETIC MANIPULATION OF FOOD PRODUCTS – CONSUMERS RIGHT TO KNOW - SOURCE: H-419/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports efforts that require clear
7 identification of any genetically manipulated food products so that consumers may
8 be properly informed as they make food choices.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000, 2005 Reaffirmed as Amended, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: CONDOM USAGE – HEALTH EDUCATION
- SOURCE: H-420/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports full disclosure of the risks
7 and benefits of condom usage and the data on condom failure rates and causes of
8 failure, whenever condom usage is taught.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: SUPPORT OF LITERACY PROGRAMS - SOURCE: H-421/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports programs that promote
7 literacy in the United States.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: HEALTHY FAMILY, SUPPORT OF - SOURCE: H-424/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) recommends that their members support healthy families by encouraging families to do the following, **BUT NOT LIMITED TO**:

1. Try to eat at least one meal per day together, using healthful nutritional guidelines
2. A set time be spent together as a family to help with school work and include reading to and with children
3. Encouraging media-free time
4. Limiting exposure to violence
5. Engaging in a healthy lifestyle that includes exercise
6. **OBTAINING ADEQUATE SLEEP**
7. **AVOIDING HARMFUL SUBSTANCES**

Background Information: Provided by AOA Staff
Current AOA Policy: 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: IMMUNIZATION OF 9 TO ~~26~~ **45** YEAR OLD MALE AND FEMALES WITH HUMAN PAPILLOMA VIRUS VACCINE - SOURCE: H-425/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports education and immunization
7 for Human Papilloma Virus (HPV).

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended
DATE: July 19, 2025

SUBJECT: SLEEP DISORDERS - PROMOTING THE UNDERSTANDING AND PREVENTION OF - SOURCE: H-427/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports programs that promote
7 education and understanding of sleep and its impact on health and encourages
8 osteopathic physicians to educate their patients about sleep disorders and the
9 importance of sleep and its impact on health.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: MINORITY HEALTH DISPARITIES - SOURCE: H428-A2020

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) adopts the following Position Statement on Minority Health Disparities.

MINORITY HEALTH DISPARITIES

The minority healthcare crisis in America stems from a multitude of factors. In particular, healthcare disparities most greatly affect underrepresented minorities, which include African-Americans, Hispanic-Americans, Asian-Americans, Native Americans and Pacific Islanders. In order to effectively create positive change, certain questions must be addressed. These include, but are not limited to**:** Which minorities are most affected by disease-specific illness? Why do these disparities exist? What can be done to eliminate them? Will a concerted effort to increase awareness and education about health-care disparities result in improved delivery of quality healthcare?

There is a need for the osteopathic profession and all of organized medicine to develop strategies which address health care disparities among minorities and prepare culturally competent physicians. Guidance should be offered to educate practicing physicians and trainees to better resolve known disparities and serve diverse populations. Efforts must be made to assure cultural competency and to identify and overcome language and other barriers to delivering health care to minorities.

Healthcare disparities include differences in health coverage, health access and quality of care. Health disparities result in morbidity and mortality experienced by one population group in relation to another.

Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a

healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high-quality care.

Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.

The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities. **REACH GRANTS HAVE BEEN FUNDED THROUGH 2028.**

~~The identified~~ **A**reas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) infectious diseases (i.e., Covid-19, influenza, HIV/Aids); ~~and~~ 6) child and adult immunizations; **AND 7).** ~~In addition, serious disparities exist in the~~ provision of care for mental health problems, substance abuse and suicide prevention.

The American Osteopathic Association ~~calls for~~ **SUPPORTS** the following actions ~~to be taken~~ to address minority health disparities and to improve cultural competency of its physician members:

1. The education of physicians regarding racial and ethnic healthcare needs, including disparities in the areas listed above.
2. The promotion of education regarding implicit or explicit biases among healthcare professionals that may play a role in clinical decision-making.
3. The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk.
4. The identification of new methods to involve physician members in the communities in which they serve.
5. The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government.
6. The inclusion of cultural competency training throughout the continuum of osteopathic education.
7. The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties.
8. The development of approaches to encourage all physicians to provide care to underserved minority populations.

9. The adoption of strategies to assist physicians to effectively communicate with their patients, addressing translation and other barriers to patient understanding.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _*Referred to Bureau of Osteopathic Research and Public Health*___

DATE: ___July 19, 2025_____

SUBJECT: INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE, SALE AND USE OF - SOURCE: H-429/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the ban on the manufacture,
7 sale and use of mobile infant walkers; and urges osteopathic physicians to educate
8 parents and other caregivers on the risks associated with using these devices.

Background Information: Provided by AOA Staff
Current AOA Policy: 2003; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE - SOURCE: H-430/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the appropriate and
7 evidence-based use of in-vitro fertilization in a manner that promotes the health and
8 safety of both the mother and embryo; and supports the ethical guidelines for the
9 practice of in-vitro fertilization that include, but are not limited to, the appropriate
10 number of embryos implanted per patient.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Not Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY - SOURCE: H-433/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages schools and vending
7 machine suppliers to include healthy choice snacks in vending machines; and
8 supports the limited use of vending machines in schools to avoid unnecessary
9 caloric intake.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: TEXTING WHILE DRIVING - SOURCE: H-435/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports efforts to educate all drivers
7 concerning the dangers of texting and driving and supports efforts to ban the use of
8 texting while driving.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGEN~~TS~~**CIES** - SOURCE: H-400/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) opposes any interference in the
7 physician-patient relationship by persons with financial and business interests
8 regarding a personal injury incident.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SCREENING FOR BREAST CANCER - SOURCE: H-438/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recognizes and promotes the
7 importance of the integrity of the patient-physician relationship and recommends
8 that breast cancer clinical preventive screenings and coverage be individualized to
9 the extent possible for every patient.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: GENDER IDENTITY NON-DISCRIMINATION
- SOURCE: H-439/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) ~~supports the provision of adequate~~
7 ~~and medically necessary treatment for transgender and gender-variant people and~~
8 opposes discrimination on the basis of gender identity.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: TRAUMATIC BRAIN INJURY AWARENESS
- SOURCE: H-440/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **SUPPORTS THE BELIEF** ~~believes~~ that osteopathic physicians should ~~be aware of and~~ utilize ~~"~~best practices~~"~~ when caring for victims of civil or military conflicts, or natural or man-made disasters, including civilians, returning veterans and their families, particularly those with Traumatic Brain Injury (TBI); ~~and the AOA will work in conjunction with state, specialty and regional societies to provide educational programs to advance this goal.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: __July 19, 2025_____

SUBJECT: SUPPORT FOR FAMILY CAREGIVERS
- SOURCE: H-441/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA), ~~recognizing~~ **RECOGNIZES THAT** a
9 growing number of family caregivers have unaddressed needs related to personal
10 health and wellbeing, **AND** supports ~~caregivers by participating in the developing~~
11 ~~public debate regarding.~~ **A** health care policy **WHICH** ~~to~~ include**S** family caregivers
12 and encourages its members to gain education in caregiver illnesses, **SEEK**
13 resources in their area and treat and/ refer when appropriate.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 19, 2025_____

SUBJECT: ADOPTING AND PROMOTING NON-STIGMATIZING LANGUAGE FOR SUBSTANCE USE DISORDERS - SOURCE: H-444/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) commit to the use of clinically-
7 accurate, non-stigmatizing, person-first language (including, but not limited to,
8 "substance use disorder," "recovery," "substance misuse," "positive or negative
9 urine screen," "person with a substance use disorder," and "recurrence of use") and
10 discourage the use of stigmatizing terminology in future publications, resolutions,
11 and educational materials both in print and online.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: AOA RESPONSE TO **URGENT, EMGERGENT, AND** NOVEL PUBLIC HEALTH THREATS - SOURCE: H-445/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will continue to serve as a trusted
7 source of information and education for physicians, health professionals and the
8 public relative to urgent, emergent and novel public health threats; and, that the
9 AOA will advocate for and support those responding to urgent, emergent and novel
10 public health threats, including all healthcare workers and volunteers; and, that the
11 AOA will advocate for proactive planning, improved public health infrastructure,
12 disease threat surveillance and evidence-based responses to **URGENT,**
13 **EMERGENT, AND** novel public health threats affecting the U.S. population

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: ~~HOMELESS~~ SUPPORT **FOR THOSE EXPERIENCING HOMELESSNESS** - SOURCE: H-449/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health added the appropriate statement from resolution H405-A/23 Concerns in People with Housing Insecurity (Source:H-428/A18) into this policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) ~~reaffirm~~ supports ~~for~~:

1. State and federal efforts, including efforts by private organizations **TO ADDRESS ~~HOMELESS~~ SUPPORT FOR THOSE EXPERIENCING HOMELESSNESS**,

2. ~~as well as those enumerated in the 2018 House of Delegates resolution number H-428 – A/2018,~~ **PROGRAMS THAT ENSURE DELIVERY OF PRIMARY AND PREVENTIVE HEALTHCARE TO ALL UNDERSERVED POPULATIONS, INCLUDING THOSE EXPERIENCING HOMELESSNESS, AND**

3. ~~and that those~~ Efforts ~~include~~ addressing social determinants affecting health, substance ~~abuse~~ **USE DISORDER** programs, mental health resources, clinical care programs, and provision of stable housing for all ~~homeless~~ individuals **EXPERIENCING HOMELESSNESS** that are seeking temporary or permanent shelter.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: H405-A/23 Concerns in People with Housing Insecurity

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: __July 19, 2025_____

SUBJECT: BREASTFEEDING WHILE ON ~~MEDICATION ASSISTED TREATMENT (MAT)~~ **MEDICATIONS FOR OPIOID USE DISORDER (MOUD)** - SOURCE: H452-A/20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the current white paper addresses opioid use disorder and ~~medication assisted treatment~~ **MEDICATIONS FOR OPIOID USE DISORDER** and the importance of breastfeeding; and

WHEREAS, the American Osteopathic Association (AOA) has other policies addressing the same issues (H431-A22 AOA Policies on Opioids and Substance Use White Paper[1] and H402-A/23 Breastfeeding Exclusivity[2]); and

WHEREAS, the American College of Obstetricians and Gynecologists (ACOG)[3] **AMERICAN COLLEGE OF OSTEOPATHIC ACADEMY OF ADDICTION MEDICINE (AOAAM)** and the Academy of Breastfeeding Medicine (ABM)[4] recommend breastfeeding while on ~~medication assisted treatment~~ **MEDICATIONS FOR OPIOID USE DISORDER** with these recommendations being readily available on their respective websites, and

WHEREAS, after review of this information the Bureau of Osteopathic Research and Public Health recommend the revised policy statements in lieu of the white paper, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Breastfeeding While on ~~Medication Assisted Therapy (MAT)~~ **MEDICATIONS FOR OPIOID USE DISORDER (MOUD)**

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE FOLLOWING POLICY STATEMENTS ON BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT):

1. **THE AOA ACKNOWLEDGES THAT EXCLUSIVE BREASTFEEDING SIGNIFICANTLY IMPROVES MATERNAL AND INFANT HEALTH OUTCOMES.**

2. **THE AOA ENCOURAGES EXCLUSIVE BREASTFEEDING AMONG MOTHERS WITH A HISTORY OF OPIOID USE DISORDER (OUD), WHO ARE UNDER PHYSICIAN CARE, ACTIVELY ENGAGED IN A RECOVERY PROGRAM, ON APPROPRIATE OPIOID AGONISTS (METHADONE OR BUPRENORPHINE), ABSTAINING FROM ILLICIT DRUGS, AND WHO HAVE NO OTHER CONTRAINDICATIONS, SUCH AS UNCONTROLLED HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND/OR HEPATITIS C WITH OPEN/BLEEDING AND CRACKED NIPPLES.**

3. **THE AOA RECOMMENDS THE USE OF COUNSELING, COORDINATION OF CARE, AND SOCIAL SUPPORT FOR MOTHERS DURING PREGNANCY AND BREASTFEEDING IN THE POSTPARTUM PERIOD.**

References

1. H431-A22 AOA Policies on Opioids and Substance Use White Paper. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H431-A-22_AOA_Policies_on_Opioids_and_Substance_Use-White_Paper.pdf

2. H402-A/23 Breastfeeding Exclusivity. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H402-A-23_Breastfeeding_Exclusivity_(H425-A18).pdf

3. American College of Obstetricians and Gynecologists. Opioid Use and Opioid Use Disorder in Pregnancy, Number 711, August 2017, Reaffirmed 2021. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

4. Harris, et al. Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/ABM%20Clinical%20Protocol%2021%20SUD_English.pdf

~~REFERRED RESOLUTION: Breastfeeding While on Medication Assisted Treatment (MAT) Policy Statement~~

~~The attached White paper, titled, "Breastfeeding While on Medication Assisted Treatment (MAT)", and the recommendations within be adopted as policy.~~

~~Breastfeeding While on Medication Assisted Therapy~~

~~Introduction~~

~~Opioid use among pregnant women is a growing public health concern. In 2014,~~

~~the Centers for Disease Control and Prevention (CDC) recorded a 333% national increase in opioid use disorder (OUD) among pregnant women, with 6.5 cases of opioid abuse per 1,000 hospital deliveries, compared to 1.5 cases in 1999.[1] Opioid use during pregnancy is not uncommon; as many as 1 in 5 pregnant women enrolled in Medicaid filled an opioid prescription during their pregnancy.[2] Prenatal opioid exposure has been directly linked to adverse health outcomes for mothers and babies across the nation. These adverse health outcomes include increased maternal mortality and morbidity, poor fetal development, preterm births, still births, birth defects, and increased incidence of Neonatal Abstinence Syndrome (NAS).[3]~~

~~Studies have found that breastfeeding among women being treated for OUD offers many benefits that can mitigate the impacts of OUD for the mother and infant. Benefits include, but are not limited to, reduced hospital stays and decreased need for morphine treatment in infants born with NAS.[4]~~

~~Opioid Use Disorder Treatment~~

~~Medication Assisted Treatment, or MAT, is defined as the use of medications in combination with counseling and behavioral therapies to treat OUD and aid patients in sustaining their recovery.[5] MAT may be utilized with pregnant women to treat opioid use disorder and avoid the severe consequences associated with untreated opioid use disorder or stopping opioid usage too quickly. The U.S. Food and Drug Administration has approved three medications, buprenorphine, methadone, and naltrexone for OUD treatment.[5]~~

~~Naltrexone is the newest therapy approved by the U.S. Food and Drug Administration to treat opioid use disorder in pregnant women. Since it is also the least studied therapy, there is a research gap regarding the safety and effectiveness of naltrexone during pregnancy.[6] As a result, MAT for pregnant women commonly entails the use of methadone or buprenorphine with naloxone, in conjunction with coordinated care among behavioral therapists, OB-GYNs, and addiction specialists.[7] Both methadone and buprenorphine treatment are endorsed by the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine as best practices for addressing opioid use during pregnancy.[4]~~

~~Methadone, a long-acting opioid agonist that decreases the desire to take opioids, was established as the standard of care in 1998 for treating OUD in pregnant women. The Substance Abuse and Mental Health Service Administration (SAMHSA) identified methadone as a safe drug to take while pregnant or preparing for pregnancy, along with counseling and participation in social support programs.[8]~~

~~Recently, The American Society of Addiction Medicine (ASAM) recognized Buprenorphine combined with Naloxone as the standard of care for the treatment of women who are pregnant or breastfeeding with OUD. The American Osteopathic Academy of Addiction Medicine (AOAAM) supports ASAM consensus that the combination of Buprenorphine and Naloxone is regularly used, safe, and effective.[9] Buprenorphine is the first medication to treat opioid use disorder that was authorized to be administered in physician offices, resulting in improved access to treatment.[10] Studies indicate that buprenorphine reduces fluctuations in fetal levels of opioids, minimizes repeated prenatal withdrawal, decreases overdoses, and limits drug interactions.[10]~~

~~Neonatal withdrawal, also called neonatal abstinence syndrome (NAS), is an anticipated and treatable condition caused by perinatal exposure to opioids, including methadone and the combination of buprenorphine with naloxone.[11] Although NAS may still occur in infants whose mothers receive MAT, the symptoms are milder than they would be without treatment.[4]~~

~~Postpartum, both infants and women on maintenance therapies can experience greater benefits through breast feeding. Although trace amounts of both methadone and buprenorphine have been found to seep into breast milk, research has shown that the benefits of breastfeeding outweigh the negligible risk associated with the medication that enters breastmilk.[8, 10]~~

~~**Breastfeeding**~~

~~Because of the associated benefits, exclusive breastfeeding, without other supplementation, is recommended for healthy women by both the American Academy of Pediatrics and the World Health Organization for the first 6 months of life.[12,13] Breastfeeding contributes to attachment between a woman and her infant, encourages skin-to-skin contact.[11] The antibodies and hormones found in breast milk defend the infant's immune system against illness and lower the risk of asthma, leukemia, childhood obesity, lower respiratory infections, eczema, diarrhea, vomiting, and Sudden Infant Death Syndrome.[14] Breastfeeding also improves the health of mothers post-delivery, simultaneously, lowering potential risk for diabetes, breast cancer, and ovarian cancer. Breast milk is also easier for infants to digest and cost efficient for parents.[14]~~

~~The American Academy of Pediatrics (AAP) recommendation applies to women who take methadone or buprenorphine as well, without regard for dosage.[15] Breastfeeding among women who are opioid dependent is also encouraged by both, the American College of Obstetricians and Gynecologists (ACOG) and the American College of Osteopathic Obstetricians and Gynecologists (ACOOG), as long as the women are taking methadone or buprenorphine consistently, abstaining from illicit drugs, and have no underlying complexities or conditions, such as human immunodeficiency virus (HIV) and or Hepatitis C with open/bleeding and cracked nipples.[11] Additionally, The ACOOG supports the ACOG committee review that women in the post-partum period who return to using street drugs and are not on stable OUD therapy should restrain from breastfeeding.[16] After 6 months, the AAP recommends continuation of breastfeeding, alongside introduction of complementary foods during the first year of life.[12]~~

~~In spite of these endorsements, less than 25% of mothers exclusively breastfeed for 6 months in the United States.[12] Formula supplementation of breast milk is commonly utilized. Supplementation is reportedly associated with many side effects that can lead to adverse infant and maternal outcomes. Formula supplements can negatively impact the "maternal milk supply, the duration of exclusive breastfeeding, and the infant's gut microbiome; alteration of the neonatal gut environment can be responsible for mucosal inflammation and disease, autoimmunity disorders, and allergic conditions in both childhood and adulthood".[17]~~

~~The Centers for Disease Control and Prevention established the breastfeeding report card, which provides national data on breastfeeding rates, breastfeeding support indicators, and breastfeeding practices.[12] The breastfeeding report card~~

~~indicates that, in 2015, 83.2% of infants were breastfed starting at birth, 57.6% were still breastfed at some level at 6 months, and 35.9% at 12 months.[12] This data suggests that "the early postpartum period is a critical time for establishing breastfeeding, but mothers may not be getting the support they need from health care providers, family members, and employers to meet their breastfeeding goals".[12]~~

~~Uptake of breastfeeding is likely even lower among women with OUD. National Institute on Drug Abuse (NIDA) states that the rate of breastfeeding is normally "low" among mothers with OUD. Increased formal breastfeeding education, direct support for mothers, health care providers training on breastfeeding techniques, and peer support are all effective interventions that promote the start and sustainability of breastfeeding among mothers.[18]~~

~~Conclusion~~

~~Increasing rates of maternal opioid use during pregnancy and NAS are public health concerns. The utilization of MAT with methadone or buprenorphine has been approved as a safe mechanism for combatting opioid use during pregnancy and while breastfeeding.~~

~~Breastfeeding improves maternal and infant morbidity and mortality and decreases the impact of adverse health conditions. Breastfeeding infants who were exposed to opioids prenatally have the added advantage of lessening the impact of other conditions, such as NAS. Encouraging breastfeeding among mothers with exposure to opioids, who are undergoing MAT, is a significant step toward addressing OUD and NAS and improving maternal and child health. It shall be noted that the ACOOG and AOAAM supports the content of this paper and the policy recommendations outlined to encourage exclusive breastfeeding among mothers with a history of OUD.~~

~~American Osteopathic Association Policy~~

~~Given the research surrounding the positive impact of breastfeeding, the American Osteopathic Association adopts the following policy statements as its official position on breastfeeding among mothers with exposure to opioid use disorder in the United States:~~

1. ~~The American Osteopathic Association (AOA) acknowledges that exclusive breastfeeding significantly improves maternal and infant health outcomes.~~
2. ~~The American Osteopathic Association supports methadone and buprenorphine/naloxone assisted treatment as standards of care for addressing opioid use disorder during pregnancy and in the postpartum period.~~
3. ~~The American Osteopathic Association (AOA) encourages exclusive breastfeeding among mothers with a history of Opioid Use Disorder (OUD), who are under physician care, actively engaged in a recovery program, on appropriate opioid agonists (methadone or buprenorphine), abstaining from illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection and or Hepatitis C with open/bleeding and cracked nipples.~~
4. ~~The American Osteopathic Association (AOA) recommends the use of counseling, coordination of care, and social support for mothers during~~

~~pregnancy and breastfeeding in the postpartum period.~~

~~References:~~

~~[1] Haight SC, KO JY, Tong VT, Bohm MK, Callaghan WM. *Opioid Use Disorder Documented at Delivery Hospitalization – United States, 199-2014*. MMWR Morb Mortal Wkly Rep 2018; 67:845-849~~

~~[2] Desai RJ, Hernandez-Diaz S, Bateman BT, Huybrechts KF. *Increase in Prescription Opioid Use During Pregnancy Among Medicaid-Enrolled Women*. Obstetric Gynecology 2014; 123-997-1002.~~

~~[3] Jilani SM, Frey MT, Pepin D, et al. *Evaluation of State – Mandated Reporting of Neonatal Abstinence Syndrome – Six States, 2013 – 2017*. MMWR Morb Mortal Wkly Rep 2019; 68; 6-10~~

~~[4] National Institute on Drug Abuse. *Treating Opioid Use Disorder During Pregnancy*. (2017); Retrieved From https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy#ref~~

~~[5] U.S. Food and Drug Administration. *Information about Medication Assisted Treatment – MAT*. (2020); Retrieved from https://www.fda.gov/drugs/information-drug-class/information-about-medication- assisted-treatment-mat~~

~~[6] National Institute on Drug Abuse. *Could Naltrexone Be Used to Treat Pregnant Women with Opioid Addiction*. (2018); Retrieved From https://www.drugabuse.gov/about-nida/noras- blog/2018/02/could-naltrexone-be-used-to-treat-pregnant-women-opioid-addiction~~

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Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: __July 19, 2025_____

SUBJECT: UNDERREPRESENTED MINORITIES – INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE - SOURCE: H-454/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, excluding 2020 and 2022, there has been a steady increase in **UNDERREPRESENTED MINORITIES (**URM**)** Applicants from 2019 to 2024. Excluding 2021 and 2022, there has been a steady increase in matriculants from 2019 to 2024; and

WHEREAS, comparing 2021-22 graduates to 2022-2023 graduates, the URM for graduation increased by 2.6%; however, there was a demographic decline for American Indian/Alaska Native, Black/African American, and non-Hispanic compared to 2021-2022 graduates; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) encourages **EFFORTS TO RECRUIT AND TRAIN QUALIFIED URM STUDENT APPLICANTS AND FACULTY BY COLLEGES OF OSTEOPATHIC MEDICINE.** ~~an increase in the total number of URM1 graduates **AND FACULTY** from colleges of osteopathic medicine by the year 2020 and encourages an increase in the total number of URM faculty by the year 2025 **2030**~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2014; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

References:
Applicants & Matriculants by Race/Ethnicity 2009-2024:
https://www.aacom.org/searches/reports/report/applicants-matriculants-by-race-ethnicity-2009-2024
Osteopathic Medical College Graduates by Race/Ethnicity 2000-2023:
https://www.aacom.org/searches/reports/report/osteopathic-medical-college-graduates-by-race-ethnicity-2000-2023

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: REGULATION OF E-CIGARETTES AND NICOTINE VAPING - SOURCE: RESOLUTION NO. H455-A/20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the current white paper provides detailed information on e-cigarettes and vaping, and their health consequences and regulation; and

WHEREAS, the CDC website includes numerous pages that are devoted to nicotine and other potential harms of e-cigarettes, nicotine addiction and withdrawal, and the impact of e-cigarettes and vaping on youth[1-3]; and

WHEREAS, the FDA website has detailed information about the regulation of e-cigarettes, vapes, and other Electronic Nicotine Delivery Systems (ENDS)[4]; and

WHEREAS, after reviewing this information, the Bureau of Osteopathic Research and Public Health recommends the updated policy statements in lieu of the white paper, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

REGULATION OF E-CIGARETTES AND NICOTINE VAPING

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE FOLLOWING POLICY STATEMENTS ON E-CIGARETTES AND VAPING:

1. **THE AOA SUPPORTS FDA AND STATE REGULATION OF THE INGREDIENTS IN ALL ELECTRONIC CIGARETTE CARTRIDGES, REQUIRING INGREDIENT LABELS AND WARNINGS, AND ELIMINATING THE USE OF FLAVORS THAT ARE BANNED IN TRADITIONAL CIGARETTES.**

2. **THE AOA SUPPORTS FDA AND STATE REGULATION PROHIBITING SALES AND ADVERTISEMENTS OF ELECTRONIC CIGARETTES TO PERSONS UNDER THE AGE OF 21. ADVERTISEMENTS FOR ELECTRONIC CIGARETTES SHOULD BE SUBJECT TO THE SAME RULES AND REGULATIONS THAT ARE ENFORCED ON**

TRADITIONAL CIGARETTES.

3. **THE AOA FURTHER ENCOURAGES FEDERAL, STATE AND LOCAL GOVERNMENT ACTION TO BAN THE USE OF ELECTRONIC CIGARETTE DEVICES IN ALL SPACES WHERE TRADITIONAL CIGARETTES ARE CURRENTLY BARRED FROM USE.**

4. **THE AOA PROMOTES TOBACCO AND NICOTINE CESSATION TREATMENT, AND THE USE OF ANY SUCH TREATMENT THAT HAS BEEN PROVEN SAFE AND EFFECTIVE BY THE US FOOD AND DRUG ADMINISTRATION (FDA). THERE IS CURRENTLY NO E-CIGARETTE APPROVED BY THE FDA TO HELP PEOPLE QUIT SMOKING.**

5. **THE AOA SUPPORTS RESEARCH BY THE FDA AND OTHER ORGANIZATIONS INTO THE HEALTH AND SAFETY IMPACT OF E-CIGARETTES AND LIQUID NICOTINE.**

6. **THE AOA ENCOURAGES PHYSICIANS TO EDUCATE PATIENTS ABOUT THE RISKS OF E-CIGARETTE USE, AND TO COUNSEL PATIENTS TO SUBMIT VOLUNTARY REPORTS TO THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES SAFETY REPORTING PORTAL (WWW.SAFETYREPORTING.HHS.GOV) IF THEY SUSTAIN ADVERSE REACTIONS TO E-CIGARETTES.**

7. **THE AOA DISCOURAGES THE PLACEMENT OF MEDICAL PRACTICES AND LIMITED-SERVICE CLINICS IN RETAIL SETTINGS THAT PROMOTE AND SELL TOBACCO.**

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~~REGULATION OF E-CIGARETTES AND NICOTINE VAPING~~

~~**BACKGROUND**~~

~~The adverse health effects associated with tobacco use are well documented public health concerns. Smoking can damage every human organ, and it can lead to death from heart disease, cancers or strokes. According to the World Health Organization (WHO), 1 in 10 deaths each year, or nearly 8 million deaths around the world, are caused by tobacco use.[1,2] More than 7 million of those deaths are the result of direct tobacco use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke.[2] In the United States, this translates to 480,000 deaths per year from cigarette smoking and second-hand smoke exposure.[3]~~

~~In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the past 4 decades.[4] The use of electronic nicotine delivery systems (ENDS), such as electronic cigarettes (e-cigarettes), has reached a rapidly expanding consumer base.[5] E-cigarettes are often used or promoted to reduce consumption of tobacco products.[6] Alternative strategies for reaching smoking cessation goals include switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.[7]~~

~~In the US, e-cigarettes are the most frequently utilized tobacco product among youth, who are also more likely than adults to use them. In 2019, over 5 million US middle and high school students had used e-cigarettes in the past 30 days.[8] In 2018, 3.2% of US adults were current e- cigarette users.[9]~~

~~The name e-cigarette is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e- hookahs, but could potentially be referred to by other terms. Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 460 brands.[10] E-cigarettes are a 2.5 billion dollar business in the United States.[11] The attraction to e-cigarettes crosses many segments of the population, appealing to tobacco cigarette smokers trying to quit as well as non-smokers who want to try nicotine without the harmful additives.[12] Though some states and municipalities have started to ban e-cigarettes, tobacco cigarette smokers can use e- cigarettes as a source of nicotine in some venues where conventional cigarettes are banned.~~

~~Costs associated with smoking-related illnesses continue to escalate. In 2014, smoking-related illness costs in the United States were more than $300 billion each year, including approximately $170 billion for direct medical care for adults, and more than $156 billion in lost productivity. Nearly $5.6 billion of the lost productivity cost was due to secondhand smoke exposure.[13]~~

~~Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death.[14] However, the effect of long term consumption of nicotine and associated aerosols remains unclear. Studies have shown that e-cigarette vapors may be harmful, particularly in places with limited ventilation and for people with compromised health. Furthermore, e-juice liquids have been found to increase accidental poisonings in children. The full scale of health and safety hazards of vaping for users and secondhand users is undetermined.[15]~~

~~ANALYSIS~~

~~Regulation of e-cigarettes by the Food and Drug Administration (FDA) only began in earnest in 2016. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) provided the FDA authority to regulate the manufacture, marketing and distribution of tobacco products.[16] However, e-cigarettes were not initially included in the FDA's regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes have enjoyed the ability to advertise on television and radio.[17] This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.[18] However, some manufacturers have voluntarily begun to limit their advertising in an attempt to avoid federally imposed restrictions on advertising.~~

~~The Composition of E-Cigarettes~~

~~The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation.[19] Using an e-cigarette may also be referred to as "vaping", or as "juuling", the branded form of flavored e-cigarettes popular among younger consumers. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients.[20] It is primarily composed of a nicotine cartridge, atomizer, and a battery.[21] The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element.[22] When screwed onto the cartridge, the nicotine liquid from the cartridge, which could also include flavoring, comes into contact with the atomizer unit and is carried to the metal coil heating element.[23] A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[24] E-cigarettes can also be used to deliver marijuana and other drugs.[25]~~

~~While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens, lipsticks, and other everyday items.[26] Often, they can be legally used where traditional tobacco products are banned.~~

~~Federal Efforts to Regulate~~

~~In 2016, the FDA finalized a rule extending regulatory authority to cover all tobacco products, including electronic nicotine delivery systems (ENDS) that meet the definition of a tobacco product.[27] The FDA now regulates the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ENDS. Prior to this rule, the FDA could regulate e-cigarettes only if the manufacturer made a therapeutic claim, such as the product was being marketed as a cessation device.[28]~~

~~The rule established restrictions on youth access to newly regulated tobacco products by: (1) banning their sale to individuals younger than 18 years of age (federal legislation raised this to 21 years in 2019) and requiring age verification via photo ID; and (2) prohibiting the sale of tobacco products in vending machines (unless in an adult-only facility).[29]~~

~~The Federal Food, Drug, and Cosmetic Act was signed into law on December 20, 2019, and raised the federal minimum age of sale for tobacco products from 18 to 21 years.[30] Retailers are now prohibited from selling tobacco products to anyone under the age of 21.~~

~~Further, in January 2020, the FDA banned all mint- and fruit-flavored e-cigarettes, but exempted menthol- and tobacco-flavored products, in an effort to target products widely used by minors while preserving an "off-ramp" for adults who are trying to quit~~

~~smoking.[31]~~

~~Tobacco is a major threat to public health, and one of the goals of the FDA is to protect Americans from tobacco-related diseases and death. This rule allows the FDA to protect youth by restricting their access to tobacco products, helps consumers better understand the risks of using these products, prohibits false and misleading product claims, and prevents new tobacco products from being marketed unless a manufacturer demonstrates that the product meets relevant public health standards.~~

~~State Efforts to Regulate~~

~~Various states and municipalities have also enacted laws restricting the sale of e-cigarettes.[32] Twenty-seven states, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and 1,107 municipalities have passed laws that ban smoking in all non-hospitality workplaces, restaurants, and bars; of these, 22 states and 929 municipalities also restrict e- cigarette use in 100% smoke-free venues.[33]~~

~~In November 2019, **Massachusetts** became the first state to restrict the sale of *all* flavored tobacco products, including e-cigarettes and menthol cigarettes.[34] **New Jersey** prohibited the use of e-cigarettes in all enclosed indoor places of public access as well as in working places, and in January 2020, the state enacted legislation banning the sale of *all* flavored e- cigarettes.[35,36] In March 2020, **Rhode Island** also announced a permanent ban on the sale of flavored e-cigarettes.[37] Six other states (Michigan, Montana, New York, Oregon, Utah and Washington) temporarily banned the sale of flavored e-cigarettes in 2019, but of those, only Montana's and Washington's bans are currently in effect while the others are facing various legal challenges.[38]~~

~~As of 2019, twenty-three (23) states and the District of Columbia have enacted statutes which require licenses for retail sales of e-cigarettes.[39]~~

~~Arguments for E-Cigarettes~~

~~Proponents of e-cigarettes consider e-cigarettes to be less harmful than traditional tobacco products and believe they increase adult smoking cessation.[40] While it has been established that e-cigarettes contain fewer carcinogenic elements than traditional tobacco cigarettes, the long-term health effects of e-cigarette use are unknown.[41] According to the American Lung Association there are approximately 600 ingredients in cigarettes.[42] When burned, they create more than 7,000 chemicals.[43] At least 69 of these chemicals are known to cause cancer, and many are poisonous.[44] While e-cigarettes may have fewer component chemicals, a study found that the usage of e-cigarettes contributes to indoor air contamination.[45] A 2016 report from the WHO determined that second-hand aerosols from e-cigarettes are a new source of pollution for hazardous particulate matter (PM). The levels of nickel, chromium, and other metals found in second-hand aerosols are higher than ambient air and higher than second-hand tobacco smoke.[46]~~

~~The greatest appeal of e-cigarettes for smoking cessation is that they deliver nicotine to alleviate nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking because of its shape and the familiar behavior aspect of smoking.[47] A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking.[48] Another survey of 3,037 e-cigarette users revealed that 77% of respondents used e- cigarettes to quit smoking or to avoid~~

~~relapse.[49] None said they used them to reduce consumption of tobacco with no intent to quit smoking.[50] However, the overall effectiveness of e- cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.[51]~~

~~Consequences of E-Cigarettes~~

~~Advocates of e-cigarettes contend that e-cigarettes are less risky than traditional tobacco products and can serve as a mode of harm reduction by reducing smoking or serving as a smoking cessation strategy.[52] While there is limited evidence that suggests that adult smokers could benefit from e-cigarette use instead of combustible tobacco products, smokers would need to fully switch to e-cigarettes and stop smoking cigarettes and other tobacco products completely to achieve any meaningful health benefits from e-cigarettes. Experts who serve on the US Preventive Services Task Force have resolved that there is insufficient evidence to recommend e-cigarettes for smoking cessation in adults, including pregnant women. Thus, e-cigarettes are not currently approved by the FDA as an aid to quit smoking.[53]~~

~~Another major concern is that e-cigarettes appeal to youth by being flavorful, trendy and a convenient accessory.[54] The flavorings being used, such as candy and other sweet flavorings are particularly attractive to younger populations. For this reason, these flavorings are banned in traditional cigarettes.[55] Despite a downturn prior to 2017, e-cigarette use among youth has drastically increased. From 2017 to 2018, the percent of middle school students who used e- cigarettes increased 48%, resulting in 570,000 middle school students, or 4.9%, who were current e-cigarette users. Among high school students during the same period, current e- cigarette use, defined as use at least one day in the past 30 days, increased by 78%, from 11.7% to 20.8%, the equivalent of 3.05 million high school students using e-cigarettes in 2018. Current e-cigarette users in high school who reported use on 20 days or more in the past 30- day period increased from 20% to 27.7%. During the same timeframe, use of flavored e- cigarettes increased among high school students who currently used e-cigarettes as well. Use of any flavored e-cigarette went up among current users from 60.9% to 67.8%, and menthol use increased from 42.3% to 51.2% among all current e-cigarette users, including consumers of multiple products, and from 21.4% to 38.1% among those using only e-cigarettes. From 2018 to 2019, the number of middle school and high school students who reportedly used e-cigarettes in the past 30 days increased from a total of 3.6 million to 5.4 million youth.[56]~~

~~In addition to exposure to the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine.[57] Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).[58] E-cigarette cartridges can contain up to 20 times the nicotine of a single cigarette, and the process of vaping lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.[59]~~

~~Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues.[60] E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or nicotine cartridge.~~

~~Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.[61]~~

~~E-cigarettes can cause other inadvertent injuries as well. The CDC, the US Food and Drug Administration (FDA), state and local health departments, and other clinical and public health organizations have investigated a national outbreak of e-cigarette, or vaping, product use- associated lung injury (EVALI).[62] EVALI is an inflammatory response in the lungs triggered by inhaled substances. EVALI has been found to vary due to the substantial variety of products and ingredients used. It may present as pneumonia or an inflammatory condition known as fibrinous pneumonitis.[63] As of February 2020, 2,807 hospitalized EVALI cases or deaths were reported to CDC from all 50 states, the District of Columbia, Puerto Rico and U.S. Virgin Islands. Sixty-eight (68) deaths were confirmed in 29 states and the District of Columbia. Vitamin E acetate, an additive in some THC-containing e-cigarette products, was found to be strongly associated with the EVALI outbreak.[64]~~

~~Additionally, e-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions.[65] Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries. Lithium-ion batteries have reportedly overheated, caught fire or exploded; an event known as thermal runaway. From 2015 to 2017, an estimated 2,035 e-cigarette explosions and burn injuries presented to hospital emergency departments. Although the explosions are relatively rare, they can cause severe injuries.[66]~~

~~CONCLUSION~~

~~The AOA supports FDA and state regulation of the ingredients in all electronic cigarette cartridges, requiring ingredient labels and warnings, and eliminating the use of flavors that are banned in traditional cigarettes.~~

~~The AOA supports FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 21. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.~~

~~The AOA further encourages federal, state and local government action to ban the use of electronic cigarette devices in all spaces where traditional cigarettes are currently barred from use.~~

~~The AOA promotes tobacco and nicotine cessation treatment, and the use of any such treatment that has been proven safe and effective by the FDA.~~

~~The AOA supports research by the FDA and other organizations into the health and safety impact of e-cigarettes and liquid nicotine.~~

~~The AOA encourages physicians to educate patients about the risks of e-cigarette use, and to counsel patients to submit voluntary reports to the US Department of Health and Human Services Safety Reporting Portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.~~

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~~52. Christopher Bullen, Electronic Cigarettes For Smoking Cessation: A Randomised Controlled Trial, The Lancet, November 16, 2013, available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961842-5/abstract~~

~~53. Jordan Paradise at 329.~~

~~54. Available at https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/fact-sheets/adult-smoking-cessation-e-cigarettes-use/index.html~~

~~55. Jordan Paradise at 329.~~

~~56. Bridget M. Kuehn, supra.~~

~~57. Available at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html#what-are-e-cigarettes~~

~~58. Neal L. Benowitz, Nicotine Addiction, 362 New. Eng. J. Med. 2295 (2010).~~

~~59. American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-V, 5th ed.; 2013. 571-4.~~

~~60. Jordan Paradise at 335.~~

~~61. Neal L. Benowitz, supra.~~

~~62. Jordan Paradise at 359.~~

~~63. EVALI: New information on vaping-induced lung injury; Available at https://www.health.harvard.edu/blog/evali-new-information-on-vaping-induced-lung-injury-2020040319359~~

~~64. Available at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#overview~~

~~65. Id. at 335.~~

~~66. Rossheim ME, Livingston MD, Soule EK, et alElectronic cigarette explosion and burn injuries, US Emergency Departments 2015–2017Tobacco Control 2019;28:472-474.~~

<u>Background Information: Provided by AOA Staff</u>

Current AOA Policy: 2015, 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SEAT BELT LAWS – PRIMARY ENFORCEMENT
- SOURCE: H408-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports the primary enforcement
8 seat belt laws in every state.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: DEATH - RIGHT TO DIE - SOURCE: H416-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) believes that the decision to withhold
8 or withdraw treatment from a patient whose prognosis is terminal, or when death is
9 imminent, shall be based upon the wishes of the patient or their family or legal
10 representative if the patient lacks capacity to act on their own behalf as mandated
11 by applicable law.

Background Information: Provided by AOA Staff
Current AOA Policy: 1979; 1984 Reaffirmed as Amended; 1989 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: TANNING DEVICES - SOURCE: H422-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports education and legislation to
8 reduce the use of tanning devices except ~~where medically indicated~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Revised; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: TOBACCO SETTLEMENT FUNDS - SOURCE: H423-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports the use of the tobacco
8 settlement fund exclusively for health care services, education and research.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS - SOURCE: H404-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports legislation at the state level
8 that requires daycare facilities to notify parents (in compliance with Health
9 Insurance Portability and Accountability Act (HIPAA) regulations and state
10 regulations where applicable) that their facility has in its care unvaccinated children
11 who may pose a health risk to high-risk populations.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ___July 19, 2025_____

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING - SOURCE: REFERED H402-A/24; SR H426-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, H402-A/24 (Source: H426-A/19) was referred to the Bureau on Federal
2 Health Programs at the 2024 House of Delegates; and

3 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

4 WHEREAS, the Bureau on Federal Health Programs believes that the policy
5 remains relevant,

6 WHEREAS, the No Surprises Act was enacted in December 2020 to protect
7 consumers from pervasive out-of-network surprise medical bills. Due to
8 ongoing litigation now, therefore be it

9 RESOLVED, that the Bureau on Federal Health Programs recommends that the
10 referred policy be REAFFIRMED.

11 The American Osteopathic Association (AOA) supports patients' right to access
12 emergency medical care at a reasonable cost; and supports a system in which
13 patients are removed from the process of resolving outstanding medical expenses
14 that is beyond their cost sharing responsibilities for in-network care; and, that
15 disputes over the reasonable cost for out of network emergency care be determined
16 by an independent, third party or arbitration.

Background Information: Provided by AOA Staff
Current AOA Policy: 2019; 2024 Referred

Prior HOD action on similar or same topic:
H402-A/24 – Referred to Bureau on Federal Health Programs

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: **UNPASTEURIZED** RAW MILK **AND DAIRY PRODUCTS** – HEALTH RISKS **OF** – SOURCE: SR-H416-A/19; REFERRED-H413-A/24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted H416-A/19 Raw Milk - Health Risks to the 2024 House of Delegates during the sunset review process and recommended that it be reaffirmed; and

WHEREAS, the 2024 House of Delegates referred this policy back to BORPH and requested that BORPH review current data and update the policy; and

WHEREAS, Koski L et al[1] published a paper in 2022 in Epidemiology and Infection which supports findings of previously published reports indicating that state laws resulting in increased availability of unpasteurized milk are associated with more outbreak-associated illnesses and outbreaks; and

WHEREAS, the U.S. Food and Drug Administration (FDA)[2] published a document on its website entitled "Raw Milk Misconceptions and the Danger of Raw Milk Consumption," which outlines 14 myths around raw milk and disputes these myths based on scientific literature; and

WHEREAS, the Centers for Disease Control and Prevention (CDC)[3] states on its website that: 1. Pasteurization is crucial for milk safety, killing harmful germs that can cause illness; 2. Consuming raw milk can lead to serious health risks, especially for certain vulnerable populations; 3. Drinking or eating products made from raw milk can expose people to germs such as *Campylobacter, Cryptosporidium, E. coli, Listeria, Brucella,* and *Salmonella*. (as of 1-31-2025, accessed 4-2-2025); and

WHEREAS, the American Academy of Pediatrics[4] strongly supports the position of the FDA and other national and international associations in endorsing the consumption of only pasteurized milk and milk products for pregnant women, infants, and children; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE FOLLOWING POLICY STATEMENTS:

1. **THE AOA SUPPORTS THE CONSUMPTION OF PASTEURIZED MILK AND DAIRY PRODUCTS OVER THOSE THAT ARE RAW AND/OR UNPASTEURIZED.**

2. **THE AOA AGREES WITH THE CDC, THE FDA, AND THE AMERICAN ACADEMY OF PEDIATRICS THAT DRINKING RAW MILK AND CONSUMING UNPASTEURIZED DAIRY PRODUCTS CAN LEAD TO SERIOUS HEALTH RISKS, ESPECIALLY FOR CERTAIN VULNERABLE POPULATIONS, INCLUDING INFANTS, CHILDREN, THE ELDERLY, PEOPLE WITH WEAKENED IMMUNE SYSTEMS, AND PREGNANT WOMEN.**

3. **THE AOA ENCOURAGES OSTEOPATHIC PHYSICIANS TO EDUCATE THEIR PATIENTS ON THE SAFETY CONCERNS AND THE HEALTH RISKS OF CONSUMING RAW MILK AND THE BENEFITS OF CONSUMING PASTEURIZED MILK AND DAIRY PRODUCTS IF AND WHEN APPROPRIATE.**

4. **THE AOA SUPPORTS CONTINUED RESEARCH INTO THE SAFETY, MICROBIOME EFFECTS, AND OVERALL HEALTH OUTCOMES OF RAW MILK CONSUMPTION TO GUIDE EVIDENCE-BASED RECOMMENDATIONS.**

5. **THE AOA ENCOURAGES COLLABORATION BETWEEN THE CDC, THE FDA, PUBLIC HEALTH AGENCIES, RAW MILK PRODUCERS, AND CONSUMERS TO DEVELOP STANDARDIZED SAFETY PRACTICES FOR RAW MILK INTENDED FOR DIRECT HUMAN CONSUMPTION, INCLUDING TESTING, CERTIFICATION, AND TRANSPARENT LABELING.**

~~The American Osteopathic Association (AOA) believes that all milk sold for human consumption should be required to be pasteurized; and encourages osteopathic physicians to educate their patients on the safety concerns and the health risks of consuming raw milk.~~

References:

1. Koski L et al (2022). Foodborne illness outbreaks linked to unpasteurized milk and relationship to changes in state laws – United States, 1998–2018. Epidemiology and Infection 150, e183,1–13. https://doi.org/10.1017/S0950268822001649

2. FDA. Raw Milk Misconceptions and the Danger of Raw Milk Consumption. https://www.fda.gov/food/buy-store-serve-safe-food/raw-milk-misconceptions-and-danger-raw-milk-consumption (updated as of 3-5-2024, accessed 4-2-2025)

3. CDC. Food Safety – Raw Milk. https://www.cdc.gov/food-safety/foods/raw-milk.html (updated as of 1-31-2025, accessed 4-2-2025)

4. American Academy of Pediatrics Committee on Infectious Diseases, Committee on Nutrition. Consumption of Raw or Unpasteurized Milk and Milk Products by Pregnant Women and Children. Pediatrics January 2014; 133 (1): 175–179. 10.1542/peds.2013-

3502. Updated and reaffirmed November 2019.
https://publications.aap.org/pediatrics/article/133/1/175/68300/Consumption-of-Raw-or-Unpasteurized-Milk-andA-Milk

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2020 Referred; 2024 Referred

Prior HOD action on similar or same topic:
H413-A/24 - Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

SUBJECT: BREAST IMPLANT ILLNESS (BII)
- SOURCE: REFERRED-H413-A/24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Ohio Osteopathic Association submitted resolution H434-A2024 Recognizing Breast Implant Illness (BII) and Promoting Informed Consent for Breast Implant Procedures; and

WHEREAS, resolution H434-A2024 was referred to the Bureau of Osteopathic Research and Public Health (BORPH); and

WHEREAS, breast augmentation procedures involving the insertion of breast implants have become increasingly common; and

WHEREAS, recent evidence has emerged regarding the risks associated with breast implants, including the development of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and systemic symptoms collectively referred to as Breast Implant Illness (BIL); and

WHEREAS, a mechanistic link of bacterial biofilm–mediated host-pathogen interaction has been found leading to immunological complications associated with breast implant illness (BII); and

WHEREAS, the Food and Drug Administration (FDA) has issued a boxed warning advising patients and health care professionals about the risks associated with breast implants, including the potential for complications over time, the increased likelihood of additional surgeries, the association with BIA-ALCL, and the occurrence of systemic symptoms; and

WHEREAS, the AOA recognizes the importance of providing patients with comprehensive information regarding the risks and benefits of breast implants; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) acknowledges that a constellation of signs and symptoms may be associated with Breast Implant Illness (BII); and be it further

RESOLVED, that the AOA encourages health care professionals to educate patients about the potential risks associated with breast implants, including developing Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and systemic symptoms, and the risks outlined in the Food and Drug Administration (FDA) boxed warning and other labeling; and be it further

32 RESOLVED, ~~that AOA supports efforts to educate patients on the risks associated~~
33 ~~with breast implants.~~**THAT THE AOA SUPPORT EFFORTS FOR**
34 **CONTINUED RESEARCH TO THE LONG-TERM EFFECTS OF BREAST**
35 **IMPLANTATION, INCLUDING RISK MITIGATION AND EARLY**
36 **DETECTION OF COMPLICATIONS.**

References:

1. Cohen Tervaert JW, Mohazab N, Redmond D, van Eeden C, Osman M. Breast implant illness: scientific evidence of its existence. Expert Rev Clin Immunol. 2022 Jan;18(1):15-29. doi: 10.1080/1744666X.2022.2010546. Epub 2022 Jan 5. PMID: 34882509Suh LJ. https://pubmed.ncbi.nlm.nih.gov/34882509/

2. Khan I, Kelley-Patteson C, Mohan G, Hassanein AH, Sinha M. Breast Implant-Associated Immunological Disorders. J Immunol Res. 2022 May 4;2022:8536149. doi: 10.1155/2022/8536149. PMID: 35571560; PMCID: PMC9095406. https://pmc.ncbi.nlm.nih.gov/articles/PMC9095406/

3. https://www.fda.gov/medical-devices/implants-and-prosthetics/breast-implants .

4. Serena TJ, Habib P, Derosa A. Breast Implant Illness: A Cohort Study. Cureus. 2023 Apr 24;15(4):e38056. doi: 10.7759/cureus.38056. PMID: 37228535; PMCID: PMC10208020. https://pubmed.ncbi.nlm.nih.gov/37228535/

5. Magnusson MR, McGuire P. Commentary on: Understanding Breast Implant Illness: Etiology is the Key. Aesthet Surg J. 2022 Mar 15;42(4):378-380. doi:10.1093/asj/sjab191. PMID: 33864368. https://academic.oup.com/asj/article/42/4/378/6231987

6. Bascone CM, McGraw JR, Couto JA, Sulkar RS, Broach RB, Butler PD, Kovach SJ 3rd. Exploring Factors Associated with Implant Removal Satisfaction in Breast Implant Illness Patients: A PRO BREAST-Q Study. Plast Reconstr Surg Glob Open. 2023 Sep 25;11(9):e5273. doi: 10.1097/GOX.0000000000005273. PMID: 37753329; PMCID: PMC10519512. https://pubmed.ncbi.nlm.nih.gov/37753329/

7. Khan, I, et.al. Biofilm-derived oxylipin 10-HOME–mediated immune response in women with breast implants. J Clin Invest. 2024;134(3):e165644. https://doi.org/10.1172/JCI165644 .

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic:
H413-A/24 - Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 19, 2025_____

SUBJECT: REAFFIRMING COMMITMENT TO EVIDENCE-BASED PROTECTION AGAINST VACCINE-PREVENTABLE ILLNESSES

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Public Affairs

WHEREAS, Jonas Salk developed the inactivated polio vaccine in the 1950s, resulting in a decrease of annual cases of 58,000 in 1957, to 161 in 1961, and eradication in 1994, ushering in an age of preventing deadly illness through vaccine efficacy in the United States; [1] and

WHEREAS, in the decade leading up to the vaccine, measles cases numbered more than three million per year in the U.S. with a drastic decline after the invention of the measles vaccine in 1963 and official eradication of measles from the U.S. in 2000, with just 47 cases in 2023 (2,3); and

~~WHEREAS, as a result of the 1989-1991 measles epidemic, Congress passed the Omnibus Budget Reconciliation Act of 1993 which formed the Vaccine for Children program which provided free access to vaccines to all eligible children less than 18 years old. To date this program has prevented more than 472 million illnesses, and 29.8 million hospitalizations; amounting to over $2.2 trillion in healthcare cost savings [4]; and~~

~~WHEREAS, per a Jan. 12, 2025, New York Times report, even prior to the current administration the percentage of kindergarteners entering with complete MMR vaccination had fallen from 95% to <93% which is equal to 280,000 children entering the classroom without protection from measles [5]; and~~

~~WHEREAS, the current Secretary of Health and Human Services (HHS) has a long history of using mis- and disinformation to promote debunked claims about the link between vaccines and neurodevelopmental outcome such as autism; and~~

WHEREAS, as of April 10, 2025, there have been 712 confirmed measles cases in the United States and 3 deaths, including 2 children, with 97% of these cases coming from individuals who are either unvaccinated or with an unknown vaccination status. This number already eclipses the 285 total cases reported for 2024 [6]; and **NOW THEREFORE BE IT**

~~WHEREAS, the U.S. is at risk of losing its status of having eradicated measles if this trend continues; now, therefore be it~~

RESOLVED, that the American Osteopathic Association (AOA) reaffirms its support for evidence-based medicine regarding the safety and efficacy of vaccinations; and be it further

RESOLVED, that the AOA supports continued public education on vaccine safety and efficacy not limited to support of community efforts to distribute information regarding the benefits of routine childhood vaccinations; and, be it further

RESOLVED, that the AOA commits to combating vaccine mis- and disinformation ~~including rejecting any literature or proclamations linking~~ **ABOUT** vaccines ~~to autism~~; and be it further

RESOLVED, that the AOA will actively oppose any and all legislation **AND EXECUTIVE ORDERS** aimed at ~~utilizing debunked science to restrict~~ **RESTRICTING** the ongoing access to ~~free~~ routine vaccination as a means of stopping the spread of preventable illness.

References:

1. World Health Organization. (n.d.). *History of polio vaccination*. https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination
2. Mayo Clinic. (n.d.). *Measles virus: Vaccine guidance from Mayo Clinic*. https://www.mayoclinic.org/diseases-conditions/history-disease-outbreaks-vaccine-timeline/measles
3. Centers for Disease Control and Prevention. (2023, December 21). *History of measles*. https://www.cdc.gov/measles/about/history.html
4. Centers for Disease Control and Prevention. (2023, October 6). *About the Vaccines for Children (VFC) program*. https://www.cdc.gov/vaccines/programs/vfc/about/index.html
5. Belluck, P. (2023, July 2). *Childhood vaccination rates were falling even before the rise of R.F.K. Jr. The New York Times.* https://www.nytimes.com/2023/07/02/health/vaccination-rates-decline-rfk-jr.html
6. Centers for Disease Control and Prevention. (2024, March 7). *Measles cases and outbreaks*. https://www.cdc.gov/measles/cases-outbreaks.html

Background Information: Provided by AOA Staff

Current AOA Policy:

H414-A/24	Vaccines
H402-A/20	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children and Adults
H407-A/20	Vaccines for Children Program
H414-A/23	Immunizations
H403-A/20	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___Adopted as Amended_

DATE _____July 19, 2025_____

SUBJECT: CONTINUED SUPPORT OF ACCESS TO AND RESEARCH ON NATIONAL NEWBORN METABOLIC SCREENING PROTOCOLS

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Public Affairs

WHEREAS, since its inception in 1960, newborn metabolic screenings have been a vital component of public health in the United States to detect potential serious conditions, as required by law[1]; and

WHEREAS, the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) recommends that every screening panel for newborns screen for 36 core conditions and an additional 26 secondary disorders put forth by the Secretary of the U.S. Department of Health and Human Sciences (HHS)[2]; and

WHEREAS, newborn screening programs are limited due to variation across states[3,4,5]; currently only two state programs offer newborn screening panels spanning all 36 conditions recommended on the Recommended Uniform Screening Panel (RUSP) and only 27 screen for at least 35 conditions[6]; and

WHEREAS, researchers estimated savings of $2.4 million per 100,000 infants screened over 60 years in spinal muscular atrophy alone[7]; and

WHEREAS, a study utilizing the National Survey of Children's Health determined that between 2016-2017, 2.8 million children ages 0-17 years old have a genetic condition emphasizing the need for effective screenings[8]; and

WHEREAS, a retrospective study conducted with 573 infants that died before the age of one had determined that 22% of the infants had a laboratory-confirmed genetic diagnosis, and 52% of those diagnosed were determined postnatally[9]; and

WHEREAS, parents/guardians of children with a positive newborn screening test reported less difficulty in receiving necessary specialist care as compared with reports of parents/guardians of children with genetic conditions who were diagnosed later[7]; and

WHEREAS, a 2020 study published in *Pediatrics*, stated that over 95% of subjects in a long-term study of children identified with inborn errors of metabolism, identified by Newborn Screenings, were successfully reaching age-appropriate developmental milestones; and,

WHEREAS, the same 2020 study stated that without these screenings, the children would have been susceptible to chronic neurologic dysfunction and mortality[10]; and

WHEREAS, a 2021 article also published in *Pediatrics* collected evidence that early diagnosis through screening prevented severe malnutrition and improved long term growth in infants diagnosed with cystic fibrosis, has proved newborn screening's utility in the interest of public health[11]; and

WHEREAS, while guidance has historically been put forth by the U.S. Secretary of HHS through the Recommended Uniform Screening Panel (RUSP), states still create and regulate their own screening policies which results in a lack of procedural standardization[1,12]; and

WHEREAS, as of a March 27, 2025, statement from the HHS announcing the consolidation of the Health Resources and Services Administration (HRSA) into the new Administration for a Healthy America (AHA)[13] which has led to the functional dissolution of both the ACHDNC and RUSP, leaving the newborn screening program without a source of guidance or funding, now therefore be it;

~~RESOLVED, that the American Osteopathic Association (AOA) commits to joining any advocacy efforts for the immediate reinstatement of the ACHDNC and RUSP; and, be it further~~

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS EFFORTS TO CREATE CLINICAL GUIDELINES THAT DESCRIBE EVIDENCE BASED RECOMMENDED UNIFORM SCREENING OF NEWBORNS, EITHER THROUGH THE REINSTATEMENT OF AN ADVISORY COMMITTEE UNDER HEALTH AND HUMAN SERVICES (HHS) TO ISSUE GUIDANCE OF HERITABLE DISORDERS IN NEWBORNS AND CHILDREN AND A RECOMMENDED UNIFORM SCREENING PANEL, OR THE DEVELOPMENT OF EVIDENCE BASED GUIDELINES BY PHYSICIAN ORGANIZATIONS.

RESOLVED, that the AOA supports an increase in research on the improved benefit of ~~interstate~~ standardization of screening protocols and their role in early diagnosis and treatment of newborn illnesses; and, be it further

RESOLVED, that the AOA encourages osteopathic physicians to increase accessibility to expecting parents on educational resources that address disparities around screening protocols, conditions available for screening, and how prompt identification and treatment of these disorders may lead to more favorable outcomes

References:

1. *About newborn screening*. About Newborn Screening | Newborn Screening.

(2023, June). https://newbornscreening.hrsa.gov/about-newborn-screening

2. Health Resources and Services Administration. (2023, August). *Advisory Committee on Heritable Disorders in newborns and children*. Advisory Committee on Heritable Disorders in Newborns and Children. https://www.hrsa.gov/advisory-committees/heritable-disorders#:~:text=The%20Committe e%20recommends%20that%20every
3. Speiser, P., Chawla, R., Chen, M., Diaz-Thomas, A., Finlayson, C., Rutter, M., Sandberg, D., Shimy, K., Talib, R., Cerise, J., Vilain, E., & Délot, E. (2020). Newborn screening protocols and positive predictive value for congenital adrenal hyperplasia vary across the United States. *International Journal of Neonatal Screening*, *6*(2), 37. https://doi.org/10.3390/ijns6020037
4. Gaviglio, A., McKasson, S., Singh, S., & Ojodu, J. (2023, April 13). *Infants with congenital diseases identified through newborn screening-United States, 2018–2020*. MDPI. https://www.mdpi.com/2409-515X/9/2/23
5. *Newborn Screening in Your State*. About Newborn Screening | Newborn Screening. (2023, December). https://newbornscreening.hrsa.gov/your-statehttps://newbornscreening.hrsa.gov/your-stat e
6. Singh, S., Ojodu, J., Kemper, A. R., Lam, W. K., & Grosse, S. D. (2023). Implementation of newborn screening for conditions in the United States first recommended during 2010–2018. *International Journal of Neonatal Screening*, *9*(2), 20. https://doi.org/10.3390/ijns9020020
7. Wojcik, M. H., Schwartz, T. S., Thiele, K. E., Paterson, H., Stadelmaier, R., Mullen, T. E., VanNoy, G. E., Genetti, C. A., Madden, J. A., Gubbels, C. S., Yu, T. W., Tan, W.-H., & Agrawal, P. B. (2019). Infant mortality: The contribution of genetic disorders. *Journal of Perinatology*, *39*(12), 1611–1619. https://doi.org/10.1038/s41372-019-0451-5
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Background Information: Provided by AOA Staff
Current AOA Policy: H-319 - A/24 Newborn HIV Testing, H625 - A/20 Newborn and Infant Hearing Screens

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __Adopted as Amended__

DATE _____July 19, 2025_____

SUBJECT: EQUITABLE USE AND COVERAGE OF ANTI-OBESITY INCRETIN MIMETIC MEDICATIONS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Public Affairs

WHEREAS, obesity is a complex, chronic disease influenced by genetic, environmental, physical, and emotional factors, necessitating a multimodal treatment approach including pharmacotherapy, lifestyle, and behavioral modifications[1,2]; and

WHEREAS, incretin-mimetic medications such as glucagon like peptide-1 receptor agonists (GLP-1 RAs) and gastric inhibitory polypeptides (GIPs) have been shown to be effective in reducing body weight, appetite, food cravings, and energy intake while increasing satiety and improving eating control[3,4,5,6,7]; and

WHEREAS, the current access to these incretin-mimetic medication for obesity management remains limited due to high costs and insurance coverage restrictions, creating significant barriers for patients who could benefit from their use[8,9,10]; and

WHEREAS, GLP-1 RAs and GIP therapeutics ~~are~~ **IN SELECTED CASES MAY BE** more effective compared to the alternative anti-obesity medications, such as phentermine-topiramate and naltrexone-bupropion, which have demonstrated efficacy but are associated with significant negative side effects[11,12]; and

WHEREAS, the economic burden of obesity is estimated at $260.6 billion annually in the United States, and improved access to effective pharmacotherapy may reduce long-term healthcare costs by mitigating obesity-related comorbidities[13]; and

WHEREAS, research suggests that the cost-effectiveness of covering pharmacotherapy for obesity may outweigh the long-term financial burden of untreated obesity and its associated comorbidities[14,15]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports policies that reduce financial barriers for patients seeking access to incretin-mimetic medications, while promoting transparency and flexibility within insurance plans to allow for diverse treatment options; and, be it further

RESOLVED, the AOA supports continued research, education, and advocacy to expand awareness and appropriate utilization of pharmacotherapy within the context of multimodal obesity care.

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: ADVOCATE FOR ACCESS TO OVERWEIGHT AND OBESITY CARE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, Per the Centers for Disease Control (CDC), from August 2021 to August 2023, the prevalence of obesity among adults in the United States was 40.3%, which remains above the Healthy People 2030 goal of 36.0%;[1]

WHEREAS**,** In June 2013, the American Medical Association (AMA) House of Delegates voted to recognize obesity as a disease state requiring treatment and prevention efforts;[2]

WHEREAS**,** the majority of insurance providers continue to exclude reimbursement for weight management visits, as well as coverage of ~~Federal~~ **FOOD AND** Drug **ADMINISTRATION** ~~Agency~~ (FDA) approved medications for treatment of patients with overweight and/or obesity;[3] now, therefore be it:

RESOLVED**,** that the American Osteopathic Association (AOA) recognize obesity as a complex, multifactorial disease, an interaction between genotype and environment, which has socioeconomic, behavioral, cultural, physiological, metabolic, and genetic factors; and be it further

RESOLVED, that the AOA advocate for payment ~~for medical services and procedures~~ **OF MEDICAL SERVICES, PROCEDURES, AND FDA-APPROVED MEDICATIONS** used to treat and manage patient's weight with or without associated weight related conditions; and be it further

RESOLVED, that the AOA advocate for insurance coverage of FDA approved medications used to treat patients with overweight and/or obesity~~; and be it further~~

~~RESOLVED, that this resolution be sent to the AOA for consideration by the 2025 AOA House of Delegates.~~

References:

[1]Emmerich SD, Fryar CD, Stierman B, Ogden CL. Obesity and severe obesity prevalence in adults: United States, August 2021–August 2023. NCHS Data Brief, no 508. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/159281

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[3]Wilding JPH, Batterham RL, Davies M, Van Gaal LF, Kandler K, Konakli K, Lingvay I, McGowan BM, Oral TK, Rosenstock J, Wadden TA, Wharton S, Yokote K, Kushner RF; STEP 1 Study Group. Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension. Diabetes Obes Metab. 2022 Aug;24(8):1553-1564. doi: 10.1111/dom.14725. Epub 2022 May 19. PMID: 35441470; PMCID: PMC9542252.

Background Information: Provided by AOA Staff

Current AOA Policy:

H322-A/23 Obesity – Health Plans should include Benefits for Treatment of
H408-A/22 Prevention and Treatment of Obesity
H421-A/23 Pediatric Obesity

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: AGAINST THE USE OF FOOD DYES AND PRESERVATIVES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS**,** synthetic food dyes such as Red 40, Yellow 5, and Blue 1 are widely used in food products despite studies linking them to hyperactivity, allergic reactions, and potential carcinogenic effects; and

WHEREAS**,** research published in the *International Journal of Occupational Medicine and Environmental Health* has associated prolonged exposure to artificial food dyes with increased oxidative stress and DNA damage (1); and

WHEREAS**,** preservatives such as sodium benzoate, butylated hydroxyanisole (BHA), and butylated hydroxytoluene (BHT) have been shown to disrupt endocrine function and increase the risk of chronic illnesses, including cancer and metabolic disorders; (2, 3) and

WHEREAS, the European Union has placed restrictions or labeling requirements on certain food dyes and preservatives due to health concerns, providing a regulatory model that prioritizes consumer safety (4); and

WHEREAS**,** educating patients and advocating for stricter regulations can help reduce exposure to potentially harmful additives, thereby improving public health; and, now therefore be it:

RESOLVED**,** the American Osteopathic Association (AOA) opposes the use in food products of synthetic dyes and preservatives that have known harmful effects and advocates for increased research and regulation on their safety; and be it further

RESOLVED**,** that a copy of this resolution be submitted to the AOA for consideration at the 2025 AOA House of Delegates.

References:

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: **ACCESS TO MENSTRUAL HEALTH PRODUCTS**~~RECOGNIZING PERIOD POVERTY AS A POLICY CONCERN~~

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, "Period poverty" is defined as a lack of access to and an inability to afford menstrual hygiene products (MHPs)[1] often leading to physical, mental, emotional, and social challenges[2]; and

WHEREAS, 16.9 million individuals who menstruate in the United States live in poverty[2]; and

WHEREAS**,** lack of access and ability to afford menstrual products leads to harmful menstrual hygiene practices such as using non-sanitary menstrual product alternatives, using ill-fitting products, and wearing products for longer than safely intended, leading to the potential for development of infection of chafed skin, toxic shock syndrome, and disrupted vaginal flora[3]; and

WHEREAS, the average menstruating American spends $18,000 across their menstruating lifetime on MHPs[4], with that estimate likely being higher in individuals who experience menorrhagia (heavy menstrual bleeding); and

~~WHEREAS, 40% of Americans have admitted to struggling at one point in their life to afford MHPs[5]; and~~

WHEREAS, policy and advocacy addressing period poverty, in public schools has been shown to have positive effects on education, such as on test scores and attendance rates [6]; and

WHEREAS, efforts by states to remove the sales tax from MHPs has been shown to improve access to these items[7,8,9]; and

WHEREAS, the American Osteopathic Association (AOA) is dedicated to protecting patient access to care through federal, state, and profession wide advocacy[10]; now, therefore be it

RESOLVED, ~~that the American Osteopathic Association (AOA) supports local, state, and federal efforts that promote menstrual health equity.~~**THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS EFFORTS ON LOCAL, STATE, AND NATIONAL LEVELS TO EXPAND ACCESS TO AFFORDABLE OR FREE MENSTRUAL HYGIENE PRODUCTS FOR INDIVIDUALS EXPERIENCING PERIOD POVERTY,**

SUPPORTS THE REMOVAL OF SALES TAX ON MENSTRUAL PRODUCTS, ENCOURAGES PUBLIC HEALTH EDUCATION ON SAFE MENSTRUAL HYGIENE PRACTICES, AND ENCOURAGES MEMBERS AND PARTNER ORGANIZATIONS TO COLLABORATE WITH COMMUNITY ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS TO REDUCE THE COMMUNITY ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS TO REDUCE THE COMMUNITY ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS TO REDUCE THE STIGMA AROUND PERIOD POVERTY TO IMPROVE MENSTRUAL HEALTH OUTCOMES.

References:

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: ____July 20, 2025__

SUBJECT: SHARING CENTRALIZED RESOURCES ON STATE-SPECIFIC REPRODUCTIVE HEALTH POLICIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, federal changes limiting access to reproductive health information on federal health websites have left physicians and patients unaware of reproductive rights on a national scale[1]; and

WHEREAS, variations in access to comprehensive reproductive health care exist across states and are constantly changing; for example, Mississippi prohibits pregnancy termination once a fetal heartbeat is detected and Alabama criminalizes pregnancy termination unless the mother's life is threatened-highlighting the need for centralized guidance[2]; and

WHEREAS, the lack of clarity and uncertain enforcement of state reproductive health laws by regulatory agencies creates a challenging landscape for physicians to navigate[3]; and

WHEREAS, without clear guidance from the profession, physicians practicing in states with restrictive reproductive health laws are hesitant to refer patients out of state for legal pregnancy termination or provide patients with online resources about pregnancy termination - that not only impacts patient access to reliable health information and care, but it also negatively affects the patient-physician relationship [4,5]; and

WHEREAS, tools, such as the Guttmacher Interactive Map[7] and the Kaiser Family Foundation's State Profiles for Women's Health[8], showing reproductive health care access across various states are available but should be shared within medical communities to raise awareness and provide centralized access to reliable, evidence-based information; and

WHEREAS, the American Osteopathic Association (AOA) is committed to protecting the sanctity of the patient-physician relationship from interference laws[9,10] and recognizes the importance of having access to federal health data and guidance[11]; and now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **MAKES AVAILABLE EXISTING** ~~shares~~ evidence-based, validated tools **WITHIN THE OSTEOPATHIC PHYSICIAN COMMUNITY** to improve physician access to **ACCURATE** reproductive health information.

References:

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11. American Osteopathic Association, American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, & American Psychiatric Association. (2025, February 6). Statement from leading physician groups on removal of data and guidance from federal websites. American Osteopathic Association. https://osteopathic.org/2025/02/06/statement-from-leading-physician-groups-on-removal-of-data-and-guidance-from-federal-websites/

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $150,000 Annually

The fiscal impact is due to staff resources to oversee the website content as information is consistently changing based on frequently changing laws, frequent guideline updates and monitoring of legal cases.

Staff resources to ensure the materials posted on the AOA website as up to date will consist of researching and vetting the information and making updates when appropriate.

ACTION TAKEN: ___Referred to the AOA Finance Committee____

DATE: _____July 20, 2025_____

SUBJECT: FAMILY PLANNING AND FERTILITY PRESERVATION RESOURCES FOR MEDICAL TRAINEES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, medical training is rigorous, spanning between 7 to 15 years, leading physician~~s~~ and trainees **FAMILIES & PARTNERSHIPS** to delay childbearing until the completion of ~~their~~ **THIS** training[1]; and

WHEREAS, this delay for training amongst female**S** ~~physicians~~ is associated with higher risk pregnancies [1,2,3]; and

WHEREAS, less than half of medical students receive education on **REPRODUCTIVE HEALTH** fertility, fertility preservation, age-related decline, in vitro fertilization (IVF), and oocyte cryopreservation[4,5]; and

WHEREAS, a study of female medical students, residents, and attendings showed an average score of 69% on the Fertility and Infertility Treatment Knowledge Score (FIT-KS), highlighting the systematic knowledge gap of infertility during medical education[6]; and

WHEREAS, a common barrier to family building for medical students and residents is the stigma associated with having children while actively in training [7,8]; and

WHEREAS, the American Osteopathic Association is dedicated to supporting and providing resources for all osteopathic medical students' careers and wellbeing[7]; now, therefore be it

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS OSTEOPATHIC MEDICAL TRAINEES IN BUILDING HOLISTIC FUTURES - BOTH PERSONAL AND PROFESSIONAL - BY PROMOTING THE PROVISION OF FAMILY PLANNING AND REPRODUCTIVE HEALTH FERTILITY GUIDANCE; AND, BE IT FURTHER

RESOLVED, that ~~the American Osteopathic Association (~~AOA~~)~~ encourage**S** already established resources~~, such as *The DO* articles~~ or mentorship opportunities~~, to encompass discussions~~ surrounding family planning and **REPRODUCTIVE HEALTH** fertility ~~preservation~~ throughout medical training**.**~~; and, be it further~~

30 ~~RESOLVED, that the AOA collaborates with its affiliates to promote the provision~~
31 ~~of family planning and fertility preservation resources to trainees~~
32 ~~throughout medical training.~~

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9. "Student Doctors." American Osteopathic Association, 9 Feb. 2024, osteopathic.org/students/

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $3,000
The fiscal impact is for staff time to collect and distribute resources.

ACTION TAKEN: _Adopted as Amended_____

DATE: ___July 20, 2025_____

SUBJECT: RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS - SOURCE H-309/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) discourages the placement of
7 medical practices and limited service clinics in retail settings that promote and sell
8 tobacco because it is contrary to the efforts and standards of the health care
9 community at large.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_

DATE: _____July 19, 2025_____

AMERICAN OSTEOPATHIC ASSOCIATION

500 Series Constitution and Bylaws Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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312.202.8000

osteopathic.org

105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (500 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Constitution and Bylaws (500 series)
This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-500	Amendments to the American Osteopathic Association Bylaws – Article VII	CAGOS	Constitution & Bylaws	Adopted as Amended

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, there is an editorial amendment to Editor-in-Chief in AOA Bylaw Article VII Board of Trustees – Section 1 (b) – to delete "-in-Chief" and the title be "Editor" to be consistent with the AOA Constitution; now therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VII - Board of Trustees

Section 1-Duties The Board of Trustees shall:

b. Appoint a Chief Executive Officer, a Chief Financial Officer, a General Counsel, and ~~the~~ **AN** Editor~~-in-Chief~~ and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, Chief Financial Officer, General Counsel, ~~the~~ Editor~~-in-Chief~~ and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the Association and not fixed by these Bylaws.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above.

Prior HOD action on similar or same topic:
None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 19, 2025_____

AMERICAN OSTEOPATHIC ASSOCIATION

600 Series Ad Hoc Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Encouraging Patient Participation in their Health Care (SR-Source-H609-A/20)	BFHP	Ad Hoc	Adopted
H-601	Veterans Administration Credentialing of Non-Physician Providers Health Records (SR-Source-H621-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-602	Tax Credits for Health Profession Shortage Areas (SR-Source-H622-A/20)	BFHP	Ad Hoc	Adopted
H-603	Prescription of Drugs for off Label Uses (SR-Source-H624-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-604	Preventive Medical Screening (SR-Source-H626-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-605	Medical Procedure Patents (SR-Source-H632-A/20)	BFHP	Ad Hoc	Adopted
H-606	Support the bolstering of Veteran Administration Resources through Provider Pay Reform (SR-Source-H649-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-607	Physician Competency Retesting (SR-Source-H607-A/20)	BOE	Ad Hoc	Adopted as Amended
H-608	Diabetics Confined to Correctional Institutions (SR-Source-H628-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-609	Postpartum Depression (SR-Source-H646-A/20)	BORPH	Ad Hoc	Adopted
H-610	Researching Patient Safety and Provider Qualifications (SR-Source-H648-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-611	Dissemination of Publications in Osteopathic Research (SR-Source-H600-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-612	Proper Badge Identification of Employees in a Hospital Setting (SR-Source-H604-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-613	Health Plan Coverage of Tobacco Cessation Treatment (SR-Source-H608-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-614	Newborn and Infant Hearing Screens (SR-Source-H625-A/20)	BORPH	Ad Hoc	Adopted

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-615	Pediatric Psychiatric Care ~~Health Records~~ (SR-Source-H617-A/20)	CERA	Ad Hoc	Adopted as Amended
H-616	Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (SR-Source-H-618-A/20)	CERA	Ad Hoc	Adopted as Amended
H-617	Prior Authorization (SR-Source-H642-A/20)	CERA	Ad Hoc	Adopted as Amended
H-618	Managed Care Plans – Service, Access and Costs in – (SR-Source H647-A/20)	CERA	Ad Hoc	Adopted
H-619	~~Interoperability o~~f Health Information Technology **AND CLINICAL SOFTWARE: INTEROPERABILITY, SAFETY, AND RELIABILITY** (SR-Source-H605-A/20)	CERA	Ad Hoc	Adopted as Amended
H-620	Electronic Health Records – Physician Assistance Programs for Transition to (SR-Source-H615-A/20)	CERA	Ad Hoc	Adopted as Amended
H-621	Provider Tax (SR-Source-H611-A/20)	CSHA	Ad Hoc	Adopted
H-622	Medicaid Payment (SR-Source-H612-A/20)	CSHA	Ad Hoc	Referred to CSHA
H-623	Lay Midwives (SR-Source-H613-A/20)	CSHA	Ad Hoc	Adopted as Amended
H-624	Managed Care – All Products Clauses (SR-Source-H631-A/20)	CSHA	Ad Hoc	Adopted as Amended
H-625	Non-Physician Clinicians (SR-Source-H640-A20)	CSHA	Ad Hoc	Adopted
H-626	Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance (SR-Source H635-A/20; Referred H633-A/24)	BFHP	Ad Hoc	Adopted as Amended
H-627	Gifts to Physicians from Industry (SR-Source-H606-A/20)	Ethics	Ad Hoc	Adopted
H-628	Confidentiality of Patient Records (SR-Source-H627-A/20)	Ethics	Ad Hoc	Adopted
H-629	Executions in Capital Crimes Criminal Cases (SR-Source-H630-A/20)	Ethics	Ad Hoc	Adopted
H-630	A Proclamation Regarding the Inaccurate Portrayals of U.S. Trained DOs in the Media (SR-Source-H651-A/20)	Ethics	Ad Hoc	Adopted
H-631	Preventing the Criminal Prosecution of Medical Decision Making	MOA (Maine)	Ad Hoc	Adopted as Amended

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-632	Withdrawn	BEL		
H-633	Protecting Patient Care: Opposing the Growing Impact of Private Equity and the Corporate Practice of Medicine	BEL	Ad Hoc	Adopted as Amended
H-634	~~Federal~~ Loan Availability for Osteopathic Medical Students	NYSOMS (New York)	Ad Hoc	Adopted as Amended

SUBJECT: ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE - SOURCE: H609-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) recommends that all insurance
8 companies consider the establishment of a system for rewarding those patients who
9 are trying to stay healthy as a means of decreasing the amount of money spent on
10 health care.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS ~~HEALTH RECORDS~~ - SOURCE: H621-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Ad Hoc

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the establishment of well-
8 defined credentialing and privileging criteria within the Veterans Administration (VA)
9 that prohibits non-physician providers **IN STATES** with expanded scope of practice
10 rights ~~in a minority of states~~ from demanding such privileges in the VA system and
11 supports the establishment of a consistent requirement for the privileging of non-
12 physician ~~providers~~ **CLINICIANS** in the VA system.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS - SOURCE: H622-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the establishment of tax
8 credits for physicians who practice full time in federally designated health
9 professions shortage areas (HPSAs) or Medicare defined physician scarcity areas
10 and federally and/or state designated underserved areas and urges that these tax
11 credits be available, on a sliding scale, to physicians who provide services on a
12 part-time basis in these communities.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: PRESCRIPTION OF DRUGS FOR OFF LABEL USES - SOURCE: H624-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends the following policy be REAFFIRMED.

IT IS THE POSITION OF the American Osteopathic Association (AOA) ~~believes it is~~ **THAT IT IS** appropriate for physicians to prescribe approved drugs for uses not included in their official ~~labeling~~ **INDICATION** when they can be supported as accepted medical practice.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed; 2005; 2010; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 19, 2025_____

SUBJECT: PREVENTIVE MEDICAL **SERVICES - MEDICARE** ~~SCREENING~~ - SOURCE: H626-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) ~~supports coverage of Medicare~~
8 ~~recipients for routine preventive medical services~~**COVERAGE OF ROUTINE**
9 **PREVENTIVE MEDICAL SERVICES FOR MEDICARE RECIPIENTS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: MEDICAL PROCEDURE PATENTS - SOURCE: H632-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports measures that restrict
8 medical procedure patents.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: SUPPORT THE BOLSTERING OF VETERAN ADMINISTRATION RESOURCES THROUGH ~~PROVIDER~~ **PHYSICIAN** PAY REFORM - SOURCE: H649-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) support both staffing management
8 and competitive pay reform at the Veterans' Health Administration (VHA) to ensure
9 that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is
10 available to meet the health needs of the United States veteran population.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PHYSICIAN COMPETENCY RETESTING - SOURCE: H607-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA):

(1) Supports the mission of physician competency, ~~the~~ **DELIVERY OF HIGH QUALITY CARE,** quality **IMPROVEMENT**~~movement~~ and patient safety through self-regulation mechanisms rather than through government mandated retesting for purposes of obtaining re-licensure or for receiving payment under a health benefits program.

(2) Continue its voluntary efforts to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels, **AND** physician assessment through osteopathic continuous certification.

Background Information: Provided by AOA Staff
Current AOA Policy: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H329-A/24 Uniform Pathway of Licensing of Osteopathic Physicians
H213-A/22 Osteopathic Licensing

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS - SOURCE: H-628/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the availability of American
7 Diabetes Association (ADA) diabetic meals, beverages, and other diabetic
8 interventions that follow ADA guidelines for all imprisoned persons with diabetes
9 who are under the care of a licensed physician and confined ~~in~~ **TO** correctional
10 institutions.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: POSTPARTUM DEPRESSION - SOURCE: H-646/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages its members to
7 participate in continuing medical education programs on postpartum depression
8 (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and
9 specialty associations to offer CME on PPD as part of their educational offerings;
10 and endorses the use of screening tools and encourage the measurement of
11 outcomes in their use.

Background Information: Provided by AOA Staff
Current AOA Policy: 2003; 2008; 2013 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: RESEARCHING PATIENT SAFETY AND ~~PROVIDER~~ **CLINICIAN** QUALIFICATIONS - SOURCE: H648/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

RESEARCHING PATIENT SAFETY AND PROVIDER QUALIFICATIONS

REVIEW OF RESEARCH

A REVIEW OF THE LITERATURE INDICATES VERY LITTLE RESEARCH INTO THE LACK OF QUALIFICATIONS OF NURSE PRACTITIONERS (NPS) AND PHYSICIAN ASSISTANTS (PAS) TO INDEPENDENTLY PROVIDE MEDICAL CARE. A 2022 AMERICAN MEDICAL ASSOCIATION (AMA) ISSUE BRIEF, ENTITLED *SUMMARY OF EXISTING STUDIES: SCOPE OF PRACTICE*, PROVIDES A SUMMARY OF 15 RESEARCH PROJECTS ON TOPICS INCLUDING COST AND QUALITY OF CARE, EDUCATION AND TRAINING, AND WORKFORCE STUDIES.[1]

IN JULY 2024, AN ARTICLE PUBLISHED BY BLOOMBERG NEWS, ENTITLED *THE MISEDUCATION OF AMERICA'S NURSE PRACTITIONERS*, ANALYZED THE SHORTCOMINGS IN NURSE PRACTITIONER EDUCATION AND TRAINING AND ITS IMPACT ON PATIENT CARE.[2]

THERE ARE MANY CHALLENGES TO CONDUCTING THE RESEARCH CALLED FOR IN THE RESOLUTION. THESE INCLUDE LACK OF FUNDING FOR COMPREHENSIVE LONGITUDINAL RESEARCH INTO NP AND PA OUTCOMES AND COST DATA. OTHER CHALLENGES INCLUDE LACK OF ACCESS TO MALPRACTICE CLAIMS DATA AND THE IMPRACTICALITY OF IDENTIFYING NPS AND PAS WHO MAY HAVE MISSED OR MISDIAGNOSED A PATIENT WHO LATER ENDS UP BEING SEEN BY A PHYSICIAN ONCE THEIR CONDITION WORSENS.

SCOPE OF PRACTICE

SCOPE OF PRACTICE IS AN AOA PRIORITY ISSUE, AND THE PUBLIC POLICY DEPARTMENT ACTIVELY ADVOCATES AGAINST INAPPROPRIATE SCOPE EXPANSION ATTEMPTS BY NON-PHYSICIAN CLINICIANS. INFORMATION REGARDING THE AOA'S ADVOCACY EFFORTS ON ALL PRIORITY ISSUES – INCLUDING SCOPE OF PRACTICE – IS PROVIDED TO PHYSICIANS VIA THE FOLLOWING COMMUNICATION CHANNELS:

- **THE OSTEOPATHIC ADVOCACY NETWORK**
- **THE DO ENGAGE**
- **THE AOA DOCUMENT REPOSITORY (CONTAINS ALL LETTERS WRITTEN ON PRIORITY ISSUES, SEARCHABLE BY KEYWORD)**
- **QUORUM SOFTWARE FOR REAL-TIME TRACKING OF PUBLIC POLICY ACTIVITY ON VARIOUS ISSUES**

SHOULD ADDITIONAL RESEARCH INTO NP AND PA COST AND QUALITY OUTCOMES BECOME AVAILABLE, STAFF WILL INVESTIGATE THE PROPER COMMUNICATIONS CHANNELS THROUGH WHICH TO DISSEMINATE IT.

AOA POLICY STATEMENT

The American Osteopathic Association (AOA) encourages independent research on the qualification**S** and outcomes of nurse practitioners, **PHYSICIAN ASSISTANTS**, and other midlevel providers that practice independently~~; and that the AOA research & public health staff perform an analysis of current, valid and published research~~ **FOCUSING SPECIFICALLY** on clinical outcomes, resource utilization and malpractice experience for independently practicing NPs and PAs, ~~**PROVIDING THIS INFORMATION**~~ **AND SHARE AS IT BECOMES AVAILABLE THROUGH OSTEOPATHIC ADVOCACY NETWORK COMMUNICATION CHANNELS OR OTHER VENUES, AS APPROPRIATE**. ~~and provide this information to osteopathic physicians.~~

References:

1. **AMERICAN MEDICAL ASSOCIATION (AMA) ISSUE BRIEF, SUMMARY OF EXISTING STUDIES: SCOPE OF PRACTICE, 2022. (ACCESSED 3-26-2025)** https://www.ama-assn.org/system/files/issue-brief-scope-practice-summary-existing-studies.pdf

2. **BLOOMBERG NEWS, THE MISEDUCATION OF AMERICA'S NURSE PRACTITIONERS, 7-24-2024. (ACCESSED 3-26-2025)** https://www.bloomberg.com/news/features/2024-07-24/is-the-nurse-practitioner-job-boom-putting-us-health-care-at-risk?sref=vAuA9CT5&leadSource=uverify%20wall&embedded-checkout=true

Background Information: Provided by AOA Staff
Current AOA Policy: H648/A2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH - SOURCE: H-600/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) will widely disseminate publications, research, and evidence-based medicine regarding Osteopathic Medicine and Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological basis to the greater public via prominent, designated public information sites, social networking, public information releases, websites, **AND IN THE DEVELOPMENT OF ARTIFICIAL INTELLEGENCE (AI) AS AN ADDITIONAL OPPORTUNITY TO DEMONSTRATE THE BENEFITS OF OSTEOPATHIC MEDICINE**~~and other media~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING - SOURCE: H-604/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages all healthcare providers
7 and hospital employees to wear hospital-issued identification badges with clear
8 delineation of their **LICENSED DESIGNATION** ~~professional role~~ and ~~that~~ they
9 verbally introduce and identify themselves and their **LICENSED DESIGNATION**
10 ~~role in the patient's treatment process~~, with the overall goal of improving patient
11 safety and patient communication.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: ~~HEALTH PLAN~~ **PAYOR** COVERAGE OF TOBACCO CESSATION TREATMENT - SOURCE: H-608/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages all ~~health plans~~
7 **PAYORS** to follow tobacco cessation recommendations of the Centers for Disease
8 Control and Prevention (CDC) and ~~encourages all health care plans~~ to accept CPT,
9 and ICD-10 codes for tobacco use **DISORDER** as legitimate codes for payment ~~for~~
10 **OF** services provided ~~for~~ **BY** these codes.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: NEWBORN AND INFANT HEARING SCREENS
- SOURCE: H-625/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports adequate funding for
7 universal hearing screening and intervention for newborns and infants.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Revised, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: PEDIATRIC PSYCHIATRIC CARE ~~HEALTH RECORDS~~ – SOURCE: H617-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association supports the development of educational programs to assist primary care physicians ~~to identify~~ **IN IDENTIFYING** and ~~initiate~~ **INITIATING** appropriate support ~~of~~ **FOR** pediatric psychiatric care, and **THE AOA** encourages **PAYORS** ~~insurance providers~~ to adequately reimburse counseling, ~~and~~ psychiatric care, **AND MEDICATION** deemed **MEDICALLY INDICATED** ~~necessary~~ by the patient's primary care physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER – SOURCE: H-618-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that this policy is no longer necessary; and

WHEREAS, there have been no questions or concerns regarding coverage of services for ADHD by primary care physicians in recent years as such coverage is now standard; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be ~~SUNSET~~**REAFFIRMED AS AMENDED**.

The American Osteopathic Association (AOA) urges ~~insurance carriers~~ **PAYORS** to provide coverage for **CARE OF** attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

SUBJECT: PRIOR AUTHORIZATION – SOURCE: H642-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization.

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden. ~~In order to~~ **TO** ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of ~~PA~~ **PRIOR AUTHORIZATION** by ~~payers~~ **PAYORS** and pharmacy benefit managers should abide by the following principles:

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.

- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.

- Payors should appropriately compensate providers for complying with utilization review.

- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.

- ~~Allow continuation of~~ **PATIENTS SHOULD BE ALLOWED TO CONTINUE ON** medications already being administered or prescribed when ~~a patient~~ **THEY** change~~s~~ health plans**,** and ~~not allow~~ **PLANS SHOULD BE PROHIBITED FROM MAKING** changes without ~~discussion and~~ approval of the ordering ~~physician~~**PRESCRIBER**.

- Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.

- Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.

- Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved

- **PLANS SHOULD NOT USE AUGMENTED/ARTIFICIAL INTELLIGENCE (AI) TO AUTOMATICALLY DENY PRIOR AUTHORIZATION REQUESTS, AND ALL DENIALS SHOULD BE REVIEWED BY A LICENSED PHYSICIAN IN A SPECIALTY RELEVANT TO THE SERVICE BEING REQUESTED.**

- There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians

As part of its efforts to advocate for these principles and ensure their incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers and pharmacy benefit managers to:

- **ELIMINATE PLAN USE OF LOW-VALUE PRIOR AUTHORIZATION REQUIREMENTS, WHERE PLANS IMPOSE REQUIREMENTS FOR SERVICES ROUTINELY APPROVED OR OF LIMITED VALUE TO IMPROVING CARE.**

- Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being

- ~~Consider a physician's attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment~~

- Include in contracts with ~~healthcare providers~~ **PHYSICIANS** hold harmless clauses that indemnify ~~healthcare providers~~ **PHYSICIANS** against financial loss due to injury to a patient as a result of the payor's failure or refusal to ~~grant a prior authorization request in a timely manner~~**MAKE A TIMELY DECISION**

- Provide appropriate **AND TIMELY** notice to patients and physicians when **BEFORE** formulary and benefit changes are made, **AND INCLUDE** ~~**PREFERRED**~~ **ALTERNATIVE OPTIONS** ~~**THAT MAY BE INDICATED**~~

- Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including EMR templates

- Publish and make available to the public all **MEDICAL ITEMS, SERVICES, AND PRODUCTS WHICH WILL REQUIRE PRIOR AUTHORIZATION,** ~~requirements~~ **AND** for prior authorization and follow those published policies

- ~~**PUBLISH AND MAKE AVAILABLE TO THE PUBLIC**~~ **THE EVIDENCE AND CLINICAL GUIDELINES UPON WHICH COVERAGE CRITERIA ARE BASED**

- Provide sufficient knowledgeable staff to ensure that healthcare providers are able to contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes

- Compensate medical practices and healthcare providers for the cost of time spent ~~on inappropriately denied PA~~ **PRIOR AUTHORIZATION** requests

- ~~To identify and hold accountable the payor's medical director/claim adjudicator for the results of their decisions~~ **TO HOLD PAYORS ACCOUNTABLE FOR FOLLOWING THEIR PUBLISHED POLICIES AND FOR THE RESULTS OR THOSE DECISIONS.**

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above, 2020; Note previous policy numbers of H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16 have been sunset and policy H642-A/20 is the current policy.

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 19, 2025_____

SUBJECT: MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN – SOURCE: H647-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) supports **MANAGED CARE PLANS HAVING SUFFICIENT FLEXIBILITY TO MANAGE COSTS AND QUALITY WHILE BEING ACCOUNTABLE FOR ENSURING ACCESS TO APPROPRIATE PATIENT CARE AND PREVENTING UNDUE BURDEN ON PHYSICIANS. THIS INCLUDES THE ABILITY OF PLANS TO** ~~efforts to~~ expand the use of variable co-pays **AND OTHER BENEFIT DESIGNS** that support program costs. The AOA also supports efforts to design benefits that align consumer needs, accountability and individual physician incentives.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 1999; 2004 Revised; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2020 Reaffirmed.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: ~~Interoperability of~~ Health Information Technology **AND CLINICAL SOFTWARE: INTEROPERABILITY, SAFETY, AND RELIABILITY** – SOURCE: H605-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) supports **A REGULATORY FRAMEWORK FOR HEALTH INFORMATION TECHNOLOGY AND RELATED CLINICAL SOFTWARE THAT APPROPRIATELY BALANCES PATIENT SAFETY, DATA PRIVACY AND SECURITY, USABILITY, AND INNOVATION. AOA SUPPORTS** a ~~new~~ risk-based oversight framework for clinical software, developed through a multi-stakeholder consensus-based process. The framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility. **POLICY REGARDING PRODUCT APPROVAL OR CERTIFICATION SHOULD EMPHASIZE PATIENT OUTCOMES AND SAFETY; DELIVERY OF PATIENT-CENTERED, WHOLE-PERSON CARE; AND USABILITY OF PRODUCTS BY PHYSICIANS TO ALLEVIATE BURDENS OF SUCH USE.** ~~Patient safety and appropriate improvements in quality, effectiveness, and efficiency of care delivery should be paramount. This framework should not conflict with or duplicate the medical device regulation framework. The AOA does not support data be treated as a medical device, regardless of the category of health it associated with the data. The AOA supports a national network for reporting patient safety events and other information vital to public health, where data can be accessed, analyzed, and communicated in a timely manner. The regulatory framework~~ **FEDERAL POLICIES** should promote interoperability, in order for clinical information systems to capture and share quality, outcome, cost, and **INDIVIDUAL** patient ~~healthcare~~ data. ~~To support coordinated health care and data analytics to promote transition to a value-based healthcare system.~~ **INTEROPERABILITY IS ESSENTIAL TO COORDINATED CARE AND IMPROVED OUTCOMES NATIONWIDE.** The AOA ~~supports~~ **WILL CONTINUE TO ADVOCATE FOR** a common data structure that will enable interoperability; ~~setting a clear course of action,~~ federal support for an exchange infrastructure; **A NATIONAL NETWORK FOR REPORTING PATIENT SAFETY EVENTS AND OTHER INFORMATION VITAL TO PUBLIC HEALTH**; and standards which will make it easier to share information so physicians and patients

can make informed decisions. **THE AOA OPPOSES VENDORS, PROVIDER ENTITIES, AND OTHER HEALTHCARE ORGANIZATIONS BLOCKING HEALTHCARE PROFESSIONALS' ABILITY TO ACCESS, VIEW, SHARE, OR TRANSFER DATA.**

The AOA will encourage public and private sector stakeholders to develop ~~clinically driven, standardized~~ products that are interoperable by design, do not require costly and time-consuming customization, and for which any upgrades or future needs can be integrated seamlessly without burdensome costs or system modifications. The AOA also supports ~~standardization of prior authorization attachments~~ **A STANDARDIZED ELECTRONIC PRIOR AUTHORIZATION PROCESS** to alleviate burden and reduce delays to care.

~~The AOA opposes vendors blocking health care professionals' ability to access, view, share, or transfer data.~~

~~The AOA supports policies and technologies that facilitate person-centered health care.~~

The AOA will remain vigilant about mitigating the level of administrative burden posed by existing and new government policies.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025_____

SUBJECT: ELECTRONIC HEALTH RECORDS – PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO – SOURCE: H615-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) will continue to support solo practice physicians and small-group practices in ~~the~~ **THEIR PURSUIT OF** adoption of health information technology (HIT). **THIS INCLUDES THE ADOPTION OF CRITICAL HIT ADD-ON FUNCTIONALITIES, SUCH AS POPULATION MANAGEMENT TOOLS OR ELECTRONIC PRIOR AUTHORIZATION FUNCTIONS, THAT ARE ESSENTIAL TO SUPPORTING IMPROVED CARE AND ENABLING PRACTICES TO REMAIN COMPETITIVE WITH LARGER ENTERPRISES**. The AOA supports incentives or enhanced payments for adoption of innovative ~~hit~~ **HIT** that improves care delivery, coordination, and value.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Revised; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PROVIDER TAX - SOURCE: H611-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) opposes any effort by a state or the
8 federal government to impose a provider tax of any type.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: ~~EQUITY IN MEDICARE &~~ **MEDICAID PAYMENTS**
- SOURCE: H612-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs determined the subject matter of H612-A/20 and H321-A/22 to be substantially similar; and now therefore be it

RESOLVED, adding language from H612-A/20 to H321-A/22 and sunsetting H612/-A/20 would provide a clear and comprehensive stance on the issue, eliminate redundancy, and streamline our policy compendium; now, therefore be it further

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED**.**

~~EQUITY IN MEDICARE &~~ **MEDICAID PAYMENTS**

The American Osteopathic Association (AOA) will actively support federal legislation, rules or regulations, to include socioeconomic risk stratification in public reporting and evaluation of physician payment in all Medicare and Medicaid pay for performance value-based purchasing incentives or penalties to account for the challenges serving socioeconomically or medically underserved patient populations to ensure continued timely access to appropriate clinical services.

The AOA will support federal and state legislation, rules or regulations to improve Medicare and Medicaid payments to physicians **AND HOSPITALS** working in socioeconomic, or medically underserved areas to ensure an adequate workforce to address the burden of care associated with complex comorbid conditions in these areas.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to Council on State Health Affairs__

DATE: _____July 19, 2025_____

SUBJECT: LAY MIDWIVES - SOURCE: H613-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) opposes the licensing of lay
8 midwives **WHO LACK FORMAL TRAINING AND CERTIFICATION** and will
9 continue providing support to affiliate societies in opposing state's efforts to license
10 lay midwives.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: MANAGED CARE – ALL PRODUCTS CLAUSES
- SOURCE: H631-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED**.**

The American Osteopathic Association (AOA) ~~and state osteopathic societies~~ oppose**S** the use of "all products/all products developed in the future" clauses in physician managed care contracts; actively opposes the use of any other clauses that may limit the ability of the physician to choose the plans in which **THEY** ~~he or she~~ participate~~s~~; and supports both state and federal legislation as well as regulatory agency regulations and rulings to prohibit the use of "all products/all products developed in the future" clauses in physician managed care contracts.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000; 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____

SUBJECT: NON-PHYSICIAN CLINICIANS - SOURCE: H640-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision.

Over the course of the past century, scientific and technological advancements have led to improvements in the treatment of disease and standards of patient care. As a result, the standardized medical education, supervised postgraduate ("residency") training and examination series that physicians in the United States are required to complete in order to obtain an unlimited medical license has increased as well. At the same time, however, some states are creating legislative pathways to independent medical practice for other types of clinicians, despite the absence of nationally standardized education, training and testing pathways for these clinician groups, or evidence regarding patient safety outcomes.

The current DO/MD medical model, in which medical students and resident physicians are required to demonstrate their ability to safely provide care to patients under the supervision of fully licensed physicians, leading to greater autonomy over time, has proven its ability to provide physicians with the complete knowledge and skill base needed to ensure patient safety and optimize outcomes. in addition, most states impose additional continuing medical education (CME) requirements, and many physicians elect to undergo rigorous certifying board examinations to demonstrate excellence in a particular specialty, which helps to ensure that physicians remain trained to provide the current highest standard of patient care over the course of their careers.

Thus, it is appropriate that the practice of medicine and the quality of medical care remain the responsibility of physicians, who are the only clinician group properly trained, licensed and regulated according to uniform laws governing medical licensure in the United States. The American Osteopathic Association (AOA) values the unique training and contributions of all members of the patient care team and

supports the concept of uniform licensure pathways for all clinician groups, based upon scope of practice. The AOA further supports appropriate physician involvement in patient care provided by non-physician clinicians, and opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates that patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. Patient Safety. The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of relevant state statutes.

B. Independent Practice. It is the AOA's position that roles within the "team" framework must be clearly defined, through established state-level supervisory protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates and patients can rest assured that physician involvement in their care will remain the same regardless of practice setting within the state. Further, all non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality and degree of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians providing care in independent practice states should be regulated and disciplined by the entities responsible for regulating and disciplining physicians (i.e. state medical boards), to ensure that all clinicians who are independently practicing medicine are held to the same standard of care and the equivalent degree of liability. To that end, the AOA also believes that non-physician clinicians should be required to obtain equivalent malpractice insurance to physicians in states that currently require physicians to possess malpractice insurance.

Background Information: Provided by AOA Staff

Current AOA Policy: 2000, 2005 Revised; 2010 Revised; 2015 Reaffirmed; 2018 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: H336-A/20 Use of the Term "Physician" "Doctor" and "Provider"; H327-A/21 Non-Physician Health Care Clinician; H626-A/23 Non-Physician Clinician Medical Liability

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE – SOURCE: REFERRED-H633-A/24; SR-H635-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, H633-A/2024 was referred to the Bureau on Federal Health Programs; and

WHEREAS, the Bureau on Federal Health Programs has reviewed and amended the referred policy; and

WHEREAS, the Board of Trustees approved the amended referred policy (as currently presented to the 2025 House of Delegates), H633-A/2024 AOA OMT Coverage Determination Guidance, as an adopted policy until it can be ratified by the House of Delegates in 2025; therefore, be it

RESOLVED, that the Bureau on Federal Health Programs and the Board of Trustees recommends that the referred policy be REAFFIRMED as AMENDED .

The American Osteopathic Association (AOA) supports the ability for physicians to bill for Osteopathic Manipulative Treatment (OMT) when performed as a separately identifiable procedure on the same date as an evaluation and management (E/M) service when the services are medically necessary and are supported with appropriate documentation according to the E/M Documentation Guidelines. The AOA will work with all payers to ensure that policies continue to support appropriate payment for OMT when billed with an E/M service. Additionally, the AOA will engage with private payers to ensure that their coverage policies are consistent with current medical practice, to address inappropriate claims denials, and to address blanket denials for services billed with a modifier 25.

The AOA approves the position paper below for OMT coverage and encourages all public and private payers to refer to AOA's policy when developing new policy or revising existing guidance for OMT coverage. The position paper is intended for use in educational efforts on proper documentation, billing, and payment for OMT; discusses best practices; and acknowledges that documentation by physicians may vary based on individual needs and circumstances that should not serve as a basis for payment denials when services are medically necessary.

American Osteopathic Association (AOA) Position Paper on Osteopathic Manipulative Treatment

Osteopathic manipulative treatment (OMT) is an essential treatment tool used by physicians for a broad range of conditions, and particularly for treating somatic dysfunction. OMT should be appropriately paid for when it is medically necessary, and documentation of the service is accurate. This document provides guidance to physicians and payers on the following:

- The physicians qualified to provide OMT;
- When payment for OMT services is appropriate;
- Proper documentation and coding of OMT services, including when the service is billed on the same date as an evaluation and management (E/M) service; and
- Appropriate reporting of E/M services in conjunction with OMT.

Physicians are encouraged to use these guidelines to inform best practices for billing, coding, and documentation. Payers should also consider these guidelines in development of coverage policy and should not inappropriately limit payment for medically necessary OMT services.

Introduction to OMT

OMT is a distinct medical procedure used by physicians (DOs/MDs) to treat somatic dysfunction and other conditions. The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as the therapeutic application of manually guided forces by a physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. The AACOM glossary further elaborates on the definition, stating:

Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: (1) the position of a body part as determined by palpation and referenced to its adjacent defined structure, (2) the directions in which motion is freer, and (3) the directions in which motion is restricted.[1]

Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions.

Osteopathic manipulative treatment can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial, and myofascial tissues (e.g. tight right shoulder muscles in a patient with gallbladder disease). Normalizing musculoskeletal activity (relaxing tense muscles, etc.) can normalize outflows through sympathetic or parasympathetic autonomic nervous systems to visceral systems, resulting in more normal visceral and organ system function. Somatic

[1] The American Association of Colleges of Osteopathic Medicine (AACOM) **EDUCATIONAL COUNCIL ON OSTEOPATHIC PRINCIPLES (ECOP) GLOSSARY OF OSTEOPATHIC TERMINOLOGY, 3RD EDITION, 2017**. ~~November 2011.~~

dysfunction is identified on the physical exam by one or more of the following elements: **T**issue texture changes, positional **A**symmetry, **R**ange of motion alterations, or changes in palpatory sensitivity, e.g., **T**enderness (TART).

Provider Types Qualified to Perform OMT

To perform OMT, a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine, or a medical doctor must have **GRADUATED FROM AN ACCREDITED ALLOPATHIC SCHOOL OF MEDICINE AND HAVE** trained in ~~a postgraduate osteopathic training program that encompasses~~ osteopathic principles and practices, including hands-on demonstration and competency testing in OMT.

OMT Payment:

The decision to utilize OMT as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical to perform a history and physical examination on initial and subsequent encounters. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall care of the patient.

OMT is a paid service when somatic dysfunction is documented in the history and/or the physical examination. OMT is not paid when somatic dysfunction is absent from the patient's history or physical examination documentation. The method of OMT employed by the physician is determined by the patient's condition, age, and the effectiveness of previous methods of treatment. Because OMT is a procedure that is separate from the evaluation and management (E/M) service, both services should be payable when rendered on the same day assuming that somatic dysfunction is identified, documentation is appropriate, and that the E/M service is above and beyond the services covered in the OMT and is documented accordingly. Payers should not deny claims on the sole basis that the E/M service is billed with modifier 25 when a procedure was performed on the same date.

OMT Documentation

The medical record documentation must support the level of E/M service billed and include the somatic dysfunction that the physician observed in the body regions treated with OMT. If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the elements that constitute the E/M service and the OMT service. Following current E/M coding guidelines, the level of E/M service selected may be based on the total time spent on the E/M portion of the encounter or medical decision making (MDM). Documentation should be consistent with Current Procedural Terminology (CPT©) guidelines to support level selection. The documentation should clearly identify the body regions affected and treated with OMT to support the procedure code(s) reported.

~~The selection of body region(s) to which OMT is applied should reflect the region(s) of documented somatic dysfunction. There may be instances when multiple regions are treated due to the occurrence of compensatory changes. When this occurs, the documentation should describe the compensatory changes and the rationale for treating these areas, especially if the patient has no complaints related to these areas. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at areas unrelated to the diagnosis.~~ **THE BODY REGION(S) TO WHICH OMT IS APPLIED MUST BE REFLECTED WITHIN DOCUMENTATION OF SOMATIC DYSFUNCTION. THERE MAY BE INSTANCES WHEN MULTIPLE REGIONS ARE TREATED WHEN THE PATIENT HAS NO COMPLAINTS RELATED TO THESE AREAS. IF THERE IS AN INTERRELATIONSHIP SUCH AS A DISTANT MECHANICAL INFLUENCE OF THE OCCURRENCE OF COMPENSATORY CHANGES, IT IS BEST TO DESCRIBE THOSE WHEN POSSIBLE. TREATMENT SHOULD GENERALLY NOT BE DIRECTED TO AREAS OF DYSFUNCTION UNRELATED TO THE DIAGNOSIS THAT HAVE NO INFLUENCING NATURE.** The type, frequency, and duration of OMT should be consistent with current standards of medical practice.

Factors that may affect frequency and duration of treatment are severity of illness, duration or chronicity of the patient's condition, and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician's treatment approach.

Overall, the American Osteopathic Association recommends that the E/M and OMT portions of the visit be distinctly documented and detail the regions treated, the techniques utilized, ~~and when appropriate, a description of how the patient tolerated the treatment.~~ **A DESCRIPTION OF HOW THE PATIENT TOLERATED THE TREATMENT, AND INCLUDE OTHER DETAILS CONSISTENT WITH TYPICAL PROCEDURE DOCUMENTATION.**

<u>OMT Coding</u>

In April 2010, the American Medical Association (AMA) Relative Value Update Committee (RUC) requested that the AOA survey the existing OMT codes to develop accurate and unbiased information for the relative value of the physician work involved in performing OMT as part of the Centers for Medicaid and Medicare Services (CMS) five-year review of the resource based relative value scale (RBRVS).

The survey process required the creation of vignettes to describe the typical patient for OMT CPT® Codes 98925-98929. Additionally, the description of the preservice, intraservice, and postservice work for OMT was included. As of January 2012, the vignettes for the typical patient and the preservice, intraservice and postservice descriptors are contained within the RUC database.

There are five OMT Service CPT© Codes (98925-98929), each corresponding to the number of body regions treated with OMT. Descriptors for each code are the following:

- 98925 *Osteopathic manipulative treatment (OMT); 1-2 body regions involved*
- 98926 *Osteopathic manipulative treatment (OMT); 3-4 body regions involved*
- 98927 *Osteopathic manipulative treatment (OMT); 5-6 body regions involved*
- 98928 *Osteopathic manipulative treatment (OMT); 7-8 body regions involved*
- 98929 *Osteopathic manipulative treatment (OMT); 9-10 body regions involved*

Vignettes and work descriptors for each OMT code can be found in Appendix C of this document. Note: The OMT service codes do not include any elements of the history, examination, and medical decision making.

<u>Reporting E/M Services:</u>

It is appropriate for an E/M service to be performed on initial visits where OMT may be performed, and on subsequent patient encounters if a new problem occurs or if original symptoms have changed. An appropriate significant, separately identifiable E/M service, documented according to the E/M guidelines, may be provided and reported so long as it is considered medically necessary and goes above and beyond the work associated with the OMT procedure itself. As patients may not present for the explicit purpose of undergoing an OMT procedure, the E/M service helps a physician determine if OMT needs to be provided and, if so, what body region(s) to treat and what technique(s) to employ.

A physician should select the appropriate E/M based on MDM or total time of the E/M portion of the encounter, and they should make sure to document a medically appropriate history and/or examination. According to CPT guidelines, four types of MDM are recognized, which include straightforward, low, moderate, and high. MDM “includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option” and is defined by three key elements:

- Number and complexity of the problem(s) addressed during the encounter;
- The amount and/or complexity of data to be reviewed or analyzed; and
- The risk of complications and/or morbidity or mortality of patient management.

Total time may be used alone to select the appropriate code level for E/M services. Time consists of the cumulative amount of face-to-face and non-face-to-face time **personally** spent by the physician in care of the patient on the date of the encounter. Total time can include the following activities when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record

- independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
- care coordination (not separately reported)

Physicians should follow the most recent CPT guidance on E/M services whenever billing these services. Documentation for both the E/M and OMT service must be complete when the services are billed on the same day.[2]
If utilizing an electronic health record (EHR), ensure that it is capable of capturing all of the history, physical examination and medical decision making and any other service(s) provided on each patient visit.
Per CPT © guidance, Evaluation and Management services may be reported separately using Modifier- 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the OMT procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for reporting of the OMT and E/M service on the same date. Documentation of any changes to symptoms from original visit are vital to the medical necessity of the E/M service.

Documenting the Patient Visit: SOAP Note Example[3]:

Below is an example of a patient encounter and a subjective, objective, assessment, and plan (SOAP) note for each to illustrate how to document the patient's visit in the medical record. Other styles and preferences exist for medical record documentation. **Note: The E/M service should be a separately identifiable service above and beyond what is normally included in the osteopathic procedure note. If somatic dysfunction is identified in exam and OMT is recommended documentation should include a procedure note. The procedure note should be a separate note following the SOAP note**.

E/M visit level can be determined based on either medical decision making (MDM) or total time.

SOAP Note – Patient Example

S. A 20-year-old African American male complains of low back pain that began three days ago after he lifted a heavy object. Cannot straighten up when walking, pain with change of position. The patient denies radiation of pain and areas of numbness, the pain stays along the back and waist. He is comfortable when lying down, aspirin helps some, has used heat with some help. Has prior history of back pain as a child. Reviewed records provided. Symptoms resolved after undergoing physical therapy. Denies allergies, surgical history is unremarkable.
O. FLEXION POSTURE WHEN STANDING. INABILITY TO EXTEND LUMBAR SPINE ON ACTIVE AND PASSIVE RANGE OF MOTION. TENDERNESS NOTED

[2] American Medical Association. CPT Evaluation and Management (E/M) Code and Guideline Changes. Effective January 1, 2023. Available here.
[3]American Osteopathic Association. "Guide to Coding and Documentation: Osteopathic Manipulative Treatment, First Edition." 2017

OVER LUMBAR AND SACRAL REGIONS. MUSCLE SPASMS NOTED OF BILATERAL PARASPINAL MUSCULATURE OF THE LUMBAR SPINE. L2 FRRSR. L/R BACKWARD SACRAL TORSION. NEUROLOGIC EXAM WITHIN NORMAL LIMITS. MUSCULOSKELETAL STRENGTH OF BILATERAL LOWER EXTREMITIES EQUAL AND WITHIN NORMAL LIMITS. ~~Tenderness noted over lumbar and sacral regions. Inability to extend lumbar spine when standing. Flexion posture when standing. Muscle spasms noted in paraspinals of the lumbar region. Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing. Neurologic exam normal.~~

A. The patient is diagnosed with lumbosacral sprain/strain, likely due to lifting a heavy object. Patient has moderate pain intensity with associated activity limitations.

Lumbosacral sprain/strain S33.8XXA

Note: Based on feedback from insurers and physicians who have completed appeals processes, the AOA encourages inclusion of a narrative of considerations and judgements synthesizing their clinical findings into a clear understanding of the presenting condition and treatment strategies.

P. 1. OMT recommended for the somatic dysfunction of lumbar and sacral regions as noted
2. Continue aspirin
3. No lifting, bending, or twisting
4. Contact office if symptoms worsen

OMT Procedure Note- Patient Example

Patient decided to proceed with OMT recommended. Verbal consent obtained. Discussed risks, benefits, and potential treatment reaction with patient and patient acknowledged comprehension. Patient put in position and technique used to treat the sacral and lumbar spine regions — hypertonic paraspinal muscles and sacral spine- piriformis muscles S2-S4.

Patient tolerated procedure well. Improved Range of Motion noted along with a decreased severity of pain.

Patient instructed to drink fluids today following procedure. Discouraged bedrest and encouraged movement. Contact office if pain increases.

CODING FOR THIS CASE

Evaluation and Management: new patient/established patient 99203/99213 (with modifier 25) **ATTACHING S33.8XXA**
OMT two body regions: lumbar/sacral 98925 **ATTACHING ICD-10 CODE M99.03 AND M99.04**

Conclusion:

OMT is a procedure that is separate from the evaluation and management service, both services should be payable when rendered on the same day considering that somatic

dysfunction is observed and both services are appropriately documented. Physicians should follow the above guidance to ensure that their documentation is appropriate. However, physicians have varying approaches to documentation, and payment should not be denied as long as the E/M service is a significant, separately identifiable service above and beyond the usual preservice and postservice work associated with the OMT procedure. Payers should also consider the above guidelines in developing coverage policies to ensure they are not inappropriately denying medically necessary services.

Appendices

Appendix A: OMT Coding Information

CPT/HCPCS Codes

98925 Osteopathic Manipulative Treatment (OMT); 1-2 Body Regions Involved
98926 Osteopathic Manipulative Treatment (OMT); 3-4 Body Regions Involved
98927 Osteopathic Manipulative Treatment (OMT); 5-6 Body Regions Involved
98928 Osteopathic Manipulative Treatment (OMT); 7-8 Body Regions Involved
98929 Osteopathic Manipulative Treatment (OMT); 9-10 Body Regions Involved

ICD-10 Diagnosis Codes

ICD-10 Codes:

M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.06	Segmental and somatic dysfunction of lower extremity
M99.07	Segmental and somatic dysfunction of upper extremity
M99.08	Segmental and somatic dysfunction of rib cage
M99.09	Segmental and somatic dysfunction of abdomen and other regions

Appendix B: OMT Techniques are listed below (~~Please refer to~~ including, but not limited to those listed in the AACOM Glossary of OMT Terminology ~~for more information~~)

Active method
Articulatory method
Articulatory treatment
Articulatory (ART)
Balanced ligamentous tension (BLT)
Chapman reflex
Combined method
Combined treatment
Compression of the fourth ventricle (CV-4)
Counterstrain (CS)
Cranial Treatment (CR)
CV-4
Dalrymple treatment
Direct method
Exaggeration method
Exaggeration technique
Facilitated oscillatory release technique (FOR)
Facilitated positional release (FPR)
FASCIAL DISTORTION MODEL (FDM)
Fascial release treatment
Fascial unwinding
Functional method
Galbreath treatment
Hepatic pump
High velocity/low amplitude technique (HVLA)
Hoover technique
Indirect method (I/IND)
Inhibitory pressure technique
Integrated neuromusculoskeletal release
Jones technique
Ligamentous articular strain technique (LAS)
Liver pump
Lymphatic pump
Mandibular drainage technique
Mesenteric release technique
Muscle energy (**ME**)
Myofascial release (MFR) direct and indirect
Myofascial technique
Myotension
Osteopathic ~~in the Cranial Field (OCF)~~**CRANIAL MANIPULATIVE MEDICINE (OCMM)**
Passive method
Pedal pump
Percussion vibrator technique

394 Positional technique
395 Progressive inhibition of neuromuscular structure (PINS)
396 Range of motion technique
397 Soft tissue **(ST)** technique
398 Spencer technique
399 Splenic pump technique
400 Spontaneous release by positioning
401 Springing technique
402 Still technique
403 Strain-Counterstrain ® **(S/CS)**
404 Thoracic pump
405 Thrust technique (HVLA)
406 Toggle technique
407 Traction technique
408 V-spread
409 Ventral techniques
410
411
412 **Appendix C: OMT Vignettes and Coding for 98925-98929**
413
414 **OMT service code 98925:** Osteopathic manipulative treatment (OMT); one to two
415 body regions involved.
416
417 Vignette:
418 A 25-year-old female presents with right lower neck pain of two weeks duration.
419 Somatic dysfunction of cervical and thoracic regions is identified on examination.
420
421 Description of Preservice Work:
422 The physician determines which osteopathic techniques (e.g., HVLA, muscle
423 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
424 in what order the affected body regions need to be treated, and whether those
425 body regions should be treated with specific segmental or general technique
426 approaches. The physician explains the intended procedure to the patient, answers
427 any preliminary questions, and obtains verbal consent for the OMT. The patient is
428 placed in the appropriate position on the treatment table for the initial technique
429 and region(s) to be treated.
430
431 Description of Intraservice Work:
432 The patient is initially in the supine position on the treatment table. Motion
433 restrictions of C6 and C7 are isolated through palpation and treated using muscle
434 energy technique. Dysfunctions of T1 and T2 are treated using passive thrust
435 (HVLA) technique. Patient position is changed as necessary for treatment of the
436 individual somatic dysfunctions. Patient feedback and palpatory changes guide
437 further technique application as appropriate.
438
439
440

441 Description of Postservice Work:
442 Post-care instructions related to the procedure are given, including side effects,
443 treatment reactions, self-care, and follow-up. The procedure is documented in the
444 medical record.
445 **OMT Service code 98926:** Osteopathic manipulative treatment (OMT); 3-4 body
446 regions involved.
447
448 Vignette:
449 A 39-year-old female presents with right lower back pain of two weeks duration
450 after a lifting injury. Somatic dysfunction of lumbar, pelvis, and sacral regions are
451 identified on exam.
452
453 Description of Pre-Service Work:
454 The physician determines which osteopathic techniques (e.g., HVLA, Muscle
455 energy, Counterstrain, articulatory, etc.) would be most appropriate for this patient,
456 in what order the affected body regions need to be treated, and whether those
457 body regions should be treated with specific segmental or general technique
458 approaches. The physician explains the intended procedure to the patient, answers
459 any preliminary questions, and obtains verbal consent for the OMT. The patient is
460 placed in the appropriate position on the treatment table for the initial technique
461 and region(s) to be treated.
462
463 Description of Intra-Service Work:
464 The patient is initially in the prone position on the treatment table. Motion
465 restrictions of sacrum and pelvis are isolated through palpation and treated using
466 muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated
467 using passive thrust (HVLA) technique. Patient position is changed as necessary
468 for treatment of the individual somatic dysfunctions. Patient feedback and
469 palpatory changes guide further technique application as appropriate.
470
471 Description of Post-Service Work:
472 Post-care instructions related to the procedure are given, including side effects,
473 treatment reactions, self-care, and follow-up. The procedure is documented in the
474 medical record.
475
476 **OMT service code 98927:** Osteopathic manipulative treatment (OMT); five to six
477 body regions involved.
478
479 Vignette:
480 A 17-year-old male presents with pain in the neck, upper and lower back, right
481 shoulder, and right chest following an injury in a high school football game two
482 days prior. Somatic dysfunctions of the right glenohumeral and acromioclavicular
483 joints, as well as the lower cervical, upper thoracic, right upper costal, and lumbar
484 areas are identified on exam.
485
486
487

488 Description of Preservice Work:
489 The physician determines which osteopathic techniques (e.g., HVLA, muscle
490 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
491 in what order the affected body regions need to be treated, and whether those
492 body regions should be treated with specific segmental or general technique
493 approaches. The physician explains the intended procedure to the patient, answers
494 any preliminary questions, and obtains verbal consent for the OMT. The patient is
495 placed in the appropriate position on the treatment table for the initial technique
496 and region(s) to be treated.
497
498 Description of Intraservice Work:
499 The patient is initially in a side-lying position on the treatment table. Motion
500 restrictions of identified joints are isolated through palpation and treated using a
501 variety of techniques as follows: acromioclavicular joint is treated with articulatory
502 technique; glenohumeral and costal dysfunctions are treated with muscle energy
503 technique; cervical spine is treated with counterstrain technique; and thoracic and
504 lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient
505 position is changed as necessary for treatment of the individual somatic
506 dysfunctions. Patient feedback and palpatory changes guide further technique
507 application as appropriate.
508
509 Description of Postservice Work:
510 Post-care instructions related to the procedure are given, including side effects,
511 treatment reactions, self-care, and follow-up. The procedure is documented in the
512 medical record.
513
514 **OMT service code 98928:** Osteopathic manipulative treatment (OMT); seven to
515 eight body regions involved.
516
517 Vignette:
518 A 64-year-old female, in rehabilitation following a left total knee replacement,
519 presents with swelling in the left lower leg, pain in her low back, hips and pelvis
520 with muscle spasms and numbness and bilateral wrist pain with use of a walker.
521 She has a history of widespread degenerative joint disease with stiffness and pain
522 making it difficult for her to actively participate in her rehabilitation program.
523 Somatic dysfunctions of the lumbar, thoracic, and cervical spine, sacrum, pelvis,
524 right leg, and bilateral wrist joints are identified on exam.
525
526 Description of Preservice Work:
527 The physician determines which osteopathic techniques (e.g., HVLA, muscle
528 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
529 in what order the affected body regions need to be treated, and whether those
530 body regions should be treated with specific segmental or general technique
531 approaches. The physician explains the intended procedure to the patient, answers
532 any preliminary questions, and obtains verbal consent for the OMT. The patient is
533 placed in the appropriate position on the treatment table for the initial technique
534 and region(s) to be treated.

535
536 Description of Intraservice Work:
537 The patient is initially in the supine position on the treatment table. Motion
538 restrictions of identified joints are isolated through palpation and treated using a
539 variety of techniques as follows: radiocarpal joints are treated using articulatory
540 and myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated
541 using balanced ligamentous tension technique; dysfunction of C5 through T3, the
542 pelvis and lower extremity are treated with muscle energy technique. Lower
543 extremity edema is treated with lymphatic drainage techniques. Patient position is
544 changed as necessary for treatment of the individual somatic dysfunctions. Patient
545 feedback and palpatory changes guide further technique application as
546 appropriate.
547
548 Description of Postservice Work:
549 Post-care instructions related to the procedure are given, including side effects,
550 treatment reactions, self-care, and follow-up. The procedure is documented in the
551 medical record.
552
553 **OMT service code 98929:** Osteopathic manipulative treatment (OMT); nine to ten
554 body regions involved.
555
556 Vignette:
557 A 40-year-old male presents with sub-occipital headache, and pain in the neck,
558 upper and lower back, left shoulder and chest, and right ankle. He was involved in
559 a rear-end motor vehicle accident two weeks prior. X-rays in the emergency
560 department (ED) were negative. He has been taking prescribed analgesic and
561 muscle relaxant medications with minimal improvement. On examination, somatic
562 dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar
563 joints, as well as the cervical, thoracic, costal, lumbar, sacral, and pelvic regions.
564
565 Description of Preservice Work:
566 The physician determines which osteopathic techniques (e.g., HVLA, muscle
567 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
568 in what order the affected body regions need to be treated, and whether those
569 body regions should be treated with specific segmental or general technique
570 approaches. The physician explains the intended procedure to the patient, answers
571 any preliminary questions, and obtains verbal consent for the OMT. The patient is
572 placed in the appropriate position on the treatment table for the initial technique
573 and region(s) to be treated.
574
575 Description of Intraservice Work:
576 The patient is initially in the supine position on the treatment table. Motion
577 restrictions of identified joints are isolated through palpation and treated using a
578 variety of techniques as follows: occipitoatlantal joint and sacrum are treated using
579 muscle energy and counterstrain techniques; right glenohumeral joint and pelvis
580 are treated with articulatory technique; lumbar, thoracic, cervical, and right ankle
581 are treated with passive thrust (HVLA) technique; costal dysfunctions are treated

582 using muscle energy technique. Patient position is changed as necessary for
583 treatment of the individual somatic dysfunctions. Patient feedback and palpatory
584 changes guide selection of further technique application as appropriate.
585
586 Description of Postservice Work:
587 Post-care instructions related to the procedure are given, including side effects,
588 treatment reactions, self-care, and follow-up. The procedure is documented in the
589 medical record.
590
591 **Sources of Information**
592 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
593 Manipulation Treatment Second Edition (2024)
594 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
595 Manipulative Treatment 1st Edition (2017)
596 American Osteopathic Association (2014).
597 Position paper on Evaluation and Management services (E/M) with Osteopathic
598 Manipulative Treatment (OMT).
599 American Osteopathic Association (1998). Protocols for Osteopathic Manipulative
600 Treatment (OMT).
601 American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic
602 Glossary of OMT Terminology.
603 American Medical Association (AMA) Current Procedural Terminology (CPT©) 2015
604 Manual
605 American Medical Association (AMA) Relative Value Update Committee (RUC) Database

Source: H635-A/20

This resolution is intended to supersede and replace current policy H635-A/20.

Background Information: Provided by AOA Staff
Current AOA Policy: H635-A/20 American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance

Explanatory Statement:
The following grid are the amendments submitted to the Ad Hoc Committee during the 2024 House of Delegates:

Amendment Offered By:	**Amendment**	**Ad Hoc Decision**
California – OPSC	**Line 73: Update Citation** The American Association of Colleges of Osteopathic Medicine (AACOM) - Educational Council on Osteopathic Principles (ECOP) Glossary of Osteopathic Terminology, 3rd edition, 2017.	**Approved**

California – OPSC	**Lines 298 and 299: Add the following** 298 Somatic dysfunction of lumbar region M99.03 299 Somatic dysfunction of sacral region M99.04	**Approved**
California – OPSC	**Lines 255 -261: Replace current language with:** Flexion posture when standing. Inability to extend lumbar spine on active and passive range of motion. Tenderness noted over lumbar and sacral regions. Muscle spasms noted of bilateral paraspinal musculature of the lumbar spine. L2 FRRSR. L/R backward sacral torsion. Neurologic exam within normal limits. Musculoskeletal strength of bilateral lower extremities equal and within normal limits.	**Approved**
Dr. Zaremski	**Lines 133 – 141: Replace current language with:** The body region(s) to which OMT is applied must be reflected within documentation of somatic dysfunction. There may be instances when multiple regions are treated when the patient has no complaints related to these areas. If there is an interrelationship such as a distant mechanical influence or the occurrence of compensatory changes, it is best to describe those when possible. Treatment should generally NOT be directed to areas of dysfunction unrelated to the diagnosis, that have no influencing nature.	**Approved**
Dr. Zaremski	Line 151: Replace current language with: … a description of how the patient tolerated the treatment, and other details consistent with typical procedure documentation.	**Approved**

New York – NYSOMS	**Lines 90-93: Replace current language with:** To perform OMT, any licensed physician must have graduated from a COCA or LCME school that has trained in osteopathic principles and practices, including hands-on demonstration and competency testing in OMT	**Disapproved - Explanatory Statement:** MDs who obtain AOA OMT designation certification can practice OMT. This language will also exclude osteopathic residents and international graduates from practicing/paid for providing OMT.
Wisconsin - WAOPS	**Lines 91 – 93:** …or a medical doctor who trains in a postgraduate osteopathic training program... OR has completed additional CME...	**Disapproved - Explanatory Statement:** MDs who obtain AOA OMT designation certification can practice OMT. Obtaining CME is not sufficient as being trained to perform OMT.
Wisconsin - WAOPS	**Line 101: Add the following** Because the evaluation and decision to utilize OMT and immediate reassessment of somatic dysfunction and symptoms following treatment is performed in the same visit, any subsequent visit should be considered new.	**Disapproved - Explanatory Statement:** CMS has statements regarding what is considered a new patient visit and what is an established patient visit. AOA guidelines must be consistent with code descriptions and CMS guidelines.
Wisconsin - WAOPS	**Line 120: Add after service – Add example** eg. Acute exacerbation of chronic low back pain due to recent garden work. Somatic dysfunction(s) consistent with presentation. Verbal consent for OMT. Immediate improvement in symptoms. Follow up as needed.	**Disapproved - Explanatory Statement:** This is not the area where examples are presented. And in the examples, we want to be simplistic versus extensive. This example was excluded for readability and to avoid confusion.
Wisconsin - WAOPS	**Lines 129 – 133: Strike and replace with:** When this occurs, the documentation should describe the compensatory changes and the rationale for treating these areas, especially if the patient has no complaints related to these areas. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at	**Disapproved - Explanatory Statement:** The Ad Hoc Committee approved/adopted an amendment to this section that is more precise.

	areas unrelated to the diagnosis. Because the compensatory changes are due to and could contribute to the maintenance of the main somatic dysfunction, other body regions may need to be address in the same encounter to achieve satisfactory treatment response.	
Dr. Zaremski	**Lines 141 – 142: Strike the following text:** The type, frequency, and duration of OMT should be consistent with current standards of medical practice. Reason: This is overly vague and does not consider the differences between and even within practice specialties, time availability and level of knowledge and skill. Therefore, inappropriate judgements of what constitutes the “standard” will likely be applied.	**Disapproved - Explanatory Statement:** This is CMS language.
Wisconsin - WAOPS	**Line 201: Add the following bullet:** The decision to use OMT would be considered in the "low" to "moderate" MDM based on the risks, benefits, alternatives, contraindications, and patient comorbidities for risk assessment.	**Disapproved - Explanatory Statement:** This is not true in all cases, and we do not want to restrict physicians to only getting paid for OMT when billing low-level E/Ms. This proposed amendment may have unintended payment consequences.
Wisconsin - WAOPS	**Line 228: Add example before “as such,”:** Eg. Because "neck pain" treated during initial assessment, now presenting at the base of the shoulders during follow up visit, is a new problem based on anatomic location, and anatomy involved.	**Disapproved - Explanatory Statement:** This is not the area where examples are presented. And in the examples, we want to make as simplistic versus extensive.
Wisconsin - WAOPS	**Line 313: Add the following:** UPDATED EXAMPLE: Assessment and Plan: Cervicalgia, left low back pain without sciatic, somatic dysfunction of ***	**Disapproved - Explanatory Statement:** Only 1 example is presented/needed for each new patient visit and established visit. One would

	Acute on chronic exacerbation of pain from recent car trip. Trial of turmeric and magnesium to address chronic nature of pain. Has improved in past with OMT. No red flags on history or examination. Verbal consent for OMT obtained, see procedural note below. Physical Exam: *** Osteopathic Procedure Note: Osteopathic examination: Cervical: C5-C6 NRrSr, hypertonic paraspinal mm and traps bilaterally R>L Thoracic: Hypertonic PSM Ribs: Thoracic Inlet FRrSr Lumbar: Hypertonic PSM, L3-5 NRrsL Sacrum: Left on left Pelvis: Compressed left SI joint Lower Extremity: HT quads and psoas bilaterally. Treatment modalities include ST, ME, MFR. Patient tolerated procedure well without immediate complication. Reassessment demonstrated improved somatic dysfunction and symptoms. Follow Up: PRN	need to be removed and replaced. So S.O.A.P. needs to be spread out and coding added. And then a separate OMT note.
California – OPSC	**Line 423: Add the following:** Somatic dysfunction of cervical and thoracic regions is identified on examination and management (E/M).	**Disapproved - Explanatory Statement:** This is AMA language from CPT code descriptors, vignettes, and guidelines. It cannot be modified. Background: RUC requested that the AOA review existing OMT codes to develop accurate and unbiased information for the relative

		value of the physician work involved in performing OMT. The survey process resulted in the creation of procedure vignettes for typical patient encounters that include descriptions of the procedure's preservice, intraservice, and post service work for each OMT CPT Code.
California – OPSC	**Lines 560: Add the following** as part of the examination and management (E/M) somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the…	**Disapproved - Explanatory Statement:** This is AMA language from CPT code descriptors, vignettes, and guidelines. It cannot be modified.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 19, 2025_____

SUBJECT: GIFTS TO PHYSICIANS FROM INDUSTRY
- SOURCE: H606-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Ethics Review and Board Appeals Committee recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) has adopted the following "Guide to Section 17 of the AOA Code of Ethics" as follows and will distribute this information to students of osteopathic medicine and osteopathic physicians.

1. Physicians' responsibility is to provide appropriate care to patients. This includes determining the best pharmaceuticals to treat their condition. This requires that physicians educate themselves as to the available alternatives and their appropriateness so they can determine the most appropriate treatment for an individual patient. Appropriate sources of information may include journal articles, continuing medical education programs, and interactions with pharmaceutical representatives.

2. It is ethical, for osteopathic physicians to meet with pharmaceutical companies and their representatives for the purpose of product education, such as, side effects, clinical effectiveness and ongoing pharmaceutical research.

3. Pharmaceutical companies may offer gifts to physicians from time to time. These gifts should be appropriate to patient care or the practice of medicine. Gifts unrelated to patient care are generally inappropriate. The use of a product or service based solely on the receipt of a gift shall be deemed unethical.

4. When a physician provides services to a pharmaceutical company, it is appropriate to receive compensation. However, it is important that compensation be in proportion to the services rendered. Compensation should not have the appearance of a relationship to the physician's use of the company's products in patient care.

Background Information: Provided by AOA Staff
Current AOA Policy: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: CONFIDENTIALITY OF PATIENT RECORDS
- SOURCE: H627-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) opposes invasion of privacy of the
7 patient record by any unauthorized person or agency; and endorses reasonable
8 programs which seek to protect patient/physician relationships and guarantee
9 confidentiality of patient records.

Background Information: Provided by AOA Staff
Current AOA Policy: 1980; 1985 Revised,1990,1995; 2000, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 19, 2025_____

SUBJECT: EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES
- SOURCE: H630-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The American Osteopathic Association deems it an unethical act for any
7 osteopathic physician to deliver or be required to deliver a lethal injection for the
8 purpose of execution in capital crimes.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Revised; 2005 Reaffirmed; 2010; 2015 Referred; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: A PROCLAMATION REGARDING THE INACCURATE PORTRAYALS OF U.S. TRAINED DOs IN MEDIA - SOURCE: H651-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The leadership and members of the American Osteopathic Association (AOA)
7 condemn the poorly researched and patently incorrect statements regarding the
8 scope of practice of U.S. trained DOs made by journalists.

9 The AOA will continue ongoing efforts using social media and other means to
10 educate the public and dispel inaccuracies of U.S. trained DOs. The AOA
11 encourages its members, affiliated organizations, our patients and our allopathic
12 colleagues to use social media and other means to accurately represent the
13 profession of osteopathic medicine to the public.

14 The AOA will continue to provide online resources and support to its members and
15 advocates to develop a grassroots social media campaign to further the
16 understanding of the profession of osteopathic medicine by the public.

17 The AOA on behalf of the osteopathic profession expresses appreciation and
18 gratitude to the journalists, organizations, and other persons that support an
19 accurate portrayal of osteopathic medicine and osteopathic physicians in the media.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted____

DATE: ____July 19, 2025_____

SUBJECT: PREVENTING THE CRIMINAL PROSECUTION OF MEDICAL DECISION MAKING

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, it is essential to the role of osteopathic physicians delivering high quality health care to establish standards of practice, review them critically, and determine when they apply and when other action must be taken; and

WHEREAS, in recent years there has been an increase in the pursuit of physicians as criminals for medical decisions made in good faith, resulting in indictment, conviction, and incarceration of physicians, including leaders of medical academies and known experts[1]; and

WHEREAS, elected bodies including state legislatures, the United States congress, and law enforcement agencies within the Department of Justice, have increasingly been ignoring established rulings of licensure boards and intruding on medical issues regarding which they have had little or no formal education or training and thus inadequate understanding; and

WHEREAS, uninformed and/or rigid implementation of clinical practice guidelines incentivizes the abandonment of our nation's most complicated and vulnerable patients because of fear of physician prosecution; and

WHEREAS, there are long established, proven mechanisms for self-regulation of physicians through state boards of licensure; now, therefore be it

~~RESOLVED, that the American Osteopathic Association (AOA) will create a distinct division within the Bureau, Committee and Council (B/C/C) structure of the AOA dedicated to monitoring the activities of federal and state law enforcement agencies with regard to criminalization of physician medical decision-making, practice activity, and practice patterns and report to the House of Delegates (HOD); and be it further~~

RESOLVED, that the AOA ~~establish formal~~ **PRIORITIZE** mechanisms to interface with law enforcement agencies within the executive branch of government as well as the federal judiciary to ensure issues of medical decision-making are adjudicated by licensure boards and/or other entities with medical expertise; and be it further

RESOLVED, that the AOA will create a public statement in support of the decision-making system already in place including State Licensing Boards and medical certification boards, for the support of the organization of osteopathic physicians.

References:

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https://injepijournal.biomedcentral.com/articles/10.1186/s40621-020-00277-
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https://www.justice.gov/opa/pr/justice-department-s-criminal-division-creates-new-england-prescription-opioid-strike-force
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https://wgme.com/news/local/she-changed-my-life-patients-surprised-after-maine-doctor-arrested-by-drug-strike-force
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[1] https://www.kevinmd.com/2023/07/the-persecution-of-pain-management-doctors.html Arnold DR. Countervailing incentives in value-based payment. Healthc (Amst). 2017 Sep;5(3):125-128. doi: 10.1016/j.hjdsi.2016.04.009. Epub 2016 May 17. PMID: 28822499.

Background Information: Provided by AOA Staff
Current AOA Policy:
H325-A/22 Interference Laws

Prior HOD action on similar or same topic:
This is a resubmission of resolution H630-A24 that was referred to Maine Osteopathic Association after the House of Delegates debated the resolution. AOA's policy (H325-A/22 Interference Laws) on non-interference in the patient-physician relationship is extensive and has a strong position on protecting the patient-physician relationship.

AOA has also engaged with various agencies and state legislatures to protect physicians' autonomy in clinical decision-making.

FISCAL IMPACT: $200,000 Annually
The fiscal impact is an estimate of a new full time AOA staff position (salary and benefits only) and also assumes that all meetings and state/federal government engagement are virtual.

Based on the resolves of the resolution, the new full time AOA staff position would be responsible for:

- Monitoring the activities of federal and state law enforcement agencies with regard to criminalization of physician medical decision-making, practice activity, and practice patterns and report to the House of Delegates (HOD).

- Interface with law enforcement agencies within the executive branch of government as well as the federal judiciary to ensure issues of medical decision-making are adjudicated by licensure boards and/or other entities with medical expertise.

ACTION TAKEN: __Adopted as Amended___

DATE: ____July 19, 2025_____

SUBJECT: PROTECTING PATIENT CARE: OPPOSING THE GROWING IMPACT OF PRIVATE EQUITY AND THE CORPORATE PRACTICE OF MEDICINE

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

WHEREAS, the Corporate Practice of Medicine Doctrine prohibits corporations from practicing medicine or employing physicians, with the aim of ensuring medical decisions are based solely on patient needs free from profit-driven motives; and

WHEREAS, the Corporate Practice of Medicine prohibition serves to protect patients, preserve the physician-patient relationship, and maintain physician autonomy, as supported by existing AOA policy (H358-A/19); and

WHEREAS, existing AOA policies already recognize the harms to patients resulting from market consolidation and mergers by non-physician corporate entities (H338-A/19, H339-A/19, H617-A/21), without specifically addressing the role of private equity firms; and

WHEREAS, the consolidation of medical practices by private equity firms and other corporate interests has resulted in a majority of physicians being employees with no ownership in their practice (77.6% as of April 2024, up from 40% in 2016)[1,2]; and

WHEREAS, the private equity acquisition of medical practices in rural areas often leads to the consolidation of and subsequent closure of medical practices and rural hospitals - further worsening healthcare access in rural communities; and

WHEREAS, private equity ownership of medical practices creates financial conflicts of interest, which have been shown to degrade quality of healthcare[3,4,5], increase costs[4,6], and undermine physician autonomy and the physician-patient relationship[6]; now, therefore be it

RESOLVED, t~~hat the American Osteopathic Association (AOA) support legislative efforts to protect patient care, access, and the physician-patient relationship by limiting and regulating the Corporate Practice of Medicine, and the acquisition of medical practices, hospitals, and other such institutions by private equity firms~~**TO PROTECT PATIENT CARE, ACCESS, AND THE PATIENT PHYSICIAN RELATIONSHIP, THE AOA SUPPORTS LEGISLATIVE EFFORTS THAT LIMIT AND REGULATE THE CORPORATE PRACTICE OF MEDICINE, INCLUDING ACQUISITION OF**

32 **MEDICAL PRACTICES, HOSPITALS, AND OTHER SUCH INSTITUTIONS**
33 **BY PRIVATE EQUITY FIRMS AND PUBLICY TRADED COMPANIES**
34 **ENTERING HEALTHCARE FOR PROFIT**.

References**:**

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3. Forman, A. J. (2022). The Importance of Vigorous Antitrust Enforcement in Health Care. https://www.justice.gov/opa/speech/file/1510391/download

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7. Fogel, A. L., Hogan, S., & Dover, J. (2022). Surgical Dermatology and Private Equity: A Review of the Literature and Discussion. Dermatologic Surgery, 48(3), 339–343. https://doi.org/10.1097/DSS.0000000000003363

Background Information: Provided by AOA Staff
Current AOA Policy: H358-A/19-Interference Laws; H338-A/19-Hospital Consoldation-Opposition to; H339-A/19-Pharmacy Benefit Managers-Increased Regulation of; H617-A/21-Health Insurer Consolidation

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____

SUBJECT: ~~FEDERAL~~ LOAN AVAILABILITY FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: New York Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, the House Education and Workforce Committee voted to approve its portion of the federal budget reconciliation bill. Without further correction, this legislation eliminates Grad PLUS Loans and caps federal student professional borrowing at ~~$150,000~~ **$200,000**; and

WHEREAS, a 2013 study of medical school debt by race, it was discovered that more than 62% of surveyed medical students anticipated having debt greater than $150,000[i]; and

WHEREAS, the average total cost of medical school tuition and living expenses is $238,420 ranging from $167,476 for in-state, public schools to $275,068 for out-of-state, private school[ii] [iii]; and

WHEREAS, Additional known expenditures for osteopathic medical students includes taking COMLEX licensing examinations for which Level 1 costs $730, Level 2-CE costs $730, and Level 3 costs $910. Taking all three levels of the COMLEX-USA costs a total of $2,370[iv] (These fees do not include additional costs such as travel to testing centers, preparation materials, or rescheduling fees); and

WHEREAS, other variable expenses include room, board and travel expenses, especially when attending off-site clinical rotations; and

WHEREAS, at a time when our nation faces a growing physician shortage, it is critical that the main sources of financial support being significantly reduced or eliminated not impose unnecessary barriers on future physicians[v]; and

WHEREAS, eliminating the PLUS program would make it harder for future doctors to afford medical school and worsen the physician shortage, especially in rural and underserved communities; and

WHEREAS, the proposed budgetary limits could affect significantly more than 60% of students pursuing medicine and other health professions[vi]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~work with other interested entities to~~ **WILL WORK WITH RELEVANT STAKEHOLDERS TO** advocate for ~~the restoration of~~ appropriate **LOW-COST GOVERNMENT**

31 **AND PRIVATE** loan availability for **OSTEOPATHIC** medical student
32 education.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/21 White Paper – Improving Access to Physician Led Care
H306-A/23 Federal Student Loan Program

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

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[i] Dugger RA, El-Sayed AM, Dogra A, Messina C, Bronson R, Galea S. The color of debt: racial disparities in anticipated medical student debt in the United States. PLoS One. 2013 Sep 3;8(9):e74693. doi: 10.1371/journal.pone.0074693. PMID: 24019975; PMCID: PMC3760863. https://pmc.ncbi.nlm.nih.gov/articles/PMC3760863/

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[iii] Hanson, Melanie. "Average Medical School Debt" EducationData.org, August 28, 2024, https://educationdata.org/average-medical-school-debt Average Medical School Debt [2024]: Student Loan Statistics

[iv] https://www.nbome.org/frequently-asked-questions/

[v] https://www.theguardian.com/us-news/2025/jun/01/republican-trump-bill-doctor-shortage

[vi] https://www.urban.org/sites/default/files/2024-06/How_Access_to_Federal_Student_Loans_Could_Change_under_the_CCRA.pdf

ACTION TAKEN: __Adopted as Amended__

DATE: __July 19, 2025_____

AMERICAN OSTEOPATHIC ASSOCIATION

700 Series Joint Budget Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (700 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTION:
Joint Board/House Budget Review Committee (700 series)
This committee reviews the AOA Strategic Plan and Budget.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-700	Approval to Concur with the AOA FY 2026 Expenditures	Finance Committee	Joint Board House Budget Review Committee	Adopted
H-701	Budget Adjustment Parameters	Finance Committee	Joint Board House Budget Review Committee	Adopted

SUBJECT: Approval to Concur with the AOA FY 2026 Annual Budget

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board of Trustees "have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, with the annual budget for the fiscal year"; and

WHEREAS, the Joint Board/House Budget Review Committee has convened, reviewed, and approved the AOA FY 2026 Operating Budget, the AOA FY 2026 Capital Expenditures Budget and the AOA FY 2026 142 E. Ontario Building Budget reports as submitted; now therefore be it

RESOLVED, the American Osteopathic Association House of Delegates approves the AOA FY 2026 Annual Budget as provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

ACTION TAKEN: __Adopted_____

DATE: ____July 19, 2025_____

SUBJECT: BUDGET ADJUSTMENT PARAMETERS - SOURCE: H701-A/22

SUBMITTED BY: Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS, this policy is to be reviewed for sunset every three years; and

WHEREAS, the Finance Committee has reviewed the Budget Adjustment Parameters Policy to confirm the policy remains relevant and appropriate and has provided input to the Joint Board/House Budget Review Committee; and

WHEREAS, the Joint Board/House Budget Review Committee has reviewed the Budget Adjustment Parameters Policy to confirm the policy remains relevant and appropriate; now, therefore be it

RESOLVED, that the Budget Adjustment Parameters policy as noted below has been reviewed by the Finance Committee and Joint Board/House Budget Review Committee and is reported to the House of Delegates with the reference committee report in July 2025.

Budget Adjustment Parameters Policy

Without explicit approval of the Joint Board/House Budget Review Committee the AOA Board of Trustees may take no financial actions between meetings of the AOA House of Delegates which, when taken together, either decrease AOA's cash or increase its long term or recurring short term debt (to include operating leases and other contractual obligations) to an aggregated amount greater than 10% of the AOA's total equity as audited in the prior year; and, that this policy will be reviewed by the Joint Board/House Budget Review Committee every three years.

Background Information: Provided by AOA Staff

The above budget adjustment parameters were initially approved by the Joint Board/House Budget Review Committee in July 1995. These parameters were re-affirmed by the Joint Board/House Budget Review Committee in July 1998, July 2001, July 2004, July 2007, July 2010, July 2013, July 2016, July 2019 and July 2022.

Current AOA Policy: H701-A22 Budget Adjustment Parameters

ACTION TAKEN: Adopted

DATE: July 19, 2025

AMERICAN OSTEOPATHIC ASSOCIATION

House of Delegates ▪ July 18 – 20, 2025

AMERICAN OSTEOPATHIC ASSOCIATION

2024 House of Delegates Resolutions

Action

July 2024

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (200 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTION:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Mandatory CME Course Requirements (SR-Source-H211-A/19)	BFHP	Educational Affairs	Adopted as Amended
H-201	Health Care Shortage in Rural America (SR-Source-H200-A/19)	BOE	Educational Affairs	Adopted as Amended
H-202	Graduate Medical Education – Increasing Opportunities (SR-Source-H201-A/19)	BOE	Educational Affairs	Adopted
H-203	Uniformed Services Physicians Requiring and Assigned to Civilian Residency Programs – AOA Support of All Osteopathically Trained (SR-Source-H204-A/19)	BOE	Educational Affairs	Adopted
H-204	Integrity and Mission of COMs UHSC Granting the DO – Maintaining the (SR-Source-H208-A/19)	BOE	Educational Affairs	Adopted
H-205	Psychiatry Curriculum and Staffing (SR-Source-H209-A/19)	BOE	Educational Affairs	Adopted as Amended
H-206	Community-Based Teaching Health Centers Residency Support (SR-Source-H212-A/19)	BOE	Educational Affairs	Adopted
H-207	Influenza Vaccination Programs for Medical Schools (SR-Source-H214-A/19)	BOE	Educational Affairs	Adopted as Amended
H-208	American Osteopathic Association Specialty Board Certification (SR-Source-H220-A/19)	BOE	Educational Affairs	Adopted as Amended
H-209	Education of Students and Faculty on Obtaining Permission Before All Student and Patient Encounters (SR-Source-H223-A/19)	BOE	Educational Affairs	Adopted
H-210	Classification of Osteopathic Medical Graduates as US Medical Graduates in Electronic Residency Application Service (SR-Source-H230-A/19)	BOE	Educational Affairs	Referred to BOE
H-211	Teenage Alcohol Abuse (SR-Source-H210-A/19)	BORPH	Educational Affairs	Adopted as Amended
H-212	Inhalation of Volatile Substances (SR-Source-H207-A19)	BORPH	Educational Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (200 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-213	Clinical Rotations for International Medical Students (SR-Source-H206-A/19)	CSHA	Educational Affairs	Adopted as Amended
H-214	AOA Recognition of the American College of Osteopathic Pediatricians (ACOP) and American Osteopathic Board of Pediatricians (AOBP)	ACOP	Educational Affairs	Adopted as Amended
H-215	Assessing the Impact of Alternative Match Processes on Osteopathic Student Residency Placement Rates	BEL	Educational Affairs	Adopted as Amended
H-216	Interdisciplinary Education and High Value Care	MOMA (Montana)	Educational Affairs	Referred to BOE
H-217	Support for Increasing Access to Training Opportunities in American Indian and Alaska Native Communities	OOA (Oklahoma)	Educational Affairs	Adopted as Amended
H-218	Support for the Creation of Specialty and Sub-Specialty Osteopathic Recognition Training Exams	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-219	Support of the Physical Exam in Education and Practice	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-220	Osteopathic Undergraduate Education Core Competencies	POMA/WOMA (Pennsylvania/ Washington)		Withdrawn
H-221	Resolution on Credential Requirements for Presidents and Leaders of Osteopathic Medical Specialty Board Societies	WAOPS (Wisconsin)	Educational Affairs	Adopted as Amended
H-222	Importance of Accredited Training and Board Certification in Aerospace Medicine for the Growing Commercial Space Industry	AOCOPM	Educational Affairs	Adopted as Amended
H-223	Certifying Board Services Workgroup Report (Policy H212-A/23 Promotion of AOA Board Certification)	AOA BOT	Educational Affairs	Adopted as Amended
H-224	Value of Osteopathic Medical School Education	MAOP (Maryland)	Educational Affairs	Referred to BOE

SUBJECT: MANDATORY CME COURSE REQUIREMENTS – SOURCE: H211-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) opposes ~~any~~ **STATE AND** federal
7 attempts to impose any specific Continuing Medical Education (CME) course
8 requirements and will assist ~~any~~ affiliate societies in opposing ~~additional~~
9 attempts ~~by states~~ to impose specific CME course requirements.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: _____July 20, 2024_____

SUBJECT: HEALTH CARE SHORTAGE IN RURAL AMERICA
-SOURCE: H200-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages the development of teaching
7 centers in rural Federally Qualified Health Centers and other eligible entities, **AND**
8 **SUPPORTS THE TEACHING HEALTH CENTER GRADUATE MEDICAL**
9 **EDUCATION GRANT PROGRAM**, so that residents can train and stay in these
10 areas and practice osteopathic medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Approved as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 20, 2024_____

SUBJECT: GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES- SOURCE: H201-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the efforts to increase the number
7 of graduate medical education training positions available to United States medical
8 graduates.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: UNIFORMED SERVICES PHYSICIANS REQUIRING AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS – AOA SUPPORT OF ALL OSTEOPATHICALLY TRAINED – SOURCE: H204-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will continue to monitor, assist and
7 support all osteopathic physicians who receive Graduate Medical Education (GME)
8 through the uniformed services process, removing barriers to osteopathic graduate
9 medical education approval.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: INTEGRITY AND MISSION OF COMS UHSC GRANTING THE DO – MAINTAINING THE - SOURCE: H208-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) upholds and supports maintaining the
7 integrity and mission of Colleges of Osteopathic Medicine and University Health
8 Science Centers granting the Doctor of Osteopathic Medicine degree.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: PSYCHIATRY CURRICULUM AND STAFFING – SOURCE: H209-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy;

WHEREAS, the Bureau of Osteopathic Education has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) supports the use of members of the American College of Osteopathic Neurology and Psychiatry (ACONP) and their commitment to serve as a resource for developing **EDUCATIONAL COMPONENTS,** core competencies**,** ~~and~~ learning objectives**, AND EDUCATIONAL EXPERIENCES** for osteopathic psychiatry both in undergraduate and graduate medical education.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_____

DATE: ___July 20, 2024_____

SUBJECT: COMMUNITY-BASED TEACHING HEALTH CENTERS RESIDENCY SUPPORT – SOURCE: H212-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports community-based programs
7 as a model of training for osteopathic primary care residents throughout the United
8 States.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 20, 2024

SUBJECT: ~~INFLUENZA~~ VACCINATION ~~PROGRAMS~~ **POLICY** FOR **OSTEOPATHIC** MEDICAL SCHOOLS – SOURCE: H214-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recommends and supports that all
7 osteopathic medical schools have an ongoing ~~influenza~~ vaccination ~~program~~
8 **POLICY** for students.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION SPECIALTY BOARD CERTIFICATION – SOURCE: H220-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA):

1. Reaffirms its commitment to the inclusion of osteopathic principles and practice in every osteopathic board certification examination, regardless of specialty

2. Continues the opportunity for osteopathic certifying boards to develop and administer OMM/OMT practical examinations which are specific and appropriate for their specialty

3. Allows a requirement for specialty-specific content in CME for re-certification/continuing certification

4. Continues to encourage the Accreditation Council for Graduate Medical Education to include an osteopathic educational component in Osteopathic Recognized ~~residencies~~ **PROGRAMS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 2019

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_____

DATE: ____July 20, 2024_____

SUBJECT: EDUCATION OF STUDENTS AND FACULTY ON OBTAINING PERMISSION BEFORE ALL STUDENT AND PATIENT ENCOUNTERS – SOURCE: H223-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy;

3 WHEREAS, the Bureau of Osteopathic Education has provided amendments to
4 provide clarity and updates to the policy, now therefore be it

5 RESOLVED, that the Bureau of Osteopathic Education recommends that the
6 following policy be REAFFIRMED.

7 Education of Students and Faculty on Obtaining Permission Before All Student and
8 Patient Encounters
9
10 The American Osteopathic Association (AOA) encourage all colleges of osteopathic
11 medicine to prepare their educators and graduates to learn and demonstrate
12 aptitude concerning the knowledge and practice of obtaining permission; and, that
13 the AOA promote and encourage both educators and students in the use of
14 obtaining permission in all OMT and/or physical contact patient interactions –
15 whether they be students in educational activities, standardized patients, or others
16 in all educational and clinical activities

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: __July 20, 2024_____

SUBJECT: CLASSIFICATION OF OSTEOPATHIC MEDICAL GRADUATES AS U.S. MEDICAL GRADUATES IN ELECTRONIC RESIDENCY APPLICATION SERVICE – SOURCE: H230-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

3 WHEREAS, the Bureau of Osteopathic Education has reviewed the current medical
4 school types reported in the American Association of Medical Colleges'
5 Electronic Residency Application Service, and

6 WHEREAS, the Bureau of Osteopathic Education has determined the policy is no
7 longer relevant, now therefore be it

8 RESOLVED, that the Bureau of Osteopathic Education recommends that the
9 following policy be SUNSET.

10 The American Osteopathic Association advocates to the American Association of
11 Medical Colleges to adjust Electronic Residency Application Service filters based on
12 medical school type such that Osteopathic applicants are included and recognized
13 within the US Public or Private Medical Graduates category.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

Following the adoption of this resolution in 2019, AOA staff met with Electronic Residency Application Service (ERAS) staff to advocate for a change to the medical school type listing in ERAS.

2019 ERAS Medical School Type	2020 ERAS Medical School Type
Canadian	Canadian School
International	International School
Osteopathic	US D.O. School
US Private School	US M.D. Private School
US Public School	US M.D. Public School

The Bureau of Osteopathic Education (BOE) supports the current listing in ERAS and believes that osteopathic medical schools should be distinctly listed and recommends the policy be sunset.

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau of Osteopathic Education (BOE)

DATE: July 20, 2024

SUBJECT: ~~TEENAGE~~ **UNDERAGE** ALCOHOL ~~ABUSE~~ **USE** –
SOURCE: H210-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association ~~endorses~~ ~~**SUPPORTS**~~ **ENCOURAGES** continuing medical education for healthcare professionals to aid them in educating ~~lower and middle~~ **K THROUGH 12** school students ~~of~~ **ABOUT** the dangers of alcohol and ~~endorses~~ ~~**SUPPORTS**~~ **ENCOURAGES** outreach programs to ~~elementary "lower" and middle schools to~~ create awareness of the dangers of alcohol.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended____

DATE: ___July 20, 2024_____

SUBJECT: INHALATION OF VOLATILE SUBSTANCES – SOURCE: H207-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) ~~endorses~~ ~~**SUPPORTS**~~
9 **ENCOURAGES** continuing medical education and medical literature to enhance
10 physician awareness of inhalation of volatile substances (huffing) and ~~endorses~~
11 ~~**SUPPORTS**~~ **ENCOURAGES** campaigns to enhance public awareness of this ~~crisis~~
12 **PROBLEM.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: ___July 20, 2024_____

SUBJECT: CLINICAL ROTATIONS FOR INTERNATIONAL MEDICAL STUDENTS **AND NON-PHYSICIAN TRAINEES** – SOURCE: H206-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED WITH AN EDITORIAL AMENDMENT**.**

7 The American Osteopathic Association supports adequate quality rotations for
8 medical students as they pursue clinical education; and, in concert with other
9 healthcare organizations, federal, state**,** and local governments, will oppose policies
10 that provide an unfair advantage to internationally-educated medical students **AND**
11 **NON-PHYSICIAN TRAINEES**.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Approved as Amended)

Prior HOD action on similar or same topic:
Audition Rotations for Osteopathic Medical Students - Source: H214-A/20
Enhancing Preceptor Knowledge of Osteopathic Manipulative Treatment (OMT) - Promoting Use Of - Source: H202-A/23
Equality In Away Rotations/Sub-Internships For Osteopathic Medical Students - Source: H217-A/22

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_____

DATE: __July 20, 2024_____

SUBJECT: AOA RECOGNITION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS (ACOP) AND AMERICAN OSTEOPATHIC BOARD OF ~~PEDIATRICIANS~~ **PEDIATRICS** (AOBP)

SUBMITTED BY: American College of Osteopathic Pediatricians (ACOP)

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American College of Osteopathic Pediatricians (ACOP) was founded in 1940 by Drs. James M. Watson and Evangeline Percival, to serve as the medical home for all osteopathically trained pediatric physicians in the U.S.; and

WHEREAS, the year following in 1941 the American Osteopathic Board of Pediatrics (AOBP) was established as means to ensure that all osteopathically trained pediatricians could be licensed by an osteopathic board of medicine for ongoing education; and

WHEREAS, since the initiation of pediatric-specific residency programs, the ACOP and AOBP have remained as the primary medical home and licensing organizations for all AOA-accredited training programs. ~~This existed until 2020 at which time due to the AOA-ACGME Combined Accreditation Agreement (aka the "Merger") placed all residency training programs under the surveillance of the ACGME;~~ and

WHEREAS, pediatrics remains a top residency choice for osteopathic medical students, ranking 4th in the 2024 Match. U.S. DO students matching into a pediatrics residency program remained consistent at 602 graduating seniors as compared to 614 in 2023; and

WHEREAS, entrance into a pediatrics residency has continued to decrease over current years, with 251 unfilled positions in the 2024 Match; an increase from the 83 unfilled positions in the 2023 Match. In contrast the percentage of first-year pediatric residents coming from osteopathic medical schools remains stable. For the 2024 Match 21.5% of all matching first-year pediatric residents were U.S. DO medical students; meaning slightly more than 1 in 5 pediatric trainees in the U.S. is a DO pediatrician-in-training; and

WHEREAS, despite this the Association of Pediatric Program Directors (APPD) and American Academy of Pediatricians (AAP) continue to have institutional memberships, ensuring automatic membership into the AAP for all incoming pediatric residents, and with that membership in the AAP Section of Osteopathic Pediatricians (SOOPe) which is free for all DO members; and

32 WHEREAS, this has led to a significant drop in ACOP membership from the student
33 to resident level, with student membership remaining steady at over 1700
34 members from April 2020 – April 2024 however, resident and fellow-in-
35 training membership having fallen from a record high of 609 to 34 members
36 over the same time period; now, therefore be it

37 RESOLVED, that the American Osteopathic Association (AOA) officially recognizes
38 the American College of Osteopathic Pediatricians (ACOP) as the official
39 medical home and educational organization for all osteopathically trained
40 pediatric residents and trainees; and, be it further

41 RESOLVED, that the AOA recognizes the American Osteopathic Board of
42 Pediatrics (AOBP) as the primary certifying organization for all
43 osteopathically trained pediatric residents, with the exception of those
44 pediatric residents wishing to extend training to a pediatric subspecialty for
45 which the AOBP does not currently have a certifying examination; and, be it
46 further

47 RESOLVED, that the AOA will support the ACOP in ongoing efforts with the
48 Association of Pediatric Program Directors (APPD) to encourage all DO
49 pediatric residents to continue membership in the ACOP by establishing
50 institutional memberships similar to those currently offered by the AAP to
51 residency programs to ensure the smooth transition from student-member to
52 resident-member status; and, be it further

53 RESOLVED, the AOA will continue to support and engage with the ACGME and
54 ABP to encourage the acceptance and equivalence of the AOBP Pediatric
55 certifying exam for DO-trained pediatric residents who wish to continue
56 training in an ACGME-accredited pediatric subspecialty fellowship. While the
57 AOBP continues to further expand its subspecialty offerings.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
Action item: H-216-A/19 - Statement of Support for the American Osteopathic Board of Neurology And Psychiatry

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: ASSESSING THE IMPACT OF ALTERNATIVE ~~MATCH~~ ~~**RESIDENT SELECTION**~~ **APPLICATION** PROCESSES ON OSTEOPATHIC STUDENT**S** ~~RESIDENCY PLACEMENT RATES~~

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

WHEREAS, The National ~~Residency~~ **RESIDENT** Match**ING** Program**S** (NRMP) is currently the predominant pathway for osteopathic and allopathic medical students to obtain postgraduate medical education, where most students in the Undergraduate Medical Education (UME) to Graduate Medical Education (GME) transition must utilize a single Match system; and

WHEREAS, Electronic Residency Application Service (ERAS) has been the predominant application service for students participating in the ~~Match~~, **RESIDENCY RECRUITMENT AND SELECTION PROCESS** placing a substantial financial burden on applicants due to rising costs; and

WHEREAS, alternatives to the traditional ~~match~~ **RESIDENCY RECRUITMENT AND SELECTION PROCESS** have been in place for decades, including the Urology Residency Match Program, the San Francisco Ophthalmology Match, and the Military Match; and

WHEREAS, most recently, OB/GYN residencies have discontinued using ERAS as the sole application provider in an effort to simplify and decrease costs for applicants in the ~~match~~ **RESIDENCY RECRUITMENT AND SELECTION** process[1]; and

WHEREAS Osteopathic students have been traditionally underrepresented in competitive specialties and have repeatedly expressed interest in changes to the ~~match~~ **RESIDENCY RECRUITMENT AND SELECTION** process; and

WHEREAS, the American Osteopathic Association has stated support for GME equity and DO access to competitive residencies as recently as the 2023 House of Delegates; ~~and~~ **NOW, THEREFORE BE IT**

~~WHEREAS, the American Medical Association has recently voted to begin looking into alternative match processes and encouraged collaboration among relevant stakeholders, including the AOA[2]; now, therefore be it~~

RESOLVED, that the American Osteopathic Association shall collaborate with relevant stakeholders to analyze the impacts of the current residency application processes ~~outside of the NRMP~~ on DO~~s'~~**,** ~~**SUCCESS IN THE TRANSITION TO RESIDENCY**~~. **placement rates**.

References:

1. APGO. (2023). New Residency Application Platform for Obstetrics and Gynecology. https://apgo.org/page/rrrapplicationplatform
2. ~~Resident and Fellow Section. (2023). AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES. In *Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations.*~~

Background Information: Provided by AOA Staff

Current AOA Policy:

Prior HOD action on similar or same topic:

H-345-A/2023 - AOA Support for the Fair Access in Residency

H-214-A/2023 - Support for Inclusion of Osteopathic Applicants into Competitive Postgraduate Training

H-231-A/2019 - Recognition of COMLEX and USMLE as Equal Licensing Examinations among Residency Programs

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: INTERDISCIPLINARY EDUCATION AND HIGH-VALUE CARE

SUBMITTED BY: Montana Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, resolution H426-A/23 Osteopathic Medicine is High-Value Care was adopted as American Osteopathic Association (AOA) policy at the 2023 AOA House of Delegates (HOD), which defined Osteopathic medicine, including Osteopathic Manipulative Treatment (OMT}, as high-value care; and

WHEREAS, a major requirement of high-value care is the need for interdisciplinary collaboration and education to delineate the high-value care that each specialty can best identify within that specialty; and

WHEREAS, historically, the Osteopathic profession has provided a high level of interdisciplinary education at all levels of education, particularly at the graduate medical education (GME) and continuing medical education (CME) levels; and

WHEREAS, this focus in Osteopathic education occurred, in large part, because all AOA specialties were required to: 1} do rotating internships before choosing a certain specialty, and, 2) obtain AOA category 1-A credits as part of their CME requirement for all specialties and this 1-A credit category, to a great extent, included interdisciplinary education and collaboration; and

WHEREAS, the adoption of a single accreditation pathway for the AOA and Accreditation Council of Graduate Medical Education (ACGME) GME, completed in July, 2020, allowed, but did not require, an Osteopathic recognition pathway for any GME program; and

WHEREAS, the continued growth in the number of graduates of Colleges of Osteopathic medicine (COM's) and GME programs has complicated the issue of GME programs including Osteopathic recognition pathways due to the fact that most GME programs currently do not have the history of being previous AOA GME accredited programs; and

WHEREAS, as HOD resolution H426-A/23 Osteopathic Medicine is High-Value Care stated, Osteopathic Principles and Practice (OPP), including OMT, is an approach to excellent patient care (high-value care}, and will tend to be lost in medical education unless it remains a formal part of medical education; now, therefore be it

32 RESOLVED, that the American Osteopathic Association (AOA) explore and define
33 ways to encourage interdisciplinary (specialty) education and collaboration,
34 to further promote high-value care in all levels of education: Colleges of
35 Osteopathic Medicine (COM's), graduate medical education (GME) through
36 communication with the Accreditation Council of Graduate Medical Education
37 (ACGME), and continuing medical education (CME); and, be it further

38 RESOLVED, that the AOA work with osteopathic stakeholders to promote this
39 educational focus, including: the American Association of Colleges of
40 Osteopathic Medicine (AACOM), the National Board of Osteopathic Medical
41 Examiners (NBOME), and osteopathic specialty societies.

Background Information: Provided by AOA Staff

Current AOA Policy:

H426-A/23 Osteopathic Medicine is High-Value Care
H436-A/21 Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) – Affirming the Scientific and Medical Foundation of Policy Statement
H618-A/23 Osteopathic Graduate Medical Education

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau of Osteopathic Education (BOE)

DATE: July 20, 2024

SUBJECT: SUPPORT FOR INCREASING ACCESS TO TRAINING OPPORTUNITIES IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

SUBMITTED BY: Oklahoma Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the federal government has a unique government-to-government relationship with 574 federally recognized tribes based on Article I, Section 8 of the U.S. Constitution; and

WHEREAS, the federal government has committed itself to provide health care services to Tribal nations under its self imposed enforceable federal Indian trust responsibility, which includes a legal fiduciary obligation to provide basic social, medical, and educational services for American Indians and Alaska Natives (AI/ANs);[1] and

WHEREAS, AI/AN are three times as likely as White individuals to be diagnosed with diabetes and to receive late or no prenatal care;[2] while they are disproportionately affected by multiple chronic conditions, including heart disease, cancer, diabetes, and stroke, as well as unintentional injuries, and;

WHEREAS, AI/AN have a lower life expectancy than their White counterparts (65.2 years vs 76.4 years), with AI/AN communities experiencing a 6.6-year decline between 2019 and 2021;[3] and

WHEREAS, the Indian Health Service (IHS) provides health care to over 2.8 million AI/AN through IHS and Tribal Health Programs and Urban Indian Organizations, often referred to as the I/T/U or the Indian Health system;[4] and

WHEREAS, the IHS is chronically under-funded compared to other federal health care systems, and the lack of funds has contributed to health disparities in Tribal communities;[5] and

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[1] "What is the federal Indian trust responsibility?" Bureau of Indian Affairs. U.S Department of the Interior.
[2] "Disparities." Indian Health Service. US Department of Health and Human Services. *See also* "Infant Mortality and American Indians/Alaska Natives." Office of Minority Health. US Department of Health and Human Services.
[3] Hill, L. and Artiga S. "What is Driving Widening Racial Disparities in Life Expectancy?" Kaiser Family Foundation. May 23, 2023. https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-is-driving-widening-racial-disparities-in-life-expectancy/
[4] FY2024 Budget in Brief; US Department of Health and Human Services, pg. 33
[5] FY2024 Budget in Brief; US Department of Health and Human Services, pg. 33. *See also* Government Accountability Office Report: Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs

WHEREAS, the IHS is the only large federal health care system to lack formalized partnerships with academic medical centers, unlike the Veterans Health Administration and the Military Health System;[6] and

WHEREAS, IHS and Tribal medical facilities often suffer from high physician staffing vacancy rates, limiting access to timely care and contributing to negative outcomes;[7] and

WHEREAS, Congress in the *Indian Health Care Improvement Act of 1976* mandated that IHS form workforce partnerships with teaching hospitals but has failed to appropriate funds to that effect;[8] and

WHEREAS, the President of the United States in the FY 2023 and FY 2024 Budget Proposals to Congress has recommended establishing and funding a Division of Graduate Medical Education in the IHS that would be tasked with expanding and supporting graduate medical education programs thus creating a pathway and an enhanced ecosystem for future physicians to address longstanding vacancy issues at IHS;[9] and

WHEREAS, the AMA reaffirmed its recommendation in 2023 to support efforts in Congress to enable the IHS to meet its obligation to bring ~~American Indian~~ **AI/AN** health up to the level of the general population in the U.S.A., and its support for efforts to establish closer ties with teaching centers to increase both the available professional manpower and the level of professional expertise available in Tribal clinics; and

WHEREAS, the AOA advocates its support for the IHS establishment of an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs, and encourages the development of funding streams to promote rotations and learning opportunities at IHS, Tribal, and Urban Indian Health Programs; and

WHEREAS, the AOA recognizes that the federal government has an obligation to provide sufficient funds to support needed health services for ~~American Indians~~ **AI/ANs**, and encourages further development and use of innovative delivery systems and staffing configurations to meet ~~American Indian~~ **AI/AN** health needs; and

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[6] Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. *JAMA.* 2022;328(4):327. doi:10.1001/jama.2022.10359

[7] https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf

[8] 25 USC Chapter 18 – Indian Health Care, §1616n – p. *See* Indian Health Care Improvement Act, Public Law 94-437. *See also* Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. *JAMA.* 2022;328(4):327. doi:10.1001/jama.2022.10359

[9] FY 2024 Justification of Estimates for Appropriations Committees; Indian Health Service; US Department of Health and Human Services; pg. CJ-47.

55 WHEREAS, the AOA acknowledges the importance of graduate medical education
56 in training the next generation of physicians, reducing physician shortages,
57 and benefiting communities;[10] and

58 WHEREAS, the AOA strenuously and continuously advocates for increasing the
59 number of GME positions to address the current and future physician
60 workforce needs of the nation;[11] and

61 WHEREAS, the AOA also is committed to strongly advocate that Congress fund
62 additional graduate medical education positions for the spectrum of critical
63 workforce and medical discipline needs;[12] and

64 WHEREAS, the AOA is also committed to sharing its content expertise and experts
65 with policymakers and the public to ensure greater awareness of the
66 significant societal value of graduate medical education, particularly for
67 underserved and at-risk populations, as well as its beneficial effects on global
68 health, research, and education;[13] and

69 RESOLVED, that the American Osteopathic Association (AOA) ~~joins with the~~
70 ~~American Medical Association (AMA) in supporting~~ **ENCOURAGES** policy
71 and communication efforts to advance legislative and regulatory policies and
72 actions that will establish, authorize, fund, and incentivize the creation of
73 graduate medical education opportunities in IHS, Tribal-administered, and
74 urban Indian health organizations and facilities and establish associated
75 partnerships with accredited medical schools and teaching hospitals; and be
76 it further

77 RESOLVED, the AOA ~~and AMA supports collaboratively~~ **ENCOURAGES** working
78 with Tribal nations, Tribal organizations, academic medical centers, policy
79 professionals, medical schools, teaching hospitals, coalition builders, and
80 other **EXTERNAL** stakeholders to advocate to Congress, The White House,
81 the Department of Health and Human Services, and other government
82 entities **FOR** the development and establishment of dedicated graduate
83 medical education funding and programs that benefit Tribal communities,
84 increase physician training sites, and reduce physician shortages, particularly
85 among underserved populations.

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[10] "Graduate Medical Education." American Osteopathic Association. H200-A/120
[11] "Graduate Medical Education." American Osteopathic Association. H201-A/19
[12] "Graduate Medical Education." American Osteopathic Association. H201-A/19
[13] "Graduate Medical Education." American Osteopathic Association. H201-A/19

Background Information: Provided by AOA Staff

Current AOA Policy:

The resolved statements are covered by content in the following policies:

- H218-A/21 Graduate Medical Education Funding and Incentives – "The AOA…supports the distribution of federal funds for GME, prioritizing areas of most need for physician training (DO and MD) programs based upon geography and specialty…"

- H200-A/20 Graduate Medical Education – Training of US Medical School Graduates – "The AOA advocates for the elimination of limitations on the number of funded graduate medical education positions to accommodate increases in US medical school enrollment; places great emphasis on establishing graduate medical education opportunities for osteopathic medical school graduates in geographic areas that lack adequate training capacity and as needed to meet future workforce needs."

- H201-A/19 Graduate Medical Education – Increasing Opportunities – "The AOA supports the efforts to increase the number of graduate medical education training positions available to United States medical graduates."

The policies above allowed Public Policy to advocate and join a letter in support of the inclusion of $30 million in new funding in the FY25 appropriations bill to address chronic clinical staff shortage across Indian Country through graduate medical education programming. Fuding was directed to Indian Health Services Facilities, Tribally Operated "638" Programs, and Urban Indian Organizations, collectively referred to as I/T/Us. The letter can be accessed here.

Prior HOD action on similar or same topic:

FISCAL IMPACT: $ No Financial Impact

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: SUPPORT FOR THE CREATION OF SPECIALTY AND SUB-SPECIALTY OSTEOPATHIC RECOGNITION TRAINING EXAMS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, Osteopathic Recognition ~~(OR)~~ is ~~an accreditation status~~ **A DESIGNATION** provided by the Accreditation Council for Graduate Medical Education (ACGME) to recognize the additional Osteopathic teaching provided by programs (1); and

WHEREAS, ~~a~~ **OSTEOPATHIC RECOGNITION** requirement of ~~OR standards (Standard~~ (V.A.2.h) ~~is to have a formal~~ **REQUIRES** knowledge based assessment in Osteopathic Principles and Practice (OPP) (1); and

WHEREAS, the Clinical Osteopathic Recognition Training Exam (CORTEx) is one of few methods (other than the American College of Osteopathic Family Physicians (ACOFP) In-service exam) that meets that standard outlined by the ~~OR Review~~ **OSTEOPATHIC RECOGNITION** Committee (2); and

WHEREAS, the CORTEx is administered by ACOFP (2); and

WHEREAS, the CORTEx contains family medicine style OPP questions across a broad spectrum of patient types or conditions that are taken from a bank to be used for either the CORTEx or the ACOFP In-service exam; and

WHEREAS, according to the ACGME, the programs that have achieved ~~OR~~ **OSTEOPATHIC RECOGNITION** include primary care, specialty care, and sub-specialty programs (3); and

WHEREAS, the American Osteopathic Association and American Association of Colleges of Osteopathic Medicine are studying the barriers that prevent programs from working to achieve ~~OR~~ **OSTEOPATHIC RECOGNITION** accreditation as the number of total programs that has achieved the designation has remained steady for a few years (3); and

WHEREAS, a reported barrier in the literature for programs to achieve ~~OR~~ **OSTEOPATHIC RECOGNITION** includes the challenges with creating buy-in among groups, including medical schools, learners, and faculty (4); and

WHEREAS, meeting the knowledge-based assessment by testing understanding of OPP content that is specialty or sub-specialty related may help create buy-in with learners taking the testing or educators administering it for these programs; now, therefore be it

31 RESOLVED, the American Osteopathic Association (AOA) advocate for the
32 creation of both specialty and subspecialty-focused knowledge-based
33 ~~evaluations~~ **ASSESSMENTS** similar to the CORTEx for programs outside of
34 primary care to meet the Osteopathic Recognition ~~(OR) standard~~
35 **REQUIREMENT**.

References:

1. ACGME Osteopathic Recognition Standards. Accreditation Council for Graduate Medical Education. 2022, March 21. doi: https://www.acgme.org/globalassets/pfassets/programrequirements/801_osteopathicrecognition_2021v2.pdf
2. Clinical Osteopathic Recognition Training Exam. American College of Osteopathic Family Physicians. 2024, March 6. doi: https://www.acofp.org/acofpimis/Acofporg/Program_Directors/cortex.aspx#:~:text=The%20Clinical%20Osteopathic%20Recognition%20Training,accredited%20programs%20with%20osteopathic%20recognition.
3. ACGME List of Programs Applying for and with Osteopathic Recognition by Specialty. 2024, March 6. doi: https://apps.acgme.org/ads/Public/Reports/Report/17
4. Hempstead LK, Rosemergey B, Foote S, Swade K, Williams KB. *Resident and Faculty Attitudes Toward Osteopathic-Focused Education*. J Am Osteopath Assoc. 2018 Apr 1;118(4):253-263. doi: 10.7556/jaoa.2018.050. PMID: 29582060.

Background Information: Provided by AOA Staff

Current AOA Policy:

H618-A/23 Osteopathic Graduate Medical Education

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_____

DATE: __July 20, 2024_____

SUBJECT: SUPPORT OF THE PHYSICAL ~~EXAM~~ **EXAMINATION** IN EDUCATION AND PRACTICE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Current Procedural Terminology (CPT) Editorial Committee reformatted the CPT Evaluation and Management (E/M) coding process in 2021 so that the determination of the level of a patient visit is based on the Medical Decision Making utilized or physician time spent, while the requirement for the physical ~~exam~~ **EXAMINATION** portion is what is merely "necessary" (1); and

WHEREAS, this new formulation of billing requirements does not account for the medico-legal requirements of documentation, particularly in the physical ~~exam~~ **EXAMINATION**, to holistically document the encounter that ensues (2); and

WHEREAS, many hospital systems are moving away from the traditional "Subjective, Objective, Assessment and Plan" (SOAP) notes in the name of efficiency for electronic medical records, and towards "Assessment, Plan, Subjective, Objective" or (APSO) notes as a means to quickly access the 'plans' of patients, leading to a deprioritizing of the physical ~~exam~~ **EXAMINATION** (3); and

WHEREAS, the advancement of medical technology has also brought a number of new diagnostic tests over the last few decades that can assist in diagnosing a variety of conditions (4); and

WHEREAS, this advanced testing may have a tendency to lead learners to use a test to determine a diagnosis for a patient verses use of critical thinking based on a detailed history and physical, thereby adding to the cost of care (5); and

~~WHEREAS, the aforementioned changes over the course of time may have a propensity for learners in medicine to perform less detailed physical exams and focus less on their utility; and~~

WHEREAS, Andrew Taylor Still, MD, DO, founder of Osteopathic Medicine, empowered his learners to understand the subtle findings of a patient using the element of touch to formulate diagnoses and holistic plans of care (6); now, therefore be it

31 RESOLVED, the American Osteopathic Association (AOA) ~~continues to support~~
32 **EMPHASIZES THE IMPORTANCE OF** ~~the~~ physical ~~exam~~ **EXAMINATION**
33 as an integral part of the evaluation of the patient; and, be it further

34 RESOLVED, the AOA recommend faculty and preceptors in Undergraduate Medical
35 Education (UME) and Graduate Medical Education (GME) emphasize and
36 model the utility of the physical ~~exam~~ **EXAMINATION** to learners.

References:

1. *AMA releases 2021 CPT code set*. American Medical Association. 2020. Sept 1. Doi: https://www.ama-assn.org/press-center/press-releases/ama-releases-2021-cpt-code-set
2. *Guidelines for Medical Record Documentation*. National Center for Quality Assurance. Found at: https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf
3. Leventhal, R. *Clinical Leaders discuss SOAP vs APSO*. Healthcare Innovation. 2015, Nov 18. Doi: https://www.hcinnovationgroup.com/clinical-it/article/13026007/clinical-leaders-discuss-soap-vs-apso
4. Gangurde, S. *8 Recent Advancements in Medical Technology and their Applications*. 2023, July 14. Doi: https://blog.creliohealth.com/the-top-8-latest-advances-in-medical-technology-and-their-significance-in-diagnostics/
5. *Trends in healthcare spending*. American Medical Association. 2023, Mar 20. Doi: https://www.ama-assn.org/about/research/trends-health-care-spending
6. APA. Seffinger, D.M. (2018). *Foundations of Osteopathic Medicine* (4th ed.). Lippincott Williams and Wilkins.

Background Information: Provided by AOA Staff

Current AOA Policy:

H-223-A/19 Education of Students and Faculty on Obtaining Permission Before All Student and Patient Encounters

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: RESOLUTION ON CREDENTIAL REQUIREMENTS FOR PRESIDENTS AND LEADERS OF OSTEOPATHIC MEDICAL SPECIALTY ~~BOARD SOCIETIES~~ **COLLEGES**

SUBMITTED BY: Wisconsin Association of Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Educational Affairs

WHEREAS, THE AMERICAN OSTEOPATHIC ASSOCIATION PROMOTES PHYSICIANS LEADING PHYSICIANS; AND

WHEREAS, THE AMERICAN COLLEGE OF CARDIOLOGY APPOINTED AN MSN, FACC AS THE FIRST NON-PHYSICIAN PRESIDENT IN 2023; AND

WHEREAS, the ~~American~~ Osteopathic **PHYSICIAN** community recognizes the vital role played by the leaders of osteopathic medical specialty ~~board societies~~ **COLLEGES** in shaping the future of the profession and upholding the highest standards of medical practice; and

~~WHEREAS, diversity in leadership can contribute to a broader perspective and foster collaboration within the medical community; and~~ **WHEREAS, SELECTED CANDIDATES SHOULD EXHIBIT OUTSTANDING LEADERSHIP SKILLS, A COMMITMENT TO EVIDENCE-BASED MEDICAL PRACTICE, AND DEDICATION TO ADVANCING OSTEOPATHIC MEDICINE; AND**

~~WHEREAS, acknowledging the educational achievements of individuals with different medical degrees can lead to a more inclusive and integrated approach to osteopathic medicine; and~~

WHEREAS, the ~~American~~ Osteopathic **PHYSICIAN** community seeks to promote unity and cooperation among healthcare professionals, regardless of their medical training background; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) hereby ~~establishes the following requirements for all presidents and leaders of any and all osteopathic medical specialty board societies~~ **RECOMMENDS**:

~~Credential Requirements:~~ **THAT ALL** candidates seeking ~~to become presidents or leaders of~~ **LEADERSHIP WITHIN** osteopathic medical specialty ~~board societies~~ **COLLEGES** ~~must~~ **BE PHYSICIANS** ~~hold~~ **HOLDING** one or more of the following credentials: Doctor of Osteopathic Medicine (DO), Doctor of Medicine (MD), or Bachelor of Medicine, Bachelor of Surgery (MBBS).

~~Emphasis on Inclusivity: The American Osteopathic Association encourages a diverse pool of qualified candidates to apply for leadership positions within the osteopathic medical specialty board societies. This diversity should reflect the broad spectrum of medical training backgrounds, fostering an environment that promotes mutual understanding and collaboration.~~

~~Qualifications and Merit: While credential requirements serve as a foundational criterion, candidates will be evaluated primarily based on their qualifications, experience, expertise, and dedication to advancing osteopathic medicine. The selection process will focus on identifying individuals who exhibit outstanding leadership skills, a commitment to evidence-based medical practice, and a vision for the future of osteopathic medicine.~~

~~Implementation and Compliance: The American Osteopathic Association shall work collaboratively with all osteopathic medical specialty board societies to implement and ensure compliance with these credential requirements. The establishment of a transparent and standardized selection process shall be pursued to uphold the principles of fairness, equality, and inclusivity in leadership positions.~~

~~Review and Revision: The credential requirements and selection process for leaders of osteopathic medical specialty board societies shall be periodically reviewed to adapt to the evolving needs and dynamics of the medical profession. Any revisions shall be made in consultation with relevant stakeholders to maintain the integrity and efficacy of the leadership selection process; now therefore be it further~~

~~RESOLVED, that the AOA by adopting these credential requirements, aims to reinforce its commitment to fostering unity, inclusivity, and excellence within the osteopathic medical community. Through strong and qualified leadership, the profession can continue to grow, adapt, and provide optimal healthcare for patients and communities.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: IMPORTANCE OF ACCREDITED TRAINING AND BOARD CERTIFICATION IN AEROSPACE MEDICINE FOR THE GROWING COMMERCIAL SPACE INDUSTRY

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Committee on Educational Affairs

WHEREAS, the commercial space industry continues to grow and push the envelope of human spaceflight, with more private citizens, new vehicles, new mission objectives, and operationally untested flights every year;

WHEREAS, The Aerospace Medical Association passed a similar resolution on 13 January, 2024 (2022-01) and seeks AOA support of same.

WHEREAS, crew and passenger safety, health, and mission success remain the highest priorities in our practice as Aerospace Medicine (AM) physicians;

WHEREAS, no current requirements or standards exist for medical providers working at commercial space companies, driving the creation of unregulated and unaccredited medical training pathways and the hiring of providers untrained in Aerospace Medicine;

WHEREAS, externally validated, national standards and core competencies have existed through the Accreditation Council of Graduate Medical Education (ACGME) and international equivalent-accredited Aerospace Medicine residency/fellowship programs and Specialty Boards since 1953, and are the established and recognized industry standards;

WHEREAS, precedent exists per AsMA Resolution 2020-01 and AOA Policy H201-A/2021 Vital Nature of Board-Certified Physicians in Aerospace Medicine (dated June 8 and July 17, 2021, respectively) affirming the "unique leadership roles, contributions, and advanced qualification of Aerospace Medicine professionals, and opposes all efforts to remove, reduce or replace Aerospace Medicine physician leadership in civilian, corporate or government Aerospace Medicine programs and aircrew healthcare support teams";

WHEREAS, board-certified AM specialists provide:

1) Operational experience and specific training in spacecraft systems and the health effects of microgravity

2) Technical authority and medical subject matter expertise on human-in-the-loop risk assessments, elimination of hazards, and trained responses to mishaps (i.e., the full spectrum from prevention to contingency response)

3) Medical screening of individuals, whose medical issues may compromise mission safety, via the specialist's education in population health

4) Clinical expertise by interfacing with crew and passengers in matters to which engineers and managers in their traditional roles are not privy, to understand and mitigate health conditions that might impact spaceflight crew performance; now, therefore be it

RESOLVED**,** that the American Osteopathic Association (AOA) affirms the importance of ACGME and international equivalent-accredited, standardized training and board certification in Aerospace Medicine as the highest standard of comprehensive physician training for human health, performance, and safety in human spaceflight and commercial aviation; and be it further

RESOLVED**,** that AOA recommends corporate and government aerospace communities have board-certified Aerospace Medicine (AM) physicians in leadership and operational roles within their integrated Aerospace Medicine (AM) and healthcare management teams; and be it further

RESOLVED**,** that AOA encourages current AM specialists to guide and mentor new programs and trainees toward a path of obtaining internationally recognized credentials, including but not limited to ~~Royal College of Physicians (UK), American Board of Preventive Medicine, and~~ American Osteopathic Board of Preventive Medicine board certification in order to maintain the aforementioned standards as the commercial space industry expands.

Background Information: Provided by AOA Staff

Current AOA Policy:

H201-A/2021 Vital Nature of Board-Certified Physicians in Aerospace Medicine

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN Adopted as Amended

DATE July 20, 2024

SUBJECT: CERTIFYING BOARD SERVICES WORKGROUP REPORT (POLICY H212-A/23 PROMOTION OF AOA BOARD CERTIFICATION)

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Educational Affairs

WHEREAS, the 2023 House of Delegates adopted Policy H212-A/23 Promotion of AOA Board Certification; and

WHEREAS, President Monka established the Certifying Board Services Workgroup to refine the process and expand awareness of the unique value offered by AOA board certification; and

WHEREAS, Policy H212-A/23 Promotion of AOA Board Certification requires the AOA to provide a report to the House of Delegates; now, therefore be it

RESOLVED, that the 2024 House of Delegates accept the AOA Certifying Board Services Workgroup Report.

AOA Certifying Board Services Workgroup Report

In April 2023, Ira P. Monka, DO, then President-Elect, established the AOA Certifying Board Services Workgroup. The desired outcomes of the workgroup were:

- Establish specific recommendations to enhance initial AOA Board Certification as the premier choice for osteopathic residents and fellows.
- Establish specific recommendations to enhance Osteopathic Continuous Certification process for current diplomates.

Twenty-five individuals were appointed to the Workgroup, under the leadership of Co-Chairs Stephen M. Scheinthal, DO and Bruce A. Wolf, DO. The Workgroup membership included leaders who serve as Designated Institutional Officers **(DIO),** Deans, Program Directors, and Directors Osteopathic Education as well as individuals with extensive experience on the Bureau of Osteopathic Specialists, Specialty Certifying Board Chairs, and specialty colleges. In addition, there were specialty/state affiliate executive directors and new diplomates, residents, fellows, and students.

The Workgroup met monthly from May to September. The first meetings focused on conducting a SWOT analysis, TOWS analysis, problem identification, and solution generation. Following its August meeting, the Workgroup drafted 38 recommendations. The draft recommendations were distributed in a feedback survey to Workgroup members, Bureau of Osteopathic Education members, Bureau of Osteopathic Specialists members, Bureau of Emerging Leaders members, specialty certifying board members, and state and specialty affiliate executive directors. Seventy-five individuals responded. In addition, Certifying Board Services staff also provided their input utilizing their knowledge about the operationality of the recommendations.

Utilizing the feedback received from stakeholders, the recommendations were revised and consolidated to 17 recommendations. Workgroup members then finalized and prioritized the recommendations at their September meeting for submission to the BOT.

The BOT approved the 17 recommendations at their October meeting:

1. Work with Marketing staff and AOA specialty certifying board staff to develop engaging, persuasive, and specialty-specific content for DIOs, program directors, coordinators, AOA board-certified core faculty, and residents.
    - Utilize analytics to provide more information (i.e., offer webinars, send printed materials) to individuals who open and click links in emails.
    - Provide specialty colleges with copies of these emails to help disseminate the message and be aware when the messaging will be arriving.
    - Consider sending emails to residents tailored to their PGY.
2. Simplify/Refresh the AOA Board Certification website, including each individual specialty certifying board's sites, to improve dissemination of specialty-specific information among diplomates, students/COMs, residents, and program directors in order to provide details about board exam processes, roadmaps, and essential resources.
    - For students and residents - a specialty-specific roadmap to major conferences and leadership opportunities that will help shape their career path and lead them to AOA Board Certification.
    - For diplomates – include timeline about the recertification process.
    - For GME leaders - Provide relevant information on exam quality, acceptance, and ACGME requirements, illustrating that selecting AOA over ABMS board certification will ensure that residents are not left out from future opportunities.
3. Engage with all program directors to ensure they know about AOA Board Certification. When new programs are accredited or there is a program director change, contact them to orient them to AOA Board Certification.
4. Continue to stress that it is an ACGME requirement that residents are educated on their board certification options.
    - Collect data on whether residents are receiving information on what boards they are eligible for from their programs. Utilize this data to inform conversations with the ACGME Board and Review Committees.
    - Create PowerPoint slides for teaching purposes at residency programs (information to be given by program coordinators, directors, chief residents).
5. Have a dedicated board certification marketing staff member (similar to the dedicated membership marketing staff) that works closely with AOA specialty certifying board staff to develop engaging, persuasive, and specialty-specific content for various marketing materials such as emails, social media posts, DO articles, and more.
6. Increase the formal AOA Board Certification presentations at national medical education meetings, program director association meetings, student and resident conferences, and osteopathic affiliate conferences, utilizing AOA board certified physicians who will already be attending these conferences to control cost.

7. Refresh AOA Physician Portal to become a one-stop page showing diplomate's OCC status (including action directives) and send out emails with more frequent and personalized information about how to access OCC process.
8. Strengthen relationships with our osteopathic specialty colleges by having at least annual meetings with specialty college and specialty board leadership and no less than semiannual contact between AOA board staff and specialty college staff.
9. Connect with osteopathic stakeholder organizations, specialty colleges, state societies, COM Deans, SOMA and COSGP to begin talking about AOA Board Certification, providing slides and talking points to share at their meetings with students, residents, and medical educators.
10. Continue to support innovations regarding pricing, exam timing, and content to meet the needs of residents, candidates, and diplomates. Partner with specialty colleges and osteopathic foundations for initial certification grants.
11. Provide opportunities for AOA specialty certifying boards to share best practices and their innovative models for longitudinal assessment and quality improvement, striving to be more meaningful and relevant to diplomates.
12. Investigate providing specialty colleges with access to see their member's general certification information (i.e., certification expiration; OCC status) to help answer their members' questions.
13. Engage with state societies ~~especially the larger~~ specialty boards, ~~in addition to~~ **AND** specialty colleges.
14. Increase awareness of AOA board certification with students throughout their medical school journey by including information on board certification in AOA student communications and COM visits.
15. Grow the subject matter expert/item writer pools for each specialty by conducting a needs assessment and organize an item writer recruitment campaign, including highlights of the incentives for AOA certification volunteers (50% off AOA membership, earning CME, exam/longitudinal assessment waivers).
16. Standardize the AOA certifying board member nomination process to reach diplomates who may not be aware of leadership opportunities available and expand our volunteer pool to introduce fresh perspectives that can enrich the certifying board.
17. After passing the initial certification exam, send any information about how new diplomates, maintain OCC, can track their CME and what the AOA certifying board and AOA membership can do for them.

At its Midyear Meeting, the BOT approved the use of $361,000 from reserves for the following items: Director of Certification Marketing FTE, Website enhancements, IT development costs to enhance OCC dashboard, and resident/recent graduate survey.

Background Information: Provided by AOA Staff
Current AOA Policy: Policy H212-A/23 Promotion of AOA Board Certification

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $361,000 approved by AOA Finance Committee and AOA BOT in February 2024.

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: VALUE OF OSTEOPATHIC MEDICAL SCHOOL EDUCATION

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, osteopathic medicine is a complete school of medicine, and;

2 WHEREAS, education has evolved and requires clear definitions of the knowledge,
3 skills and attitudes required for the science and practice of osteopathic
4 medicine, and;

5 WHEREAS, the AAMC, ACGME and AACOM have put together a shared list of
6 competencies required for undergraduate medical education, and;

7 WHEREAS, the draft documents address osteopathic medicine in a superficial and
8 unclear manner, and;

9 WHEREAS, the competencies differentiating education at an osteopathic and
10 allopathic medical school seem to be the outlook and orientation of the
11 practitioner and does not list the body of knowledge or specific skills taught,
12 and therefore be it

13 RESOLVED, that the American Osteopathic Association work to define the specific
14 competencies taught to DO students that differentiate DO education, and;

15 RESOLVED, that the AOA engage subject matter experts engaged in osteopathic
16 medical education to delineate the details of the difference in educational
17 experiences to include pathways for MD's to acquire the skills mastered by
18 DO students.

Background Information: Provided by AOA Staff

Current AOA Policy:

H608-A/23: Tenets of Osteopathic Medicine

COM curriculum is dictated by each program in accordance with COCA standards:

COCA Standards Element 6.4: Osteopathic Core Competencies (CORE)

A COM and any branch campus must teach and educate students to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment.

Prior HOD action on similar or same topic:
H608-A/23: Tenets of Osteopathic Medicine

FISCAL IMPACT: Unknown

ACTION TAKEN: _Referred to the Bureau of Osteopathic Education (BOE)

DATE: ___July 20, 2024_____

AMERICAN OSTEOPATHIC ASSOCIATION

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osteopathic.org

104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Professional Affairs (300 series)
This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Drug Formularies (SR-Source-H308-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-301	Importation of Medications (SR-Source-H313-A/19)	BFHP	Professional Affairs	Adopted
H-302	Maternal Mortality (SR-Source-H335-A/19)	BFHP	Professional Affairs	Adopted
H-303	Extending Medicaid to 12 Months Postpartum (SR-Source-H336-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-304	Hospital Consolidation – Opposition to (SR-Source-H338-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-305	Misaligned Incentives in Medicare Plans (SR-Source-H342-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-306	Opposing Targeted Regulation of Abortion Providers (Trap Laws) (SR-Source-H335-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-307	Physically Active Video Games – (Exergaming Health) Benefits (SR-Source-H316-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-308	Cardiovascular Disease and Women (SR-Source-H319-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-309	Healthy Weight for Families (SR-Source-H320-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-310	End-of-Life Care – Use of Placebos in (SR-Source-H322-A/19)	BORPH	Professional Affairs	Referred to BORPH
H-311	Abuse of Performance Enhancing Substances and Procedures (SR-Source-H327-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-312	Tobacco Use Status – Reporting in the Medical Record (SR-Source-H329-A/19)	BORPH	Professional Affairs	Adopted
H-313	Testosterone Therapy: Long Term Effect on Health (SR-Source-H332-A/19)	BORPH	Professional Affairs	Adopted as Amended

AMERICAN OSTEOPATHIC ASSOCIATION

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-314	Home-Based Care for Frail Elderly (SR-Source-H309-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-315	Health Care Costs in Long Term Services and Support (SR-Source-H310-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-316	Human Cloning (SR-Source-H341-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-317	White Papers – Updating (SR-Source-H343-A/19)	BORPH	Professional Affairs	Adopted
H-318	Direct-to-Consumer Marketing of Health Screening and Testing (SR-Source-H303-A/19)	BORPH	Professional Affairs	Adopted
H-319	Newborn HIV Testing (SR-Source-H304-A/19)	BORPH	Professional Affairs	Adopted
H-320	Influenza Immunization for Health Care Workers and Educators (SR-Source-H306-A/19)	BORPH	Professional Affairs	Adopted
H-321	Flu Pandemic – Osteopathic Treatment of (SR-Source-H302-A19)	BORPH	Professional Affairs	Adopted
H-322	Osteopathic Manipulative Treatment (OMT) of the Cervical Spine (SR-Source-H324-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-323	Compensation Tied to Patient Satisfaction Surveys – Osteopathic Physician (SR-Source-H333-A/19)	CERA	Professional Affairs	Adopted as Amended
H-324	Administrative Fees (SR-Source-H321-A/19)	CERA	Professional Affairs	Adopted
H-325	Availability of Biosimilar Products (SR-Source-H334-A/19	CERA	Professional Affairs	Adopted as Amended
H-326	Medicare – Prescription Assistance for Medicare Patients (SR-Source-H317-A/19)	CERA	Professional Affairs	Adopted as Amended
H-327	State Graduate Medical Education Funding Alternatives (SR-Source-H359-19)	CSHA	Professional Affairs	Adopted as Amended
H-328	Office Based Surgery (SR-Source-H360-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-329	Uniform Pathway of Licensing of Osteopathic Physicians (SR-Source-H361-A/19)	CSHA	Professional Affairs	Adopted

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2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-330	Safe Haven Non-Reporting Protection for Physicians-Support for (SR-Source-H362-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-331	Electronic Prescribing (H327-A/14) (SR-Source-H318-A/19)	CSHA	Professional Affairs	Not Adopted
H-332	Right to Privately Contract (H334-A/14) (SR-Source-H325-A/19)	CSHA	Professional Affairs	Adopted
H-333	Any Willing Provider Legislation (SR-Source-H314-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-334	Pharmacy Benefit Managers-Increased Regulation of (SR-Source-H339-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-335	Support for OMT Privileges (SR-Source-H349-A/19)	BOE	Professional Affairs	Referred to BOE
H-336	Diversity In Leadership Positions (SR-Source-H328-A/19)	BOM	Professional Affairs	Adopted
H-337	Due Process for Alleged Impaired Physicians (SR-Source-H307-A/19)	BOM	Professional Affairs	Adopted
H-338	National Practitioner Data Bank-Membership Action (SR-Source-H312-A/19)	BOM	Professional Affairs	Adopted
H-339	Promoting Diversity in AOA Membership and Leadership (SR-Source-H326-A/19)	BOM	Professional Affairs	Adopted as Amended
H-340	Clarification on the Terms "Osteopathy, and "Osteopath" in the United States (Amendment to Policy H316-A/21)	OPSC (California)	Professional Affairs	Adopted as Amended
H-341	Increased awareness of Mental Health Conditions in Nursing Home Residents	SOMA	Professional Affairs	Adopted as Amended
H-342	Airline Medical Kits (SR-Source-H302-A/18)	AOCOPM	Professional Affairs	Adopted as amended
H-343	Whistleblower Policy (SR-Source-H346-A/19)	AOA BOT	Professional Affairs	Adopted as Amended
H-344	Locations of Future Meetings	FOMA (Florida)	Professional Affairs	Not Adopted
H-345	Opioid Crisis, Causes	IOMA (Iowa)	Professional Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-346	Supporting the Rights of Residents to Unionize	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-347	Expanding Naloxone and other Opioid Reversal Agent or Antagonist availability and accessibility: Promoting Emergency use in Communities	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-348	GME Equity Annual Report (Policy H345-A/23 – AOA Support for GME Equity)	AOA BOT	Professional Affairs	Adopted
H-349	Removing intrusive Mental Health Questions from Licensure and Credentialing Applications	ACOFP	Professional Affairs	Not Adopted

SUBJECT: DRUG FORMULARIES – SOURCE: H308-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) supports ~~drug formularies which~~
7 ~~allow for~~ **POLICIES THAT ENSURE DRUG FORMULARIES OFFER**
8 **ROBUST COVERAGE OF TREATMENT OPTIONS ACROSS**
9 **THERAPEUTIC AREAS, AND POLICIES THAT ENSURE PLANS**
10 **PROVIDE** an expeditious appeal process with a further peer to peer review
11 option.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended 2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended____

DATE: ___July 20, 2024_____

SUBJECT: IMPORTATION OF MEDICATIONS – SOURCE: H313-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the importation of
7 medications that may be imported under the authority of the U.S. Food and Drug
8 Administration and encourages its members to assist patients in utilizing the many
9 programs that are available to provide patients with free or reduced-cost
10 medications.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; Reaffirmed 2009; 2014; Reaffirmed 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: MATERNAL MORTALITY – SOURCE: H335-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports:

1. The important work of maternal mortality review committees

2. The work with state and relevant specialty medical societies to advocate for state and federal legislation to establish and maintain Maternal Mortality Review Committees

3. The work with state and relevant specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: __July 20, 2024_____

SUBJECT: EXTENDING MEDICAID TO 12 MONTHS POSTPARTUM – SOURCE: H336-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association support**S** state ~~legislation, Section 1115~~
7 ~~waiver applications,~~ and federal ~~legislation~~ **POLICY** to extend Medicaid
8 coverage to 12-months postpartum.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: HOSPITAL CONSOLIDATION – OPPOSITION TO – SOURCE: H338-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) opposes further consolidations of
7 hospitals and health systems that ~~are absent of~~ **(1) LACK** sufficient evidence of ~~and~~
8 ~~commitment~~ **BENEFIT** to ~~protect~~ patients' access to quality and affordable care**; (2)**
9 **LIMIT** ~~and~~ physicians' ability to negotiate equitable relationships with hospitals and
10 payors **DUE TO DISPROPORTIONATE MARKET CONTROL; AND (3) DISTORT**
11 **MARKET DYNAMICS IN A MANNER THAT DISCOURAGES COMPETITION AND**
12 **PATIENTCHOICE**.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019 Reaffirm as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended

DATE: ___July 20, 2024_____

SUBJECT: MISALIGNED INCENTIVES IN MEDICARE PLANS – SOURCE: H342-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) support efforts to align patient's behaviors with cost-effective, reportable high quality care; and, that the AOA will work to identify these misaligned incentives**,** and advocate for changes to the **M**edicare program that support physicians in delivering high-value care and discourage plans from preventing patients from seeking lower cost-effective treatment options; and, ~~that the AOA will seek to educate third party payers and Pharmacy Benefit Managers to align patient and physician incentives, and~~, that the AOA will advocate against misaligned payment and quality incentives in Federal Healthcare programs that do not promote improved health outcomes**;** and, that the AOA works to educate the NCQA regarding the need to modify Healthcare Effectiveness Data and Information Set (HEDIS) rules.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019 Reaffirm as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended____

DATE: ___July 20, 2024_____

SUBJECT: OPPOSING TARGETED REGULATION OF ABORTION PROVIDERS (TRAP LAWS) – SOURCE: H335-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association oppose the Targeted Regulation of Abortion
7 Providers (TRAP laws) that impede and discriminate against a physician's ability to
8 provide appropriate care to patients seeking ~~family planning~~ **COMPREHENSIVE**
9 **REPRODUCTIVE HEALTH** services, including abortion.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS – SOURCE: H316-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) **ENCOURAGES OSTEOPATHIC**
9 **PHYSICIANS** ~~recommends: (1)~~ **TO INCREASE THEIR AWARENESS** ~~physicians~~
10 ~~should be aware~~ of the potential benefits of exergaming **AND** ~~; (2) physicians~~
11 ~~should consider recommending~~ **INCLUDE** exergaming as a component of a
12 person's exercise program or when situational circumstances prohibit other types of
13 exercise.~~; and (3) additional research that demonstrates the benefits of exergaming.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: See above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: CARDIOVASCULAR DISEASE AND WOMEN – SOURCE: H319-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA):

1. Encourages its members to participate in continuing medical education programs on cardiovascular disease (CVD) in women

2. Urges osteopathic state and specialty associations to offer CME on CVD in women, as part of their educational offerings

3. Encourages its members to participate in national initiatives on women's health, ~~especially cardiovascular health such as the National Heart, Lung, and Blood Institute's The Heart Truth (Red Dress) campaign;~~

4. Will continue to recognize national women's health week and national women's check-up day

5. Encourages appropriately designed studies on contributors to CVD in women

6. **ENCOURAGE LAWMAKERS TO ENHANCE FUNDING FOR FEMALE CARDIOVASCULAR RISK REDUCTION AND EDUCATION PROGRAMS**

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2004; 2009; Reaffirmed as Amended 2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended____

DATE: ___July 20, 2024_____

SUBJECT: HEALTHY WEIGHT FOR FAMILIES – SOURCE: H320-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) encourages participation of its
9 members in personal health promotion; ~~strongly recommends~~ **ENCOURAGES**
10 osteopathic medical schools **TO** incorporate personal health promotion as a part of
11 their graded curriculum; ~~strongly recommends~~ **SUPPORTS** participation of its
12 members in outreach efforts to engage with local school districts in order to develop
13 and improve wellness policy interventions to reduce childhood obesity; ~~strongly~~
14 ~~recommends the~~ **ENCOURAGES** state and specialty associations to collaborate
15 with local school districts and major local employers to enhance wellness policy
16 development, implementation, data assessment and improvements; **AND**
17 encourages its members to participate in national and local initiatives on obesity.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: END-OF-LIFE CARE – USE OF PLACEBOS IN – SOURCE: H322-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the policy was reviewed by two End of Life Care experts, including a member of the Bureau of Osteopathic Research and Public Health, who determined that the current is accurate as written, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

End-of-Life Care – Use of Placebos In

Policy Statement

The AOA approves the attached position paper on Use of Placebos for Pain Management in End-of-Life Care and will be updated according to the current literature.

USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE

The placebo effect of medication can be a significant resultant action of any prescription. However, the substitution of a placebo in place of effective pain medication has been widely recognized as unethical, ineffective and potentially harmful. ([1-9]) A number of organizations have advised against the use of placebo substitution, including the American Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical Association), American Nursing Association, and the American Society of Pain Management Nurses.

This white paper describes the literature and rationale in support of the AOA's position on the controversial subject of the use of placebos for pain management in terminally ill patients.

I. Definition of Terms

A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution means the substitution of a physiologically inactive substance for a comparison with the physiologically active substance. Placebo effect is the positive psychosomatic response of an individual to a treatment; in contrast, the nocebo response is a negative psychosomatic response to a treatment. ([10]) The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician's treatment plan and/or prescription for the symptom relief are more likely to obtain relief. ([4, 2])

Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a "nocebo response". A pleasant effect is called a "positive placebo response". It has been noted that, "a positive placebo response simply speaks to the strength of an individual's central control processes (i.e., mind) to recruit their descending inhibitory system to block pain. The trained osteopathic physician knows that pain relief occurs both in the mind and in the body." ([4]) The basis of the placebo effect in a therapeutic physician-patient relationship also involves good communication skills as well as listening to the patient. ([4, 11, 12])

To summarize, a placebo is a type of treatment, necessarily used in controlled clinical trials, that has no inherent physiological action yet is designed to mimic a therapy with a known active physiologic effect. Positive changes resulting from placebo administration would be due to expectations of success by the patient. Thus, the use of placebo effect is based on the patient's perception of the role of the placebo agent with symptom relief. The placebo response may be enhanced with a positive patient-physician relationship.

B. Addiction, substance abuse and dependence, tolerance, withdrawal and pseudo-addiction.

Some physicians inappropriately justify using placebo in pain management to avoid "addicting" the patient. Addiction, as defined by the American Academy of Pain Medicine,([13]) "is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving."

Substance abuse is defined as psychological and physical dependence on substances. Some physicians are concerned that prescribing narcotics may lead to substance abuse and therefore may attempt to use a placebo to assess whether the patient truly requires narcotics for pain relief. However, there is no scientific basis for using placebo in the assessment of the patient in pain who has or may have the potential for a substance abuse. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)

([14]), lists definitive criteria for diagnosis of psychological and physical dependence on substances. This text categorizes “Substance-Related Disorders” but does not utilize the term addiction; further, nowhere in the DSM-V is placebo administration utilized with criteria for diagnosing various forms of substance abuse. Substance dependence is defined as a cluster of cognitive, behavioral and physiological symptoms. The essential feature of a substance dependent individual is continuous use of the substance despite significant substance-related problems, such as deleterious effects on occupation, relationships, health, and others.

Physicians may become uncomfortable with requests for increased dosages of pain medications, fearing that a patient is manifesting a substance-related disorder. A better understanding of the concepts of tolerance, physical dependence, physiological dependence withdrawal symptoms and pseudo-addiction, may help physicians understand and more effectively treat these patients.

Tolerance represents a markedly diminished effect that can occur with continued use of most medications; the degree depends upon the daily dose and length of use. The need for medication titration, either due to development of tolerance or to incomplete responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory changes in receptors and/or increased clearance resulting from induction of various metabolic pathways. The problem of tolerance should therefore be anticipated as a possible outcome in prescription pain medications.

Withdrawal is defined by the DSM-V ([14]) as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such “drug seeking behavior” has been deemed as “proof” of “addiction.” The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a substance-abusing patient according to the DSM-V. ([14])

II. Legal Considerations in the Use of Placebos in Pain Management

While there are no specific laws governing the use of placebos in any circumstance, there is a considerable amount of legislation regarding a patient’s right to pain management. There are several state statutes that address this issue, some of which are based on the Federation of State Medical Boards’ Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.([15]) This document clarifies that legislative statutes accepting these guidelines understand the ongoing increased scientific knowledge of pain

management, and thus have no need to modify legislation as the science of pain management changes. This document does not mention placebo usage.

The American Bar Association (ABA) ([16]) adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, "…that the American Bar Association urges federal, state, and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual's life." Placebo substitution for active pain medicine without informed consent on the part of the patients clearly violates the nature and substance of the ABA's position. Additionally, in two Supreme Court decisions regarding the right to assisted suicide, the court promoted the right of individuals to appropriate palliative care and pain management. ([17, 18])

While there is little case law concerning tort or administrative findings against physicians for inadequate pain management, this is likely to change in the near future. The main barrier to malpractice claims for inadequate pain management is use of the customary local standard to determine what constitutes ordinary care. The courts are steadily moving away from this standard to a national standard which uses clinical guidelines as the determinant of ordinary care. This is seen in the decision in the case of Nowatske v. Oserloh, where the court stated, "should customary medical practice fail to keep pace with development and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care…" ([19])

Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality ([1]), the American Pain Society, ([7]) the Healthcare Facilities Accreditation Program ([20]) as well as the Joint Commission on Accreditation of Healthcare Organizations ([21]) are good examples of sources the courts are using to determine ordinary practice. These guidelines do not support the use of placebo in any fashion except in approved research studies when the appropriate patient informed consent has been obtained. Therefore, the physician thus cannot justify the use of placebo for pain management by attempting to diagnose "addiction" or with support from any of the above regulatory agencies. ([5])
Furthermore, under California's elder abuse statute, ([22]) a physician was successfully sued by the deceased's family for inadequate pain management at the end of life. ([23])

III. Adverse Effects of Placebo Use

Pain is a universal experience and is subjective by nature. Despite the common colloquialism, "I feel your pain," no individual can truly experience another's pain. There are no laboratory tests or consistently reliable physical findings for assessment of pain. Patient self-report remains the gold standard for pain assessment. ([24]) Use of a placebo in place of an effective pain medication for attempting to determine whether the patient at end-of life is really in pain is under no circumstances appropriate.

There is a concern if a physician deceives the patient and substitutes a placebo treatment in the place of a known effective treatment without informing the patient. Deception has no place within the therapeutic relationship and is counter-productive. A physician may counsel a patient that “this treatment may be effective in treating your condition,” but evidence-based medicine cannot guarantee a treatment outcome.

In this era of informed consent, deception of the patient poses many problems, including erosion of the trust individuals and society as a whole have for physicians. There are methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a highly specialized procedure performed by a few skilled pain management physicians with appropriate informed consent.

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association’s 2000 report, is an ongoing problem. ([25]) While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. ([7, 26]) It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a “suicidogen,” whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death. ([6]) In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects ([3]) and potentially precipitate hyperalgesia ([27]) or withdrawal in patients previously treated with pain medications.

IV. Summary

Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of known effective pain medication for determining whether the patient is really in pain is under no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose substance abuse, commonly referred to by some physicians as “addiction.” There is no medical justification for the use of placebos to assess or treat pain at end of life.

The only appropriate use of a placebo is in approved clinical research with informed consent.

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau of Osteopathic Research and Public Health (BORPH)

DATE: July 20, 2024

SUBJECT: ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES – SOURCE: H327-A19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA): (1) supports efforts to eliminate the abuse of performance enhancing substances~~, known as doping,~~ for the purpose of enhancing athletic performance or physical appearance; (2) supports the efforts of ~~the United States Anti-Doping Agency (USADA) and its program in accordance with the World Anti-Doping agency (WADA) code and the WADA International Standards (IST)~~ **APPROPRIATE NATIONAL AND INTERNATIONAL REGULATORY BODIES** to protect clean athletes and ensure their rights to compete on a fair and level playing field, free from the pressures of performance enhancing drugs; and (3) **SUPPORTS THE** ~~encourages~~ education of athletes, the public and physicians of the dangers of these substances.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1989; 1994 Reaffirmed as Amended; 1999 Reaffirmed; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: TOBACCO USE STATUS – REPORTING IN THE MEDICAL RECORD – SOURCE: H329-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the U.S. Preventive
7 Services Task Force (USPSTF) guideline on tobacco use cessation that
8 specifically recommends identifying tobacco use status on each patient visit to
9 increase the likelihood of physician intervention with their patients who use
10 tobacco.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH -SOURCE: H332-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association **SUPPORTS ONGOING FUNDING AND**
9 ~~requests that the National Institutes of Health fund~~ independent research ~~of~~ **ON** the
10 long-term risk/benefits of testosterone therapy.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ____July 20, 2024_____

SUBJECT: HOME-BASED CARE FOR FRAIL ~~ELDERLY~~ **PERSONS** – SOURCE: H309-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) ~~encourages all parties with economic~~
9 ~~and clinical responsibility to develop~~ **SUPPORTS THE DEVELOPMENT OF**
10 programs~~,~~ ~~and systems to assist, the frail elderly patient population and~~ **THAT**
11 provide appropriate access to healthcare services **INCLUDING HOME-BASED**
12 **CARE FOR THE FRAIL ~~ELDERLY~~ PATIENT POPULATION.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: HEALTH CARE COSTS IN LONG TERM SERVICES AND SUPPORT – SOURCE: H310-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **SUPPORTS** ~~reaffirms its commitment to~~ the development and implementation of programs that improve ~~the of~~ long-term services and support and ensure the delivery of quality care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1984; Revised 1989; Reaffirmed 1994; Revised 1999; Reaffirmed 2004; Reaffirmed as Amended 2009; Reaffirmed as Amended 2014; Reaffirmed as Amended 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: HUMAN CLONING – SOURCE: H341-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health updated the references now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Human Cloning White Paper

Policy Statement

The American Osteopathic Association has adopted the following white paper:

White Paper – Human Cloning

BACKGROUND

Somatic cell nuclear transfer (SCNT) or, to use the more common vernacular, cloning is the process of creating genetic duplication of a cell or an organism naturally or artificially.[1,2,3] The National Institute of Health (NIH) describes “cloning” as a process “that can be used to produce genetically identical copies of a biological entity”.[4] More specifically, the National Human Genome Research Institute (NHGRI) of NIH, identifies three categories of artificial cloning: gene, reproductive and therapeutic. The latter two types of cloning are often lumped together as “human cloning,” which is controversial and the focus of much debate.

TYPES OF CLONING

Gene Cloning

Gene cloning (also known as DNA cloning or molecular cloning) is the process wherein genes or segments of DNA are copied. DNA cloning is beneficial to medicine because the technology allows doctors to treat patients by replacing flawed genes associated with inherited diseases with healthy ones. Gene cloning is primarily seen in genetically engineered food and in animals to help them grow stronger. This type of cloning does not have the possibility of creating an adult living creature.

Reproductive Cloning

Reproductive cloning is the process of using SCNT to obtain eggs that could develop into an adult living creature. The mature somatic cell is transferred into another egg cell and allowed to develop into an embryo in a test-tube and then implanted into the womb of a living creature. The hope is that the outcome will be a birth with the same genetic makeup as the living creature from which the mature somatic cell was taken.

Reproductive cloning experimentation has been occurring for many decades but has primarily focused on animals as opposed to human beings. In 1979, mice were cloned by splitting mouse embryos. In 1996, the lamb, Dolly was successfully cloned. In 1998, several calves were cloned. Another notable cloning of a mammal was in 2003, when an endangered ox, Banteg, was cloned. **A RECENT ANNOUNCEMENT WAS MADE IN JANUARY 2024 OF THE SUCCESSFUL CLONING OF A RHESUS MONKEY IN CHINA IN 2020.[5]** While there have been a few successfully cloned mammals, there have been no verified successful attempts to clone a human embryo/being.

Therapeutic (Research) Cloning

Therapeutic cloning is the process of creating a cloned embryo in an effort to produce embryonic stem cells to help understand the epidemiology of diseases and to develop new treatments.[4,~~5~~ **6**] Therapeutic cloning involves some of the same techniques used in reproductive cloning. However, the stem cells are harvested from the embryo during the test tube phase, therein destroying the embryo.

ARGUMENTS FOR OR AGAINST CLONING

In the United States and worldwide, cloning remains a moral and ethical point of consternation. There are arguments both for and against the use of cloning, but there appears to be a consensus amongst many that cloning an actual human being is not acceptable.[~~5,6~~ **6,7,8**] Therapeutic cloning is often the center of most debates for many regarding balancing patient care, morals and ethics.

Arguments against therapeutic and reproductive cloning[~~6~~ **8**]:

- Reproductive and therapeutic cloning leads to the destruction of human embryos which many see as viable human life.

- Reproductive cloning usurps the divine plan or interferes with the natural order.

- Cloning violates human dignity and treats human beings as commodities or items to be manufactured.

- Cloning causes risks to human health; the majority of implanted embryos die in gestation or result in births with significant abnormalities. In addition, the need for human embryos may cause women in poverty to compromise health due to incentives to sell embryos.

Arguments for therapeutic and reproductive cloning[6] [8]:

- Reproductive and therapeutic cloning presents a unique ability to research and identify treatments to address human diseases by providing insight to researchers on developmental and pathogenic events not discoverable otherwise.

- Cloning may lead to alleviation of human suffering and cures for costly and debilitating diseases by providing genetically matched tissue for transplantation.

- Cloning promotes scientific inquiry.

LEGISLATION IN THE U.S. ON CLONING

Currently, the federal government does not explicitly prohibit cloning. However, the government does prohibit the use of federal funds for cloning, regardless of the purpose (therapeutic or reproductive cloning). [6,7] [8,9,10] The NIH primarily conducts gene cloning. NIH relies on federal funding which is prohibited from being used in therapeutic or reproductive cloning activities, and accordingly, NIH researchers have not cloned any mammals nor have any of the institutions or centers supported human cloning activities.

The Food and Drug Administration (FDA) has weighed in on human reproductive cloning. In a 1998 letter about human cloning, the FDA claimed jurisdiction over clinical research using cloning technology for reproductive purposes. The FDA equated using cloning technology to the same process as developing new drugs.[8] [11] In a second letter dated March 28, 2001, regarding Cloning Technology, the agency reiterated its jurisdiction over clinical research using such technology. The FDA explicitly stated that the process is subject to the Health Service Act and the Federal Food, Drug and Cosmetic Act. also indicated that all approval responsibilities for any human clinical use of any therapies derived from cloning research fell within its purview.[9] [12]

In an effort to address the void left by the federal government, several state legislatures have provided guidance on human cloning.[7] [9]

- **Eight (8) states** prohibit human cloning for any purpose – no reproductive or therapeutic cloning (cloned human embryos for embryonic stem cell research as well as to implant in a uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota and Virginia

- **Six (6) states** prohibit state funding of human cloning for any purpose – Arizona, Arkansas[10], Indiana, Louisiana, Maine and Nebraska

- **Ten (10) states** have “clone and kill” laws which allow therapeutic cloning research, but prohibit cloning of embryos to be implanted for childbirth (reproductive cloning) – California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, Montana, New Jersey and Rhode Island

- **Five (5) states** allow state funding for embryonic stem cell research (therapeutic cloning or in vitro fertilization) – California, Illinois, Missouri, Maryland and New York

- **Two (2) states** have legislation that precludes health professionals from being compelled to participate in human cloning (healthcare rights of conscience laws) – Idaho and Louisiana

Twenty-six (26) states and the District of Columbia do not have any legislation addressing therapeutic (biomedical research) and/or reproductive (to produce children) cloning. ~~These data were pulled from sources dated between 2015 through 2019. To the best of BSAPH's knowledge, these policies remain in effect as of May 1, 2019.~~ **SINCE 2019 THERE HAS BEEN LITTLE LEGISLATION ACTIVITY AT THE STATE AND FEDERAL LEVEL.**

KEY ORGANIZATIONS SUPPORTING THERAPEUTIC/RESEARCH CLONING

Many key organizations have made position statements regarding the benefits it views in therapeutic cloning and accordingly expressed their support. In addition, these organizations have declined to support cloning for reproductive purposes. These organizations include:

American Association for the Advancement of Science (AAAS) – The AAAS has a statement on Human Cloning that states it endorses a legally enforceable ban on efforts to implant a human cloned embryo for the purpose of reproduction.[11] AAAS recognizes that the health risks associated with reproductive cloning make such cloning unconscionable. The AAAS, however, does encourage continued dialogue as new technological advances emerge.

Also, AAAS supports stem cell research (genetic and therapeutic cloning) which has potential health benefits. The AAAS calls for strict monitoring of the process and developments and appropriate oversight through regulation. [11]

~~***American Association of Medical Colleges (AAMC)*** – On its website under the Advocacy section, the AAMC expressly supports ongoing research into SCNT and endorses legislation that would allow therapeutic/research cloning.[12] Additionally, the AAMC recommends a ban on all forms of reproductive cloning.~~

~~***American Bar Association (ABA)*** - The ABA addressed this issue in 2002 and 2004. ABA supports law and policy prohibiting reproductive cloning. [13,14]~~

American Medical Association (AMA) - The AMA does not endorse reproductive cloning. However, if in the future reproductive cloning is permitted, the AMA acknowledges that physicians must be educated and understand somatic cell donors must provide informed consent. Additionally, any child produced through reproductive cloning is recognized as a human-being. Code of Medical Ethics Opinion 4.2.6.[15]

The AMA says physicians can determine whether they will participate in stem cell research or use its products. The AMA implores clinician researchers to be able to articulate the risks and benefits of embryonic stem cell use for research purposes. In addition, AMA

encourages physicians to allow their commitment to the welfare of patients to guide them in their professional standards. Code of Medical Ethics Opinion 7.3.**8**[16]

National Academies of Medicine, Sciences and Engineering (National Academies) - The National Academies, based on recommendations generated by 2002 joint panel, recommends a legally enforceable ban on the practice of human reproductive cloning, but does support using SCNT to produce stem cells for developing new medical therapies for life-threatening diseases and advancing knowledge.[17]

AOA AND HUMAN CLONING

The osteopathic community and the AOA have discussed this issue at length since 1998. Recognizing the moral and ethical dilemmas of human cloning, AOA has continued to monitor the issue and provide updates to its constituents in order to facilitate a discussion.

After reviewing the existing literature on cloning, the American Osteopathic Association (AOA) adopts the following policies:

1. The AOA does not endorse the practice of human cloning for purposes of reproduction (efforts to implant a human cloned embryo for the purpose of reproduction).
2. The AOA recognizes the benefits and harms of human cloning for therapeutic (research) purposes with respect to embryos, donors and patients suffering from debilitating and life-threatening diseases and conditions. Physicians shall have the autonomy to determine whether or not they will participate in therapeutic cloning. They should carefully weigh all ethical and moral aspects of the process and determine what is best for the well-being of patients, society as a whole, and the advancement of medical knowledge and practice.
3. The AOA shall review its policy in light of any new evidence that will be generated by research entities as well as monitor state and federal legislation in the field and update the policy as necessary.

References:

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~~7.~~ **9.** Witherspoon Council on Ethics and the Integrity of Science. (2015). The Threat of Human Cloning. Ethics, Recent Developments, and the Case for Action. The New Atlantis, 46, Appendix pp.95-106. https://www.thenewatlantis.com/publications/appendix-state-laws-on-human-cloning

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~~9.~~**12.** FDA. Letter to Associations – Cloning Technology dated March 28, 2001~~. Retrieved on May 1, 2019~~ **ACCESSED 2-20-2024** from https://wayback.archive-it.org/7993/20170404210751/https://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/ucm105853.htm.

~~10. HB1399 (April 2019).~~

13. JARDINE, JASON J., THE LAW AND HUMAN CLONING, KNOBBE AND MARTENS, JUNE 11, 2018. HTTPS://WWW.KNOBBE.COM/NEWS/2018/06/LAW-AND-HUMAN-CLONING#:~:TEXT=THERE%20ARE%20CURRENTLY%208%20STATES,HUMAN%20CLONING%20FOR%20ANY%20PURPOSE

~~11.~~ **14.** American Academy for the Advancement of Science, American Association for the Advancement of Science Statement on Human Cloning. ~~Retrieved May 1, 2019~~ **ACCESSED 1-23-2024** from https://www.aaas.org/resources/american-association-advancement-science-statement-human-cloning

~~12. Association of American Medical Colleges. Somatic Cell Nuclear Transfer (Therapeutic Cloning). Retrieved May 1, 2019 from https://www.aamc.org/advocacy/research/283222/stemcellresearch.html~~. **NOTE: UNABLE TO ACCESS 1-23-2024**

~~13. American Bar Association. House of Delegates Resolution on Cloning, adopted August 9-10, 2004.~~ . **NOTE: UNABLE TO ACCESS 1-23-2024**

~~14. American Bar Association. Section on Individual Rights and Responsibilities (Aug. 2002).~~ **NOTE: UNABLE TO ACCESS 1-23-2024**

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Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: __July 20, 2024_____

SUBJECT: WHITE PAPERS - UPDATING – SOURCE: H343-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 When policies which are or include a “white paper” as a part of the policy are
7 reviewed as part of the regular policy review process, the reviewing entity shall
8 review and update all statistics, studies, and other data to ensure that these
9 references are the most up-to-date statistics, studies, and data that are available;
10 and, that the reviewing entity shall affirm in an explanatory statement that all
11 statistics, studies, and other data have been reviewed and are the most current
12 available.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: __July 20, 2024_____

SUBJECT: DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING – SOURCE: H303-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) is against direct-to-consumer
7 marketing of medical tests and exams that may be unnecessary and encourages
8 its members to educate their patients about which services are appropriate based
9 on US Preventive Services Task Force recommendations and other nationally
10 recognized clinical practice guidelines.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: NEWBORN HIV TESTING – SOURCE: H304-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 American Osteopathic Association (AOA) recommends HIV testing immediately
7 with expeditious reporting of results of newborns whose mothers' HIV status is
8 unknown and where clinically indicated.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: __July 20, 2024_____

SUBJECT: INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS – SOURCE: H306-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) strongly supports and recommends
7 influenza vaccinations for all health care workers and educators according to
8 current guidelines of the Centers for Disease Control and Prevention.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted_____

DATE: __July 20, 2024_____

SUBJECT: FLU PANDEMIC – OSTEOPATHIC TREATMENT OF – SOURCE: H302-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the active utilization of
7 osteopathic manipulative treatment, along with other recognized and approved
8 medical interventions, in the treatment of flu pandemics and other infectious
9 outbreaks; and will conduct programs to disseminate appropriate training in
10 Osteopathic Manipulative Treatment (OMT).

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE – SOURCE: H324-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy and references; and

WHEREAS, the Bureau of Osteopathic Research and Public Health would like to thank the **OSTEOPATHIC NEUROMUSKULOSKELETAL MEDICINE** (ONMM) physicians at Berkshire Osteopathic Health for their contributions to the policy revisions, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Osteopathic Manipulative Treatment (OMT) of the Cervical Spine

Policy Statement

The American Osteopathic Association, in the hopes of advancing the science of osteopathic medicine adopts the following position:

These recommendations are provided for osteopathic educators and physicians making decisions regarding the instruction of cervical spinal manipulation and the care of patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by a patient's physician. Like all reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the understanding that continued research is needed.

AMERICAN OSTEOPATHIC ASSOCIATION OSTEOPATHIC MANIPULATIVE TREATMENT OF THE CERVICAL SPINE

Background and Statement of Issue

Treating chronic pain continues to be an important health issue for osteopathic physicians. ~~Chronic pain affects over **50**-100 million Americans over the age of 18~~

~~and negatively impacts their quality of life.[1]~~ **GLOBALLY, IN 2020, NECK PAIN AFFECTED 203 MILLION PEOPLE.** ~~In addition, it costs $600 billion a year in healthcare costs and loss of productivity.[1]~~ **AS OF 2016, LOW BACK AND NECK PAIN HAD THE HIGHEST AMOUNT OF HEALTH CARE SPENDING IN THE U.S. WITH AN ESTIMATED $134.5 BILLION IN SPENDING**. Back and neck pain are two leading causes of chronic pain and they are amongst the leading causes of people living with disabilities in the United States (U.S.) as well as worldwide. More specifically, back and neck pain are ranked in the top 8 diseases and injuries in the U.S. regarding years lived with disability (YLDs) and in the top 6 globally.[2,3] Cervical spine manipulation is one option for treating back and neck pain.

Concerns continue to arise regarding the safety of cervical spine manipulation. Specifically, concerns center on the potential development of serious adverse events such as stroke and cervical artery dissection after spinal manipulation. Since spinal manipulation is an option available to osteopathic physicians to incorporate into the care of their patients, it is important to examine these concerns and develop a position on the issue. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harms, and make a recommendation about its use.

Benefit

Spinal manipulation has been reviewed in various systematic reviews and meta-analyses over the past three decades. The majority of the studies conducted on spinal manipulation focus on low back pain for which the evidence has shown spinal manipulation has clear benefits.[4-8] For neck pain, however, there are fewer studies and the findings vary, but there is ~~some~~ evidence ~~that conclude~~ **CONCLUDING THAT** spinal manipulation benefit~~s~~ patients **WHO** present~~ing~~ with neck pain.[9-14] This evidence indicates that the benefits of spinal manipulation include relief of acute neck pain, and reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care.[14-18] Bronfort et al specifically concluded that for patients with chronic neck pain, there is moderate evidence that (1) manipulation and mobilization are superior to general practitioner management in the short term, (2) high-technology exercise results in more pain improvement than manipulation in the long term for a mix of patients with acute and chronic pain, and (3) mobilization is superior to physical therapy and general medical care and similar to manipulation in both the short and long term.[16]

Benefits of spinal manipulation for areas beyond the low back and neck include short-term relief from tension-type headaches, **TEMPOROMANDIBULAR JOINT DISORDERS AND SHOULDER PAIN**.[8,15,19] **ADDITIONALLY**, ~~M~~manipulation ~~relieves~~ **FOR** cervicogenic headache ~~and~~ is comparable to commonly used first line ~~prophylactic~~ **PREVENTATIVE** prescription medications for tension-type headache and migraine.[16]

RISK ~~Harm~~

~~Overall~~

The literature presents varying conclusions on the harms of spinal manipulative treatment (SMT).[6,7] In a 2017 review of risks associated with spinal manipulation, 46% percent of the studies reviewed found spinal manipulation to be safe, 42% percent were neutral (did not find harm/benefit); and the remaining 12% percent concluded that spinal manipulation was unsafe because of the possibility of serious adverse events.[7] Nevertheless, the existence of any adverse effect should not be trivialized.

Studies have noted that there are two types of adverse effects as a result of SMT. The first type ~~is~~ ARE considered ~~to be~~ mild adverse events that are short-term and non-serious such as dizziness, fatigue, and muscle soreness/ discomfort.[7,20] **WHEN PRESENT** ~~T~~these side effects occur in 23-83% of patients. The second type of adverse events is more serious and includes cervical artery dissection, stroke, spinal cord injuries, and other serious conditions outcomes related to vertebrobasilar accidents (VBAs). Currently, much of the literature discusses vertebrobasilar insufficiency or vertebrobasilar ischemia (VBI) which is a type of VBA and is often determined to be the link to the more serious adverse events. Nonetheless, serious adverse events are seen as a rarity, and it is estimated that they occur in the range of **ONE IN** every 20,000 to 250,000,000 manipulation**S** performed.[7,13,20-28]

Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low Amplitude (HVLA) types of manipulative treatment.[20,26] Unfortunately, many of the reported cases do not distinguish the type of manipulative treatment provided.

VERTEBROBASILAR ACCIDENTS ~~VBAs~~

VERTEBROBASILAR ACCIDENTS (VBA) account for 1.3 in 1000 cases of stroke, making them a rare event. Approximately 5% of patients with a VBA die as a result, while 75% have a good functional recovery.[29] The most common risk factors for VBAs are migraine, hypertension, oral contraceptive use and smoking.[30] Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for a VBA.[31] **THE MORE RISK FACTORS THAT AN INDIVIDUAL HAS, THE MORE LIKELY THEY ARE TO SUSTAIN A VBA.[32]**

The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.[15] A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.[33]

A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine manipulation was unpredictable.[25] The authors, however, concluded that a VBA following cervical spine manipulation was “idiosyncratic and rare”. Further review of the data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.[34]

Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for a VBA.[15] “Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises.”[25] In some cases manipulation may not be the primary culprit for causing the dissection, but an aggravating factor or coincidental event.[34]

It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. Fifty-one percent (51%) involved rotation, with the remaining 49% representing a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.[34]

Cervical Artery Dissection (CAD)

CAD occurs at a rate of 2.9 per 100,000 individuals every year in the general population, and a large majority (89%) of the individuals diagnosed with CAD have no symptoms or no significant disability that prohibits them from being productive within the following three months of the event.[32] Among those with symptoms, headaches and neck pain are the predominant symptoms for CAD. This creates a dilemma for physicians because cervical spine manipulation is often sought to treat these medical issues. Thus, it is difficult to determine if manipulation causes CAD or if CAD existed at the time of treatment.

Limitations of Studies and Concerns with Pre-manipulation Screening

Due to the design of studies (case reports or retrospective surveys), infrequent reporting of adverse events, and the rare occurrence of many of the more serious complications, it is difficult to determine a causal relationship between SMT and the serious adverse effect.[7,32] Thus the lingering question of whether or not pre-existing pathologies may have existed prior to the patient receiving SMT remains.[20,27,35]

In Malone et al., the authors reported that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation.[27] This report describes complications such as radiculopathy, myelopathy, and vertebral

artery compression by a lateral cervical disc herniation. The incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation.[27,36]

Another noteworthy point to highlight is that the literature does not clearly distinguish the type of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with serious adverse effects. This information may help to understand the mechanism of injury leading to serious adverse effects, as there are differences in education and practice among the various professions that utilize this type of treatment. It is duly noted that the osteopathic approach strictly limits the “thrust”, which is more commonly referred to as “impulse” in osteopathic practicums, to the physiologic barrier as opposed to the chiropractic approach may extend to the paraphysiologic space.

Additionally, pre-manipulation screening tools, that might be used to identify a patient’s risk for VBA and cervical artery dissection have been widely criticized because they have been found to be unreliable and difficult to validate.[29,30,37-44] These studies have examined the **WALLENBERG AND** DeKleyn’s test and others like it and determined the tests are unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery.[37-45] **THERE IS ACKNOWLEDGEMENT THAT FURTHER RESEARCH SHOULD BE COMPLETED TO ASSESS THE RELIABILITY OF THESE TESTS FOR VALIDITY.[45]** For this reason, researchers and groups such as the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders recommend that all health care providers conduct a thorough patient history, physical examination and patient self-assessment to rule out certain pre-existing conditions.[14,46]

Alternative Treatments

PHARMACOLOGIC

Non-steroidal anti-inflammatory drugs (NSAIDs)

NSAIDS such as ibuprofen and aspirin are the ~~most commonly prescribed~~ **FIRST LINE** medications for neck pain. More than 30 million people worldwide use NSAIDs regularly.[47] In fact, 5% of all medical visit outcomes in the U.S. include a prescription for NSAIDS.[48] NSAIDs offer temporary relief, but long-term use, gender, age, strength of dose as well as consumption of multiple medications simultaneously may be associated with serious risks affecting the gastrointestinal (GI), renal and cardiovascular systems.[49,50] Eighty-one percent (81%) of GI bleeds related to NSAID use occur without prior symptoms.[51] Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications.[31] The annual cost of GI tract complications in the U.S. is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year therein making GI toxicity from NSAIDs the 15th most common cause of death in the United States.[51-53] **SECOND**

LINE PHARMACOLOGIC INTERVENTION INCLUDES THE USE OF A SHORT COURSE OF MUSCLE RELAXERS SUCH AS CYCLOBENZAPRINE OR TIZANIDINE.[54] NERVOUS SYSTEM INTERACTIONS INCLUDING SEDATION AND DIZZINESS MAY BE ASSOCIATED WITH THE USE OF THESE MEDICATIONS. ADDITIONALLY, THERE ARE MANY DRUG-DRUG INTERACTIONS AND HEPATIC/RENAL FUNCTION SHOULD BE CONSIDERED WHEN PRESCRIBING.[55]

INTERVENTIONAL ~~Epidural steroid injections~~

TRIGGER POINTS ARE DEFINED AS "DISCRETE, FOCAL, HYPERIRRITABLE SPOTS" WHICH ARE OFTEN TREATED WITH THE USE OF POINT INJECTIONS (TPIS). THE LITERATURE INDICATES THAT THE USE OF TRIGGER POINT INJECTIONS IS ASSOCIATED WITH DECREASED SUBJECTIVE PAIN INTENSITY AND IMPROVED RANGE OF MOTION FOR NECK PAIN SUFFERERS. OFTEN LOCAL ANESTHETIC MEDICATIONS ARE USED FOR TPIS WHICH ARE COMPOSED OF ONE LONG AND ONE SHORT ACTING ANESTHETIC. TRIGGER POINT INJECTIONS ARE NOT INTENDED FOR LONG TERM USE. SOME OF THE IMMEDIATE COMPLICATIONS INCLUDE VASOVAGAL SYNCOPE, INFECTION AT THE INJECTION SITE, PNEUMOTHORAX, NEEDLE BREAKAGE, HEMATOMA FORMATION AND DAMAGE TO SURROUNDING STRUCTURES.[56] MORE SERIOUS COMPLICATIONS INCLUDE ACCIDENTAL INTRAVASCULAR INJECTION OF THE TPI WHICH HAVE A THEORETICAL RISK OF CARDIOVASCULAR AND NEUROTOXICITY. NERVE BLOCKS HAVE AN INCIDENCE OF INTRAVASCULAR NEEDLE ENTRANCE BETWEEN 14-23% OF THE TIME.[57]

Epidural steroid injections (ESIs) are a popular treatment for neck pain.[52] Complications **FROM** ~~to~~ ESIs generally occur because of needle placement or drug administration. Common risks associated with needle placement include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of procedures, intrathecal injection occurs in ~ 0.6-10.9% of procedures, and intravascular injection, the most significant risk, occurs in ~ 2% of procedures.[53] Other risks include cervical epidural abscess, dural puncture, spinal cord trauma, infection, hematoma, nerve damage, vascular injury and cerebral vascular or pulmonary embolus.[58,59] Complications that may arise from drug administration include osteoporosis, Cushing's syndrome, avascular necrosis of bone, and steroid myopathy. While complications due to needle placement or administration of steroids are rare, they have been reported in the literature.[58,59]

Conclusion

Osteopathic manipulative treatment of the cervical spine, including but not limited to HVLA treatment, is effective for low back and neck pain and is safe. Because of the rarity of serious adverse events, trainees and practicing physicians should be

provided with sufficient information so they are advised of the potential risks and able to communicate the potential risks to their patients. Prior to recommending cervical spine manipulations, physicians should conduct a thorough patient exam and medical history review to try to identify any preexisting conditions that may indicate the patient is at risk for a serious adverse event. **KNOWLEDGE OF ABSOLUTE AND RELATIVE CONTRAINDICATIONS IS IMPORTANT TO AVOID COMPLICATIONS ASSOCIATED WITH CERVICAL MANIPULATION, TESTING FOR VERTEBRAL ARTERY INSUFFICIENCY IN HIGHER RISK PATIENTS COULD BE CONSIDERED AS WELL.** Additionally, it is recognized that there is a need for research to distinguish the risk of VBA and CAD associated with manipulation done by specific provider types as well as research to determine the nature of the relationship between the different types of manipulative treatment and VBA and CAD.

It is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including HVLA, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients. Physicians should use a combination of medical history reviews and physical exams, diagnostic studies, and best judgment to determine if a patient has any pre-existing conditions that place the patient at risk of suffering a serious adverse event.

~~Special Acknowledgements~~

~~In crafting the updated Position Statement, the Bureau of Osteopathic would like to thank the Osteopathic Manipulation Medicine and Osteopathic Manipulative Treatment (OMM/OMT) Research Task Force for its input, and a special thank you to Hollis King, DO, PhD, who served as an outside contributor.~~

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(IF APPROVED AS AMENDED, APPLIES TO LINES 28-29) GBD 2021 NECK PAIN COLLABORATORS. GLOBAL, REGIONAL, AND NATIONAL BURDEN OF NECK PAIN, 1990-2020, AND PROJECTIONS TO 2050: A SYSTEMATIC ANALYSIS OF GLOBAL BURDEN OF DISEASE STUDY 2021. THE LANCET RHEUMATOLOGY. 19 MARCH 2024. DOI: 10.1016/S2665-9913(23)00321-1.

ADDITIONAL CITATION ADDED (SEE PAGE 12)

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS – OSTEOPATHIC PHYSICIAN – SOURCE: H333-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association supports participation in patient satisfaction
7 surveys without ~~minimal~~ impact on physician payment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; Reaffirmed as Amended 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ____July 20, 2024_____

SUBJECT: ADMINISTRATIVE FEES – SOURCE: H321-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) has determined that it is ethical for an
7 osteopathic physician to charge patients fair and reasonable administrative fees as
8 long as the patient is informed of these fees in advance, and the charging of
9 administrative fees does not violate contractual or state law.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: AVAILABILITY OF BIOSIMILAR PRODUCTS – SOURCE: H334-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) ~~supports~~ **ADVOCATES FOR** policies that strengthen the biosimilar market **AND ENABLE PATIENTS TO ACCESS POTENTIALLY MORE AFFORDABLE THERAPIES** while preserving the physician-patient relationship and protecting patient safety~~.; and, that~~ **POLICIES IMPROVING ACCESS TO BIOSIMILARS SHOULD**:

1) FOSTER GREATER COMPETITION AMONG PRESCRIPTION PRODUCTS

2) SUPPORT REDUCED CO-INSURANCE OR COST SHARING BY THE PATIENT

3) ENSURE THAT PATIENTS ARE ABLE TO ACCESS EITHER A REFERENCE BIOLOGIC OR (INTERCHANGEABLE AND/OR NONINTERCHANGEABLE) BIOSIMILAR BASED ON THE DECISION MADE BETWEEN THE PHYSICIAN AND PATIENT, AND THAT PAYORS COVER MORE THAN ONE PRODUCT WHEN AVAILABLE; AND

4) ENSURE THAT PHYSICIANS MAINTAIN AUTONOMY TO DESIGNATE WHICH PRODUCT IS DISPENSED, AND PREVENT SUBSTITUTIONS WHEN SUBSTITUTION IS RESTRICTED BY THE PHYSICIAN

~~FDA approved drugs should be accessible to patients, and, that the decision on which biologic or biosimilar should be used rest with the patient and the physician.; and, that the AOA supports payor coverage of all FDA approved biologics and biosimilars to enhance patient access and choice~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: MEDICARE - PRESCRIPTION ASSISTANCE FOR MEDICARE PATIENTS – SOURCE: H317-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) ~~supports~~ **ADVOCATES FOR POLICIES** ~~legislation to eliminate the coverage gap (donut hole) in Medicare Part D and the~~ **THAT ENSURE THE AFFORDABILITY OF PRESCRIPTION DRUGS UNDER MEDICARE PART D AND OPPOSES** restrictions that limit patients from utilizing prescription discounts and vouchers.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2009; Reaffirmed 2014; Reaffirmed as Amended 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES – SOURCE: H359-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant but requires updating to reflect recent changes at the state level; now, therefore be it

RESOLVED, that the Council On State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

State Graduate Medical Education Funding Alternatives

Policy Statement

INTRODUCTION

The following ~~policy~~ **WHITE** paper and the recommendations provided within are approved to assist the American Osteopathic Association (AOA) in responding to policy proposals aimed at funding graduate medical education (GME) at the state-level; the AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within this paper.

WHITE PAPER—STATE GRADUATE MEDICAL EDUCATION FUNDING

BACKGROUND

Physician training requires students to attend four years of medical school, usually paying those costs out-of-pocket or through loans. Following successful completion of medical school, their training continues as medical residents. Medical residents see and treat patients under the supervision of more experienced physicians. This training usually takes place in hospitals though residents often rotate to ambulatory sites such as clinics and physician offices. On average, this residency training takes four years to complete, although highly specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues.[1] However, the federal government is currently the largest single funder of GME, providing approximately $1**6**~~5~~.**2**~~9~~ billion in funding through the Centers for Medicare and Medicaid Services (CMS) in 20**20**~~18~~.[2] ~~Nearly two-thirds of this funding comes from Medicare, with the majority of the remainder funded through medicaid.[3]~~ Additional fund**S**~~ing~~ ~~is~~**ARE** provided by the Department of Defense, the Department of Veterans Affairs and the **HEALTH RESOURCES AND SERVICES ADMINISTRATION**~~U.S. Public Health Service~~.[~~4~~**3**] In providing Medicare funding, **CONGRESS HAS ACKNOWLEDGED THAT TRAINING PHYSICIANS IS A PUBLIC GOOD. DESPITE THAT ACKNOWLEDGEMENT, AND PASSAGE OF FEDERAL LEGISLATION IN 2020 TO SUPPORT 1,000 ADDITIONAL GME SLOTS, FEDERAL SPENDING CONTINUES TO FALL SHORT OF THE AMOUNT NEEDED TO ADEQUATELY ADDRESS A NATIONWIDE PHYSICIAN SHORTAGE THAT IS PROJECTED TO REACH UP TO 139,000 BY 2033.[4] THIS PAPER CONSIDERS ALTERNATIVE FUNDING MECHANISMS THAT STATES CAN IMPLEMENT TO HELP FILL THE PROJECTED GAP IN THE PHYSICIAN WORKFORCE.** ~~there have been periodic calls to remove GME from Medicare and Medicaid and secure other sources of funding. So far, Congress has neither acted on these recommendations nor have other entities stepped up to assume a greater share of the financial responsibility (relative to Medicare or Medicaid) for physician training.~~

~~With CAPS on the federal budget, GME funding has been and will continue to be relatively flat. additionally, the Trump Administration has supported both consolidation and reduction of GME funding as part of a comprehensive approach to reducing overall federal spending.[5] Additionally, in December 2018, the congressional budget office issued recommendations to consolidate and reduce federal payments for GME at teaching hospitals.[6] Conversely, medical schools, hospitals and medical associations see a need to increase funding and residency slots to help train physicians and fill projected workforce shortages and are working at both the state and federal levels to achieve increased funding for GME.~~

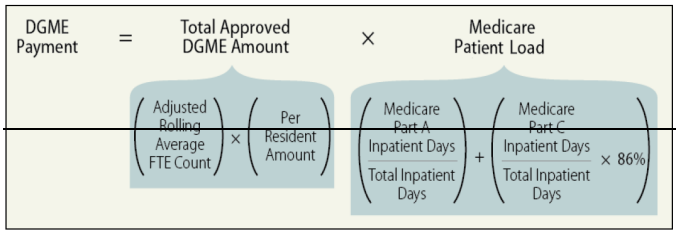
There are two mechanisms through which Medicare and Medicaid distribute GME funding: Direct Medical Education (DME) and Indirect Medical Education (IME) payments. DME payments are based on resident salaries, supervision and other educational costs. IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest obstacles to federal GME funding is the Balanced Budget Act of 1997 which limited the number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME payment.[**5**] The law also reduced the IME multiplier over a four-year period, however, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 delayed the IME reduction. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments which took effect on April 1, 2013.[~~7~~**6**]

MEDICARE

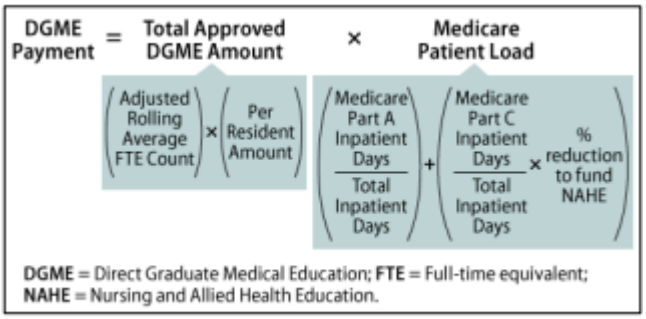
The formula for determining Medicare payments to hospitals for direct costs of approved GME programs is established in section 1886(h) of the Social Security Act.[~~9~~**7**] A DME payment is determined by multiplying a hospital-specific, base-period per resident amount by the weighted number of full-time equivalent residents working in all areas of the hospital

and the hospital's Medicare share of total inpatient days.[~~10~~8] The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to count residents training in non-hospital settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time residents spend in that setting.[~~11~~9]

Figure 1. Medicare DGME Payment Formula



Source: CRS analysis of Title XVIII of the Social Security Act (SSA) and relevant regulations.
Note: The adjusted rolling average FTE count is subject to the GME cap.



Source: CRS analysis of 42 U.S.C. §1395ww(h)(3) and 42 C.F.R. §413.75-88.

As previously mentioned, IME payments are based on additional operating costs of a GME program. The factors for IME payment generally include sicker/more complex patients, maintaining stand-by capacity for certain specialized services (e.g., burn units), residents ordering more tests and trainees being less efficient in providing care. IME payments provide for the legitimate increase in costs training hospitals incur.[~~12~~10] IME payments are calculated by adding the individual intern/resident-to-bed ratio into a formula already established in the Medicare statute. The current IME adjustment is calculated using a multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately 5.5% in Medicare payments for every 10-resident increase per 100 beds.[11]

MEDICAID

~~Despite federal law not requiring state Medicaid programs to support GME,~~ **AFTER MEDICARE,** Medicaid is the second largest funder of GME programs. A majority of states have implemented mechanisms within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME funding is structured similarly to Medicare, providing direct and indirect payments. The most recent data available estimates that Medicaid paid Approximately $**7.39**~~4.3~~ billion to GME programs in 20**22**~~15~~, up from $3.87 in 2012.[~~13, 14~~12] ~~Despite the fact that much of that funding came from matching federal payments, three states reported that they explicitly reduced their Medicaid spending on GME, and another seven reported at least a ten percent reduction in Medicaid GME payments between 2012 and 2015.~~[~~15~~]

In 20**22**~~05~~, ~~47~~ **44** states provided **AN ADDITIONAL** $**7.39**~~18~~ billion through Medicaid to support GME.[13~~6~~ ~~18, 19~~] **OF THOSE STATES, TWENTY-FOUR ACKNOWLEDGED AND FUNDED BOTH DME AND IME COSTS, ELEVEN ONLY ACKNOWLEDGED AND FUNDED DME COSTS AND TEN DID NOT DIFFERENTIATE BETWEEN DME AND IME COSTS IN SOME OR ALL OF THEIR MEDICAID GME PAYMENTS.**[14]

Medicaid Fee-for-Service

Forty-**ONE** states and the District of Columbia make DME and/or IME payments under the Medicaid fee-for-service program.[15] A fee-for-service program is a payment model where services are unbundled and paid for separately.[16][20] ~~Fourteen~~**SIXTEEN** states and DC fund DME and/or IME programs using a calculation method similar to Medicare's GME funding formula, sometimes in addition to other methods which usually include variations of a per-resident or lump-sum amount. The per-resident or lump-sum amounts are based on the "hospital's share of total Medicaid revenues, costs or patient volumes." ~~Twenty-nine~~**TEN** states reported calculating payments ~~solely~~ by **A DIFFERENT METHOD**.[17] ~~"some other method" in 2015.~~[21]

Medicaid Managed Care

Capitated managed care is a state's use of risk-based capitation payments within their Medicaid program. This typically includes contracting with one or multiple managed care organizations (MCOs) to administer the Medicaid program for a defined population of Medicaid patients.[18][22] Thirty-nine states and DC use capitated Medicaid managed care programs.

Sixteen states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments. [19][23] This represents an increase in the number of states who have made direct payments under managed care since 2012.[20][24] States who make direct Medicaid payments indicate that they wish to help train future physicians who will service Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state health policy goals.

Twelve states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations, and **THREE STATES USE BOTH FORMS OF DISTRIBUTION**.[21] ~~Half of these states – Iowa, Kansas, Kentucky, Michigan, Minnesota, and Mississippi – require MCOs to distribute the negotiated payments to teaching hospitals. The other six assume MCOs will distribute the payments.~~[25]

ALIGNING GME FUNDING WITH HEALTH POLICY PRIORITIES

SOME S~~s~~tates continue to look to align GME funding with other health policy goals. This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians.[22] ~~A 2016 study revealed that thirty-two states linked Medicaid GME payments to a state policy goal of increasing the size of the physician workforce, compared to 22 states in 2012.~~[26]

Florida and Kansas

FLORIDA AND KANSAS ARE TWO EXAMPLES OF STATES THAT LINK MEDICAID GME PAYMENTS TO STATED POLICY GOALS,~~. I~~in an effort to promote accountability in the use of GME funds.~~, Florida and Kansas link Medicaid GME payments to stated state~~

~~policy goals. In Florida~~ **T**~~t~~his applies to both **THEIR** fee-for-service (FFS) and managed care Medicaid programs, ~~while Kansas focuses solely on FFS payments.[27] Like most states, Florida and Kansas have~~ **AND** focuse**S**~~d~~ on encouraging training in primary care specialties and increasing access to care in rural and medically underserved areas.[23]

Kansas also uses GME payments to **FUND TEACHING HOSPITALS AS WELL AS TEACHING SITES IN NON-HOSPITAL SETTINGS, AND** promote an increased supply of physicians serving the Medicaid population~~., and funds teaching hospitals as well as teaching sites in non-hospital settings~~. In Florida, GME payments have been extended to individual teaching physicians under FFS. The State also uses alternative sources to fund residency programs in addition to Medicaid and Medicare, including the statewide Medicaid residency program and the graduate medical education startup bonus program.[24~~8~~] The former was created in 2013 with $80 million in recurring state and matching federal funds to support payments to hospitals with accredited residency programs, while the latter was created in 2015 with $100 million allocated to educating and training physicians in specialties which are in a statewide deficit. In 20**22**~~18~~, the Florida legislature appropriated $2**91.64**~~2.3~~ million to these programs. [25~~9~~]

Texas

In 2014, the Texas legislature allocated $12 million to several initiatives which together created 100 new residency positions across nine new primary care and two non-primary care programs.[26~~30~~] In 2015, the legislature consolidated these initiatives into a single GME expansion program, to which it appropriated $49.5 **MILLION** biennially. **THIS FUNDING HAS ENABLED THE ESTABLISHMENT OF 472 ADDITIONAL FIRST-YEAR RESIDENCY POSITIONS BETWEEN 2014 AND 2021**.[27] ~~This~~ **FUNDING FOR THE GME EXPANSION PROGRAM WAS FURTHER EXTENDED DURING THE 2022-2023 FISCAL YEAR, WITH A BIENNIAL ALLOCATION OF $199.1 MILLION.**[28, 29] ~~resulted in an increase in per-resident funding from $65,000 to $75,000 per year and the creation of 130 new residency positions in 2016-2017.[31]~~

Since 2009, the Texas Health and Human Services Commission (HHSC) has also provided supplemental funding to five state-owned teaching hospitals for approved medical residency training programs. The HHSC reimburses each hospital directly using a calculation that is based upon the hospital's self-reported Medicaid inpatient days and resident full-time equivalents. HHSC also separately provides IME payments to teaching hospitals to offset their higher patient care costs relative to non-teaching hospitals, including costs related to supervising and maintaining resident records.[30~~3~~]

~~These increases follow years of cuts to GME funding, including a 50% cut in 2012-2013, which led to the elimination of the Texas higher education coordinating board (THECB) primary care residency program and the THECB GME program in 2019.~~

~~*Utah*~~

~~In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state's physician shortage and coordinate GME funding that would be better aligned with the state's workforce needs.[31] UMEC is a quasi-governmental body whose responsibilities~~

~~include assessing the physician workforce demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician shortages in rural locations and managing the GME funds from CMS.~~

~~To better address the state's GME funding needs, Utah applied for, and was granted, a CMS waiver that placed GME funding into a funding pool, rather than directing money to hospitals.[32] By pooling all of the state's GME funding, UMEC was able to distribute the funds directly to hospitals and programs based on specific workforce needs and objectives.[34] The waiver resulted in a 29% increase between 1997 and 2007, from 442 residents in 25 programs to 568 residents in 30 programs.[35] But ultimately ended on June 30, 2010.[36] According to UMEC'S most recent (2016) report, the state has averaged 202 residents per year between 2006 – 2016, representing an apparent decline from levels under the waiver.[37]~~

ADDITIONAL GME FUNDING MODELS

There are several other GME funding models that have the potential to provide revenue for GME programs. These models differ based on who would receive payment, how funds would be allocated among recipients, what mechanisms would be needed to assure accountability and whether payment would be linked to the achievement of specific performance measures. These models are not mutually exclusive and could be combined to enhance stability and accommodate GME policy objectives. In some cases, a combination of several models would be necessary to pay for different kinds of costs to address specific educational or workforce objectives.

All-Payor System

Several states have experimented with variations on an all-payor system, which combines funding from all public and private sources to pay for state GME programs, but only Maryland's is currently operational. ~~Although private payors rarely finance GME directly, the higher rates that they pay to teaching institutions help to subsidize GME programs~~.

Maryland implemented their all-payor system in 1977. [31~~8~~] ~~Prior to~~ **BEFORE** 2014, the state used a prospective, diagnosis-based payment model, which kept the rate of increased spending per admission below the national rate, although it was less successful at containing overall hospital spending due to increased admission rates. [32~~9~~] Since 2014, Maryland has used a payment model that requires each hospital to monitor both the number and cost of admissions. Payment rates are established by the quasi-governmental Health Services Cost Review Commission, and all payors must pay a given hospital the same rate for the same service, but each hospital negotiates its own rates. [33~~40~~] Maryland has built costs associated with GME funding, as well as surcharges to support an "uncompensated care pool" and a public plan for residents with chronic health conditions, into its rate-setting system.[34~~41~~] Maryland also has a Medicare waiver that allows it to set Medicare payment rates. Historically, Maryland had to keep its Medicare costs below national growth for hospital payments per admission in order to maintain its waiver, but the test under the current waiver focuses on the per capita growth in hospital spending.[35~~42~~]

IN ADDITION, New York previously operated an all-payor system that levied a "covered lives assessment" tax on private health insurers based upon member fees by region and type of insurance. [36~~43~~] The moneies collected went into two pools, one that subsidized care for individuals who were unable to pay and another that funded GME. In the late 2000s, however, the GME funding pool was reallocated toward uncompensated care in teaching hospitals, and other "high priority" items. [37~~44~~]

Health Care Provider Model

Medicare pays for GME through a health care provider model. This approach links payments for clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital's patient care costs, this model is particularly appropriate for IME payment.

Several variants of this model have been proposed to encourage more training in nonhospital settings. These variants include a direct pay approach whereby payment would follow the resident training in a nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the entities or a fixed allocation developed in accordance with national cost data; or payment to the entity that bears substantially of the costs of the nonhospital rotations. The first two variants would create substantial administrative burdens. Although less burdensome and disruptive, the third option appears less likely to achieve its stated goal. A voucher or "set-aside" system also could be established whereby a specified share of payment for direct training costs would be earmarked for nonhospital settings.

The principle advantage of the provider model is that regulatory, cost reporting, auditing and compliance mechanisms already are in place and well established. To this extent, these mechanisms have created persistent problems, which is also a disadvantage. This model also fails to provide financial support for training that occurs outside of patient care settings (e.g., much of the training in preventative medicine).

Education Model

Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing education and/or health care services (e.g., a health department, public health agency, organized health care delivery system or hospital system.) Because this model treats direct GME costs as costs of education not patient care, adherents suggest that greater weight will be placed on educational needs as training decisions are made. In return for payment, the program sponsor (or its designees) would assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME costs and payments would be established through written agreements between the sponsor and clinical training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME payment.

The principle advantage of this approach is its focus on education. Unfortunately, it also would require a major shift in program accountability and funding, particularly when

265 training occurs in community teaching hospitals rather than academic medical centers,
266 where medical schools and hospitals are linked through common ownership or other
267 longstanding corporate or strategic ties. This approach could also discourage hospitals
268 from maintaining or starting GME programs.

269 As a variant to this model, vouchers could be given directly to residents so that they could
270 purchase their own GME. Unlike the vouchers mentioned in conjunction with the provider
271 model, these vouchers would permit residents to control funding for their graduate training,
272 allowing monies to flow to all training sites. In theory, this approach would enhance
273 competition among GME programs. It is not clear, however, how much effect it would have
274 because programs already compete for residents and rotation sites.

275 Besides the disadvantages mentioned above, this approach would require a new
276 regulatory mechanism for determining which residents qualify for funding and how many
277 positions would be funded. It also fails to address national physician workforce needs or to
278 assure that adequate resources are available in needed specialties and geographic areas.
279 Implementing this approach could result in substantial year-to-year fluctuations in program
280 size, undermining the stability of existing programs and making faculty and resource
281 allocations difficult. Residents could also be hard pressed to hold their programs
282 accountable once training decisions are made.

283 *Planning Model*

284 Under this approach, funding would be channeled through planning or coordinating bodies
285 such as GME consortia, state GME, physician workforce commissions or task forces. The
286 primary function of these bodies would be to assess the health care needs of their
287 communities and to allocate funds based on local workforce considerations.

288 Because this approach ties training and funding decisions to local health care needs, it
289 could provide the states, payers and consumers a stronger role in allocating funds to meet
290 workforce objectives. According to the Council on Graduate Medical Education, however,
291 existing evidence tends to suggest that reliance on consortia to assume such a role may
292 be premature. Adopting this model would also require development of a new regulatory
293 mechanism to assure accountability. Payment to state entities or consortia provides little
294 incentive to nonteaching hospitals to initiate new GME programs.

295 *Performance Model*

296 This model links payment to the achievement of specific performance measures or
297 objectives. Funding could also be used to support specific projects or demonstrations on
298 infrastructure development or particular workforce goals.

299 While this approach encourages innovation and quality enhancement, it is more suitable
300 as a supplemental funding mechanism than as a primary source of GME payment. This
301 model is also dependent on well-defined quality measures and workforce priorities. Neither
302 may be sufficiently well developed to support all GME funding decisions at this time. This
303 approach could also result in substantial year-to-year fluctuation in payments if all funding
304 decisions are based on meeting specific performance measures.

CONCLUSION

With federal and state ~~budgets~~**POLICYMAKERS** look**ING** to cut spending, GME programs are particularly vulnerable. ~~AOA policy, "affirms its support for maintaining and enhancing the quality of teaching programs."~~[44] As states address shortfalls in federal GME funding, the AOA encourages all viable models to be examined. While all-payor systems have proven effective in some states, each state is different and may require its own unique GME funding system. Additionally, as states and the federal government implement health insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to fund GME. This will help address concerns related to workforce shortages as the covered population grows.

AOA POLICY STATEMENTS

1. The AOA supports states creation of alternative GME funding mechanisms and the alignment of this funding with their states health care priorities. Most important, within these priorities are training those specialties with the largest workforce shortages and providing care to those residents in the greatest needs (those in rural and underserved areas).

2. The AOA believes that state GME funding must account for osteopathic programs that incorporate the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

3. The AOA believes that state GME funding should focus on programs that address comprehensive health care systems that deliver care through a variety of settings. This includes training residents in hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs should also provide training in advancing technologies within the delivery of care.

4. The AOA believes that state GME funding should emphasize the importance of both basic and clinical research in an effort to advance the practice of medicine and the care patients receive.

5. The AOA supports the physician-led, team-based model of care. The AOA believes that state GME funding should promote this model of care by promoting interprofessional education, so that physicians can not only learn to lead the health care team, but also better understand the skills and abilities each member brings to that team.

6. Finally, this policy is intended to complement AOA Policy, ~~H329-A/2016~~ Graduate Medical Education Funding and Incentives -Source: H218-A/21, and the AOA should continue to support the osteopathic community in its efforts to increase GME funding

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic:
Access To Healthcare – Developing A New Model of Administering Osteopathic Primary Care Residencies In The United States - Source: H210 – A/21

Ambulatory-Based Primary Care Residency Programs - Source: H201 – A/22

Assure Graduate Medical Education Residency Positions to Graduates of U.S. Medical School - Source: H203 – A/19

Medical Postdoctoral Training Programs - Source: H202 – A/20

Graduate Medical Education Funding and Incentives - Source: H218 – A/21

Graduate Medical Education – Increasing Opportunities - Source: H201 – A/19

Graduate Medical Education – Training of U.S. Medical School Graduates - Source: H200 – A/20

Osteopathic Graduate Medical Education - Source: H618 – A/23

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: OFFICE BASED SURGERY – SOURCE: H360-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant but requires updating to reflect subsequent changes at the state level; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following be REAFFIRMED AS AMENDED.

WHITE PAPER – OFFICE-BASED SURGERY

INTRODUCTION

DUE TO ITS CONVENIENCE AND POTENTIAL FOR COST SAVINGS, OFFICE-BASED SURGERY IS AN ATTRACTIVE OPTION FOR PATIENTS; HOWEVER, REGULATORY STANDARDS AND OVERSIGHT VARIES BY STATE, LEADING TO CONCERNS OVER PATIENT SAFETY. FURTHER, THERE IS A LACK OF COMPREHENSIVE, STANDARDIZED GUIDELINES FOR STATES TO RELY UPON TO ENSURE THAT OFFICE-BASED SURGERY PRACTICES ARE SAFE. THE GOAL OF THIS WHITE PAPER IS TO PROVIDE DETAILED RECOMMENDATIONS ON PHYSICIAN QUALIFICATIONS, EQUIPMENT, EMERGENCY PROTOCOLS, AND REPORTING MECHANISMS THAT STATES CAN IMPLEMENT TO BENEFIT PATIENTS, BEYOND A SIMPLE POLICY STATEMENT IN SUPPORT OF OR OPPOSITION TO THE PRACTICE OF OFFICE-BASED SURGERY. THIS HELPS PHYSICIANS –INCLUDING OSTEOPATHIC PHYSICIANS – AND PATIENTS, BY ENSURING THAT OFFICE-BASED PROCEDURES REMAIN A SAFE AND CONVENIENT OPTION.

Background

~~A~~**THE** number of surgical procedures that were once only performed in hospitals or ambulatory surgery Centers (ASCs~~S~~) ~~can~~ **THAT ARE** now be**ING** performed in a physician's office **HAS GROWN TO 53% AS OF 2023[1]. ALTHOUGH THERE ARE NO OFFICIAL SAFETY STATISTICS MAINTAINED FOR PROCEDURES CONDUCTED IN OFFICE SETTINGS, VARIOUS STUDIES, SUCH AS A 2020 REPORT PUBLISHED IN THE JOURNAL OF VASCULAR SURGERY, INDICATE A CONSISTENTLY STRONG**

TRACK RECORD OF PATIENT SAFETY~~Of the 80 million outpatient surgeries performed in the US in 2009, the most recent year for which comprehensive data is available, it is estimated that over 12 million were performed in physicians' offices~~.[~~1~~**2**] Proponents of office-based surgery ~~assert~~**BELIEVE** that many procedures can be performed safely and effectively in a physician's office due to advances in technology, anesthesia, and laparoscopic techniques. In addition, many ~~argue~~**INDICATE** that office-based surgery is easier to schedule and more comfortable for patients than surgery performed in a hospital. Perhaps most significant, however, is the reported cost savings for office-based surgery compared to surgery performed in a hospital. One study reported that the average cost of an Unicompartmental Knee Arthroplasty done in an office setting was an average of $20,500 less than the average charge of $46,845 for the same procedure in the hospital.[2]

Despite these benefits, the practice of office-based surgery has been controversial due to the lack of ~~established~~**STANDARDIZED** rules and regulations **ACROSS STATES**. At the beginning of the 21st century, the fact that most states did not regulate office-based surgery led some observers to compare it to the "Wild West."[3] As of 20~~1~~4**23**,**45** ~~29~~ states had enacted rules, regulations or guidelines that specifically appl**Y**~~ied~~ to office-based surgery.[4] These regulations help to ensure that office-based surgery is conducted with appropriate equipment, adequately trained personnel and established patient safety standards. However, because this practice remains unregulated **OR UNDER-REGULATED** in ~~many~~**SOME** states, the concern that surgery performed in a physician's office may not be as safe as surgery performed in a hospital or licensed ASC persists.

While the media has reported a number of stories of tragic outcomes following office-based surgery, the actual rate of morbidity and mortality following **t**~~T~~hese procedures is hard to determine because adverse event reporting is **NOT** required in ~~less than half of~~ all states.[5]

According to a 2017 Florida report **(THE MOST RECENT YEAR FOR WHICH INFORMATION WAS AVAILABLE)** that compared risk-adjusted hospitalization rates following surgical procedures across physician offices, freestanding ASCS, and hospital outpatient departments in Florida, rates were generally higher for office-based procedures, especially more complex procedures. [6]

Although office-based surgery may be appropriate for many surgical patients, proper attention must be given to patient safety in order to minimize adverse events.

Need for Office-Based Surgery Rule Development

States have taken different approaches to the regulation of office-based surgery. A number of state medical boards have adopted guidelines or rules for physicians to follow when performing office-based procedures. A position statement issued by the North Carolina medical board on this issue contains recommendations on physician credentialing, emergencies, performance improvement, medical records, equipment and supplies, and personnel. Any failure to comply puts a physician at risk of disciplinary action by the board.[**7**]

In many states, office-based surgery centers are exempt from licensure requirements that apply to hospitals and ASCS because the procedures that they perform are considered to be relatively low-risk. Some states require centers to register with a state agency such as the department of health, while others do not require any general oversight, and surgical practitioners are regulated by state medical licensing boards in the normal course of their physician oversight duties.[8]

Classification of Office-Based Surgery

Office-based surgical procedures are usually classified based on the level of anesthesia used. Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and C.[9] While not uniform, these classifications are often referred to by state medical boards and state legislators; therefore, understanding the different levels is an important basis for a discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures performed under topical, local, or infiltration block anesthesia without preoperative sedation. Second, Level 2 surgical procedures are minor or major procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally, Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and require the support of bodily functions.[10]

Physicians and Staff in the Office-Based Surgical Facility

UNLIKE PROCEDURES THAT TAKE PLACE IN A HOSPITAL, WHERE CREDENTIALING REQUIREMENTS MEAN THAT PHYSICIANS WHO PERFORM SURGERIES ARE BOARD CERTIFIED OR OTHERWISE TRAINED TO DO SO, WITHOUT STATE ACTION, NO SUCH REQUIREMENTS EXIST IN THE OFFICE-BASED SETTING. ~~For example, a 2010 study found that nearly 40% of physicians offering liposuction in southern California had no specific surgical training.[11] Further, four deaths have been reported since 2013 at a single south Florida clinic where cosmetic surgery is performed by physicians who are not formally trained or board certified in plastic surgery.[12]~~ While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, ~~such~~ incidents **OF ADVERSE OUTCOMES RELATED TO A LACK OF SPECIALIZED TRAINING** may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

Equipment Required

Equipment used in office-based surgery must be kept in excellent working condition and replaced as necessary. The type of monitoring equipment required in office-based settings depends on the type of anesthesia used and individual patient needs. However, every facility must have emergency supplies immediately available, including emergency drugs and equipment appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

Transfer Agreement

Emergencies occasionally arise during surgery requiring patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a comprehensively outfitted and staffed facility located nearby should it be needed.

Adverse Incident Reporting

Adverse events that may occur in office-based surgical facilities include patient deaths, cardio-respiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes. Reporting of adverse incidents to an appropriate state entity is an important patient safety measure.

Regulation of Office-Based Surgery

Unlike hospitals and ambulatory surgery centers, not all office-based surgical facilities are subject to regulations on emergencies, fire, sanitation, drugs, staff, training, and unanticipated patient transfers. Common sense dictates that states should take steps to ensure that patients who undergo surgery in physicians' offices receive the same standard of care as patients in ambulatory surgery centers or hospitals.

~~Conclusion~~ AOA POLICY STATEMENTS

The practice of office-based surgery will likely **ONLY** continue to grow in the coming years. The following statements represent the AOA's position on the appropriate use of office-based surgery:

1. The AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery;

2. The AOA supports state licensing boards in surveying their licensees or researching the issue of office-based surgery regulation to determine if office-based surgery rule development is necessary;

3. The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as the Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC) or the AAAHC'S healthcare facilities accreditation program;

4. The AOA believes that surgery performed in a physician's office must be done by a physician or non-physician clinician qualified by education and training to perform that specific procedure with appropriate physician oversight;

5. The AOA believes that only health care providers who have completed the appropriate education and training should perform office surgical procedures;

6. The AOA believes that a physician must administer ~~the~~ anesthesia or if a non-physician clinician administers ~~the~~ anesthesia, a supervising physician must be physically present in the office-based surgical facility during the administration of anesthesia and remain physically available until the patient has fully recovered and has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until the patient is discharged;

7. The AOA believes office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer's specifications;

8. The AOA believes physicians and non-physician clinicians who perform office-based surgery shall be responsible for coordinating and ensuring appropriate care for patients who require emergent, unexpected postoperative transfer and/or hospitalization. Written protocols must be in place for timely transfer to an accredited hospital located within reasonable proximity to the office. Office personnel must be appropriately trained in emergency protocols in order to be able to respond when emergency or extended services are needed to protect the health or well-being of the patients;

9. The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure; and

10. The AOA supports the position that state medical licensing boards are the appropriate entity to create and implement regulations regarding office-based surgery. 2019

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS – SOURCE: H361-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association states that the examination of the National
8 Board of Osteopathic Medical Examiners must remain ~~as~~ the avenue for the
9 licensure of osteopathic physicians and supports a uniform pathway of licensing
10 osteopathic physicians through the mechanisms of the National Board of
11 Osteopathic Medical Examiners, to be effective after 12/31/19.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1991; 1993 Reaffirmed as Amended ; 1998 Reaffirmed; 2003 Reaffirmed; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
COMLEX And USMLE As Equal Licensing Examinations Among Residency Programs – Recognition Of - Source: H-231-A/19

Osteopathic Licensing - Source: H-213-A/22

Special Licensing Pathways For Physicians-Opposition To - Source: H-339-A/23

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS – SUPPORT FOR – SOURCE: H362-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the white paper remains relevant but requires updating to reflect subsequent changes at the state level; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following be REAFFIRMED AS AMENDED.

~~AOA POLICY PAPER~~:

WHITE PAPER – SAFE HAVEN NON-REPORTING PROTECTIONS FOR PHYSICIANS

INTRODUCTION

IN THE WAKE OF RISING BURNOUT RATES AMONG U.S. MEDICAL PROFESSIONALS—A PHENOMENON THAT HAS DIRE CONSEQUENCES FOR BOTH HEALTHCARE PROVIDERS AND THE PATIENTS THEY SERVE—THERE IS COMPELLING EVIDENCE THAT A SIGNIFICANT PROPORTION OF U.S. PHYSICIANS AND MEDICAL STUDENTS EXPERIENCE SYMPTOMS OF BURNOUT, COMPOUNDED BY THE STIGMA SURROUNDING MENTAL HEALTH AND SUBSTANCE USE TREATMENT. CONSEQUENTLY, THERE IS A CRITICAL DEMAND FOR POLICY REVISIONS THAT OFFER SUPPORT WITHOUT THE FEAR OF DISCIPLINARY ACTIONS OR PROFESSIONAL REPERCUSSIONS BY ADVOCATING FOR 'SAFE HAVEN NON-REPORTING' PROTECTIONS, WE AIM TO FOSTER AN ENVIRONMENT WHERE PHYSICIANS CAN SEEK NECESSARY TREATMENT CONFIDENTIALLY, THEREBY SAFEGUARDING THEIR WELL-BEING AND ENSURING THE CONTINUED PROVISION OF HIGH-QUALITY CARE TO THEIR PATIENTS. THROUGH DETAILED RECOMMENDATIONS, THIS PAPER INTENDS TO PAVE THE WAY FOR A MORE SUPPORTIVE, UNDERSTANDING, AND RESILIENT HEALTHCARE SYSTEM.

Background

Burnout among US medical students, residents and practicing physicians is a significant problem that negatively impacts medical professionals as well as the patients that they serve. **IN 2021, A RESEARCH STUDY FOUND THAT 62.8% OF U.S. PHYSICIANS**

EXHIBITED AT LEAST ONE SYMPTOM OF BURNOUT, UP FROM 38.2% IN 2020, 43.9% IN 2017, 54.4% IN 2014, AND 45.5% IN 2011.~~Physicians in the US report symptoms of burnout at nearly double the rate of other US workers after controlling for work hours and other factors, and between 2011 and 2014, this percentage increased by 9%.[1] Further~~**IN ADDITION, 54%** ~~twenty to forty percent~~ of medical students, interns and residents report**ED** experiencing symptoms of burnout.[2]

Burnout is characterized by a "wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression and suicidal ideation."[3] It has also been shown to negatively impact a physician's prescribing habits, test ordering, risk of malpractice suits, and whether patients adhere to their recommendations.[4] Although the aforementioned description does not explicitly reference substance use disorders, we will hereafter reference symptoms of burnout, mental health and substance use issues (and their treatment) interchangeably.

Even when resources are available to help physicians and students address symptoms of burnout; however, both groups report similar concerns about pursuing them. For purposes of this policy paper, we will focus on concerns regarding lack of confidentiality and possible disciplinary or discriminatory action by schools, employers, state medical licensing boards and other academic or professional entities.

~~**Report of the FSMB Workgroup on Physician Wellness and Burnout**~~ **FEDERATION OF STATE MEDICAL BOARDS' RECOMMENDATIONS**

IN 2016, t~~T~~he Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Wellness and Burnout (Workgroup) to study the issue of physician burnout and draft**ED** recommendations to help groups in the medical community better address this issue. The Workgroup found that although numerous resources exist to help medical students and physicians experiencing symptoms of burnout or impairment through academic institutions, medical licensing boards and state physician health programs, social and professional pressures make students and physicians reluctant to seek treatment or to report seeking it.[5] Both medical students and physicians cited fears that seeking help would result in documentation on academic or professional records which could lead to discrimination or denial of a medical license, and ultimately jeopardize their ability to practice medicine.

ALTHOUGH THE FSMB RECOMMENDATIONS CAME OUT IN 201~~6~~8, A 2023 MEDSCAPE REPORT FOUND THAT SOME ISSUES REMAIN, WITH FOUR IN 10 PHYSICIANS STATING THAT THEY AVOIDED SEEKING HELP FOR DEPRESSION OR BURNOUT DUE TO CONCERNS ABOUT THEIR EMPLOYERS OR STATE MEDICAL BOARDS FINDING OUT. ~~According to a poll conducted by the FSMB and the Medical Society of the State of New York, a state that does not currently include any questions about mental health or substance use on medical licensure applications, sixty-nine percent of physician respondents who were experiencing symptoms of burnout reported that they would be significantly less likely to seek treatment if they were required to report it on a licensing application or renewal.~~[6]

Further, despite evidence showing that a past history of mental health or substance use disorders does not reliably predict future risk to the public, **APPROXIMATELY ONE-QUARTER OF** state licensing applications still contain questions about applicants' histories with these issues. **AS OF OCTOBER 2023, 26 STATE MEDICAL BOARDS HAD REMOVED INTRUSIVE LANGUAGE FROM THEIR LICENSURE APPLICATIONS, and 11 STATES WERE IN THE PROCESS OF MAKING THESE CHANGES.[7] THIS SHIFT SIGNIFIES A GROWING RECOGNITION WITHIN THE MEDICAL COMMUNITY OF THE IMPORTANCE OF ADDRESSING MENTAL HEALTH CONCERNS WITHOUT STIGMA OR FEAR OF PROFESSIONAL REPERCUSSIONS; HOWEVER, ADDITIONAL ACTION IS NEEDED TO ENACT THESE CHANGES IN ALL 50 STATES.** ~~As of 2017, 43 states asked questions about both mental and physical health conditions on their medical licensing applications, but just 23 limited all questions to disorders causing functional impairment and only six limited them to current problems.[7]~~

~~Although a similar number of medical licensing boards asked about both mental and physical health, questions about the latter tended to be much more lenient and vague while questions about the former were much more specific and probing.[8] Boards were significantly more likely to ask if physicians had ever been diagnosed, treated or hospitalized for a mental health or substance use disorder than for a physical disorder, and unlike questions about physical disorders, the questions were not limited to just those conditions that might *currently* affect a physician's ability to practice.~~

~~Responses by medical licensing boards to disclosures made by physicians about their mental health were also unpredictable and varied greatly from state to state. Some boards asked for a doctor's note, others requested all medical records related to an applicant's history and treatment, others required applicants to appear before the board to defend their ability to practice medicine and still others required applicants to undergo ongoing monitoring or practice under a restricted license.~~

ALTHOUGH MEDICAL LICENSING BOARDS PREVIOUSLY ASKED ABOUT BOTH MENTAL AND PHYSICAL HEALTH, HISTORICAL PRACTICES SHOWED A DISPARITY IN THE SPECIFICITY AND INTENSITY OF QUESTIONS, WITH MENTAL HEALTH INQUIRIES BEING MORE PROBING. RECENT CHANGES ACROSS VARIOUS STATES NOW REFLECT A MORE BALANCED APPROACH, ENSURING QUESTIONS ARE LIMITED TO CONDITIONS THAT DIRECTLY IMPACT A PHYSICIAN'S ABILITY TO PRACTICE MEDICINE.

THE RESPONSE OF MEDICAL LICENSING BOARDS TO PHYSICIANS' DISCLOSURES OF MENTAL HEALTH ISSUES HAS ALSO EVOLVED, AIMING FOR A MORE SUPPORTIVE APPROACH. FORTY-SEVEN STATES NOW OFFER PHYSICIAN HEALTH PROGRAMS, WHICH TYPICALLY SERVE AS AN ALTERNATIVE TO DISCIPLINE IF A PHYSICIAN VOLUNTARILY DISCLOSES A MENTAL OR BEHAVIORAL HEALTH CONDITION AND REMAINS IN COMPLIANCE WITH A RECOMMENDED TREATMENT PLAN.[8] THESE CHANGES HIGHLIGHT A COMMITMENT TO REDUCING THE STIGMA AROUND MENTAL HEALTH AND SUPPORTING PHYSICIANS IN SEEKING CARE, THEREBY PROMOTING A HEALTHIER, SAFER ENVIRONMENT FOR PHYSICIANS AND THEIR PATIENTS.

In addition to the deterrent effect that questions from medical licensing boards regarding mental health appear to have on physicians' willingness to seek help when needed or report seeking it, courts have found that many such questions run afoul of the Americans with Disabilities Act (ADA). The ADA protects individuals with disabilities, including psychiatric disabilities, from discrimination. Professional licensing bodies are not exempt from the requirements of the ADA, and courts have stated that "[public entities] may not administer a licensing or certification program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability."[8] Public entities such as a medical licensing board also may not "impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability … unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."[9]~~5~~

In order to encourage medical students and physicians to seek appropriate treatment for mental health and substance use disorders, and ensure that medical licensing boards comply with the ADA, the FSMB encourages medical licensing boards to adopt policies that support physician "safe haven non-reporting."

"Safe haven non-reporting" allows physicians who are receiving appropriate treatment for mental health or substance use issues who are monitored and in good standing with their confidential treatment program to (re)apply for licensure without having to disclose their treatment to the board. Only disclosures related to issues that are not being appropriately treated and could inhibit a physician's ability to safely practice medicine would be required.

~~RECOMMENDATIONS~~ AOA POLICY STATEMENTS

The AOA adopts the following statements as its official position on "safe haven non-reporting:"

1. The presence or history of a mental health or substance use disorder does not automatically render a physician unfit to practice medicine, and the AOA opposes discrimination or disciplinary action against a physician or medical student based solely on the presence of such a disorder, without taking into consideration the individual's behavior or treatment.

2. The AOA urges state medical licensing boards **AND CREDENTIALING ENTITITES** to regard physical and mental health disorders similarly and refrain from asking about past history of mental health or substance use diagnoses or treatment on licensure applications or renewals **WHICH CONFLICTS WITH THE AMERICANS WITH DISABILITIES ACT.** Instead, the AOA encourages ~~boards~~ **ENTITIES** to focus on whether any *current* physical or mental disorders are present which may impair that individual's ability to safely practice medicine. The AOA further encourages ~~state medical licensing boards~~ **PHYSICIAN LICENSING AND CREDENTIALING ENTITIES** to offer a "safe haven non-reporting" option for physician applicants who are undergoing appropriate treatment for current mental

172 health or substance use disorders. This alternative helps to ensure confidentiality of
173 such treatment for the individual physician while ensuring patient safety.
174
175 **3.** If ~~medical licensing boards~~ **PHYSICIAN LICENSING AND CREDENTIALING**
176 **ENTITIES** decide to use questions related to mental health or substance use
177 disorders on ~~a medical licensure application or renewal~~ **AN APPLICATION OR**
178 **RENEWAL**, the AOA encourages ~~boards~~ **ENTITIES** to consider phrasing them
179 similarly to questions about physical health. For example:
180
181 ***"Are you currently suffering from any condition for which you are not being***
182 ***appropriately treated that impairs your judgment or that would otherwise***
183 ***adversely affect your ability to practice medicine in a competent, ethical and***
184 ***professional manner? (Yes/No)"***
185
186 **4.** "Appropriate treatment" includes physician participation provided through state
187 physician health programs ~~accredited~~ **RECOGNIZED** by the Federation of State
188 Physician Health Programs, or programs following similar standards and guidelines,
189 and adherence to treatment recommendations.
190
191 **5.** Finally, the AOA encourages medical educational and professional entities, as well
192 organizations throughout the medical community, to support and educate students
193 and physicians about confidential treatment and "safe haven non-reporting" options,
194 in order to encourage these individuals to seek appropriate treatment without fear of
195 documentation, disciplinary action or other repercussions.

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~~*and Physical Illness Equivalently?*" Journal of Family Medicine, June 2017. 49(6):464-467. Available at: https://www.stfm.org/FamilyMedicine/Vol49Issue6/Gold464.~~

8. **SAVAGE S. STATE PROGRAMS. HOME. 2023. HTTPS://WWW.FSPHP.ORG/STATE-PROGRAMS.** ~~https://labblog.uofmhealth.org/industry-dx/state-medical-licensing-boards-practices-may-hurt-physician-mental-health.~~
9. **AMERICANS WITH DISABILITIES ACT OF 1990, AS AMENDED. ADA.GOV. 2008. HTTPS://WWW.ADA.GOV/LAW-AND-REGS/ADA/.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic:
Access To Mental Health Services and Awareness In U.S. Osteopathic Medical Students- Source: H211-A/21

Healthy Life Styles- Source: H411-A/23

Mental Health – Osteopathic Medical Student, Resident, And Physician - Source: H634-A/20

Physician Psychological Trauma and Mental Health- Source: H356-A/19

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: ELECTRONIC PRESCRIBING – SOURCE: H318-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports electronic prescribing (e-prescribing) for non-scheduled pharmaceuticals.

The AOA supports e-prescribing for all scheduled pharmaceuticals on a voluntary basis without CMS monetary penalty and without state sanctioned civil or criminal penalties.

The AOA encourages pharmacies to utilize e-prescribing systems that are in compliance with state and federal law.

The AOA supports the following principles in its advocacy efforts relating to the development of e-prescribing standards:

- SAFETY: Safety alerts should be prioritized and readily distinguishable from commercial messages; these messages should be allowed to be suppressed for efficiency.

- E-PRESCRIBING drugs should be listed with both generic and name brands.

- PRIVACY: Information on patients' medication should be current, comprehensive, accurate and maintained in compliance with HIPAA.

- TRANSPARENCY: Third part involvement must be transparent and disclosed to the prescribing physician and patient.

- DESIGN: Financial interests should not dictate the design of systems (i.e., all drugs should be available). Standards must require fail-safes in any system to prevent the introduction of health care errors.

36
37 • INTEGRATION: Systems and should integrate with existing healthcare
38 technology and existing workflow (i.e., download of patient data from
39 EMR).
40
41 • SCALABILITY: Any standards should be broad-based and applicable to
42 all healthcare delivery systems.
43
44 • TIMING: These standards should be in place at the earliest possible time
45 to allow software vendors and practitioners adequate time to become
46 compliant with said standards and perform all necessary testing prior to
47 the implementation.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; Reaffirmed as Amended 2009; Reaffirmed as Amended 2014; Reaffirmed as Amended 2019)

Prior HOD action on similar or same topic:
Availability of Modalities of Prescribing - Source: H301-A/21

FISCAL IMPACT: $0

ACTION TAKEN: Not Adopted

DATE: July 20, 2024

SUBJECT: RIGHT TO PRIVATELY CONTRACT – SOURCE: H325-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs determined the subject matter of
4 H314-A/19 and H325-A/19 to be substantially similar; and

5 WHEREAS, adding language from H325-A/19 to H314-A/19 and sunsetting H325/-
6 A/19 would provide a clear and comprehensive stance on the issue,
7 eliminate redundancy, and streamline our policy compendium; now, therefore
8 be it

9 RESOLVED, that the Council on State Health Affairs recommends that the following
10 policy be SUNSET.

11 The American Osteopathic Association (AOA) supports the fundamental right of
12 physicians to privately contract with patients without penalties and regardless of
13 payor, supports changes in statutes and regulations to allow physicians individually
14 and as defined groups to negotiate fair contracts with private sector and public
15 sector health plans.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic:
Any Willing Provider Legislation - Source: H314-A/19

Managed Care – All Products Clauses - Source: H631-A/20

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted (for Sunset)__

DATE: _____July 20, 2024_____

SUBJECT: ANY WILLING PROVIDER LEGISLATION **AND THE RIGHT TO PRIVATELY CONTRACT – SUPPORT FOR** – SOURCE: H314-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs determined the subject matter of H314-A/19 and H325-A/19 to be substantially similar; and

WHEREAS, adding language from H325-A/19 to H314-A/19 and sunsetting H325/-A/19 would provide a clear and comprehensive stance on the issue, eliminate redundancy, and streamline our policy compendium; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following be REAFFIRMED AS AMENDED.

ANY WILLING PROVIDER LEGISLATION **AND THE RIGHT TO PRIVATELY CONTRACT – SUPPORT FOR**

The American Osteopathic Association encourages and supports the passage of legislation that will ensure the freedom of patients and physicians to enter into private contracts for health care services without regard to restrictions by any third party ~~carrier;~~ **PAYER; AND SUPPORTS CHANGES IN STATUTES AND REGULATIONS TO ALLOW PHYSICIANS INDIVIDUALLY AND AS DEFINED GROUPS TO NEGOTIATE FAIR CONTRACTS WITH PRIVATE SECTOR AND PUBLIC SECTOR HEALTH PLANS; AND, BE IT FURTHER**

RESOLVED, THAT THE AOA supports legislation that will allow any qualified physician (DO/MD) to negotiate with any third party ~~carrier~~ **PAYER** the terms for service to be provided; and supports legislation that will require any third party carrier to provide prompt and complete explanation to any requesting physician (DO/MD) whom it may deem unqualified.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; Reaffirmed 2009; 2014; Reaffirmed 2019)

Prior HOD action on similar or same topic:
Right to Privately Contract - Source: H325-A/19

Managed Care – All Products Clauses - Source: H631-A/20

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended____

DATE: ____July 20, 2024_____

SUBJECT: PHARMACY BENEFIT MANAGERS – INCREASED REGULATION OF – SOURCE: H339-A/19

SUBMITTED BY: Council on State Health Affairs and the Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs and the Bureau on Federal Health Programs believe that the policy remains relevant but requires updating to reflect recent changes at the state level; now, therefore be it

RESOLVED, that the Council on State Health Affairs and the Bureau on Federal Health Programs recommend that the following be REAFFIRMED AS AMENDED.

WHITE PAPER– PHARMACY BENEFIT MANAGERS-INCREASED REGULATION OF

Policy Statement

INTRODUCTION

THE AFFORDABILITY OF PRESCRIPTION DRUGS REMAINS A MAJOR ISSUE FOR PATIENTS AND, BY EXTENSION, THEIR PHYSICIANS, AND PHARMACY BENEFIT MANAGERS (PBMS) CONTINUE TO PLAY A ROLE IN DRIVING UP THE COST OF DRUGS IN THE UNITED STATES.THEREFORE, A COMPREHENSIVE WHITE PAPER ON PHARMACY BENEFIT MANAGERS (PBMS) REMAINS NECESSARY, TO ENABLE US TO SUPPORT LEGISLATION TO ADDRESS THE VARIOUS WAYS IN WHICH PBMS EXTRACT PROFITS FROM THE DRUG SUPPLY CHAIN AND KEEP MEDICATION COSTS HIGH FOR PATIENTS.

Background

The ~~rising~~ **HIGH** cost of drugs is a major concern in the U.S., where consumers pay two to ~~six~~**FOUR** times more for prescription drugs than the rest of the world.[1] ~~Between 2007 and 2017, drug spending in the U.S. increased by 40%, an increase largely attributable to existing drugs rather than new drugs entering the market[2]~~ Increased drug prices have resulted in patient noncompliance, with sometimes fatal consequences, as patients are either unable to afford their prescription medications or are forced to choose between buying them or other necessities like food and shelter.

ONE MAJOR FACTOR IMPACTING A COUNTRY'S DRUG SPENDING IS THE FACT THAT MANY OTHER GOVERNMENTS AROUND THE WORLD DIRECTLY REGULATE OR NEGOTIATE DRUG PRICES. ~~There are a number of factors that distinguish the U.S. health care system and drug spending from other industrialized nations; for one, almost all countries except the U.S. have policies in place to lower drug prices, including price controls and cost-effectiveness thresholds[3].~~ By contrast, **WITH THE EXCEPTION OF DRUGS IDENTIFIED UNDER THE INFLATION REDUCTION ACT,** the U.S. government does not directly negotiate drug prices, instead leaving it up to individual insurers to negotiate prices with drug makers. This fragmented and opaque system often results in different prices for different buyers, a power imbalance that favors corporate entities at the expense of consumers.

While numerous factors contribute to prescription drug pricing and affordability in the U.S., for purposes of this policy paper we will focus on the role of pharmacy benefit managers (PBMs).[2]

Pharmacy Benefit Managers

PBMs are companies hired by insurers, employers, and government entities to manage prescription drug programs on behalf of health plan beneficiaries.[~~5~~3] Originating several decades ago as processors of prescription drug claims for insurers, for which they earned a flat fee, PBMs initially lowered drug prices by forming large networks of health plan customers which enabled them to negotiate discounts with drug makers. Since then, consolidation among PBMs has concentrated an 8~~5~~**0**% market share in the hands of three major players (CVS Caremark, Express Scripts and OptumRX), and drug prices have risen as a result.[~~6~~4]

PBMs affect numerous aspects of the drug supply chain, and they are adept at leveraging their power with drug makers, employers and pharmacies to extract profits that they keep for themselves rather than passing them on to patients. As a result, patients pay cost shares that do not reflect the actual lower cost of the drug, which increases out-of-pocket costs and co-pays.

The following represents a summary of PBM revenue sources:

Rebates. PBMs decide which drugs will be covered on a prescription drug plan or plan formulary, and drug makers often pay "rebates" or other fees to PBMs to have their drugs included. Drug makers then pass these costs on to consumers in the form of higher drug prices.

PBMs also determine which pharmacies will be included in a prescription drug plan's network and how much they will be paid. Sometimes, PBMs entice plan sponsors to require beneficiaries to use a mail order pharmacy – usually one with financial ties to the PBM – for certain medications.

Prior Authorization. PBMs use prior-authorization requirements to steer patients to formulary drugs regardless of their efficacy, by requiring them to obtain prior authorization if they or their providers prefer to continue the original (non-formulary) drug. This can result

in harm to patients who may miss doses or experience other negative effects from adjusting to a new drug, which may not be as effective as the one they were previously stable on.

Spread pricing. "Spread pricing" refers to the difference between what a PBM charges an insurer for a drug and what it reimburses the pharmacy for it. Neither the insurer nor the pharmacy knows what the PBM charges or reimburses the other for a particular drug, and PBMs take advantage of this lack of transparency to pocket the spread.

Gag clauses (partially mooted by the federal Patient Right to Know Drug Prices and the Know the Lowest Price Acts of 2018). Prior to the passage of the aforementioned Acts in October 2018, PBMs in most states could utilize "gag clauses" to prevent pharmacists from telling customers when their copayment amount would exceed the out-of-pocket cost of a drug. PBMs then kept the customer's overpayment, known as a "clawback," as profit. The Acts banned gag clauses, giving pharmacists the option – but *not* requiring them – to tell patients when a drug would cost less out-of-pocket.

Direct and Indirect Remuneration (DIR) Fees. DIR refers to the monies that a PBM may collect from a dispensing pharmacy to offset member costs.[~~7~~**5**] The Centers for Medicare and Medicaid Services (CMS) originally created DIR as a way to track rebates and other price adjustments applied to Medicare Part D prescription drug plans that were not captured at the point of sale and that resulted in savings to a PBM, and ultimately to CMS (in theory).

Since its inception, DIR has transformed into a catchall term for any fees a pharmacy pays to a PBM, including **FEES ASSOCIATED WITH QUALITY-BASED BONUS PAYMENT MODELS PBMS IMPOSE ON PHARMACIES,** such as fees to participate in the PBM's network or fees paid for failing to meet certain quality measures.[~~8~~**6**] PBMs have also begun expanding the use of DIR from just Medicare Part D plans to commercial plans, and pocketing the savings. While some DIR fees are legitimate, many are assessed in an arbitrary and opaque manner that prevents pharmacies from fully understanding how much they will be reimbursed for a prescription when entering into a PBM contract. In addition, **DIR** ~~many of the~~ fees are **NOW** charged **AT THE POINT OF SALE, POTENTIALLY CAUSING CASH FLOW PROBLEMS FOR SMALL AND COMMUNITY-BASED PHARMACIES THAT ARE TRYING TO BUDGET FOR, AND ULTIMATELY IMPLEMENT, NEW PATIENT SERVICES**. ~~retroactively which impacts the ability of independent pharmacies in particular to budget for, and ultimately implement, new patient services.~~

State Action

AS OF 2023, ALL 50 STATES HAVE TAKEN SOME LEGISLATIVE ACTION RELATED TO PBMS, IN AN EFFORT TO BRING MORE FAIRNESS AND TRANSPARENCY TO THEIR IMPACT ON DRUG PRICING. ~~There is a growing desire among states to regulate PBMs, but approaches vary from state to state. Besides the gag clause ban, which Congress enacted nationally in 2018, state legislative proposals typically include one or more of the following elements: requirements that PBMs register with the state,~~

~~requirements for certain mandatory disclosures by PBMs, and prohibitions on PBMs incentivizing the use of mail-order pharmacies[9].~~

IN A ~~A~~ **MAJORITY OF STATES,**~~s of December 2018, 23 states require~~ PBMs **ARE NOW REQUIRED** to be licensed by a state agency.[7] The agency promulgates rules for licensure, which may include state approval of compensation arrangements between PBMs and pharmacies to ensure that reimbursement rates are fair and reasonable, or requirements that PBMs disclose aggregate rebates to purchasers.

SOME STATES, INCLUDING ARKANSAS, FLORIDA, INDIANA, NEW JERSEY, NEW MEXICO AND WYOMING, HAVE ENACTED BILLS THAT FOCUS ON ENSURING THAT THE REBATES THAT PBMS NEGOTIATE FROM DRUG MANUFACTURERS ARE PASSED ON TO CONSUMERS. THESE LAWS REQUIRE THAT PATIENTS' COST-SHARING RESPONSIBILITY BE CALCULATED AT THE POINT OF SALE AND REDUCED BY A PERCENTAGE OF THOSE REBATES, AIMING TO LOWER OUT-OF-POCKET EXPENSES.[8]

~~Thirteen states require substantial disclosures by PBMs, and sometimes by insurers as well, to promote transparency regarding rebates and the extent to which PBMs pass them on to insurers, and ultimately to patients, in the form of premium reductions or decreased cost-sharing requirements.~~

~~Three~~ **EIGHTEEN** states currently have laws preventing PBMs from requiring or incentivizing patients to **USE PHARMACIES THAT THEY OWN OR ARE AFFILIATED WITH, WHICH ARE OFTEN** mail-order pharmacies.[9]~~, which~~ **PBM "STEERAGE" TOWARDS MAIL-ORDER PHARMACIES** could drive some independent pharmacies out of business, thereby costing patients access to other services that their local pharmacies may provide[10] All major PBMs have their own mail-order pharmacies, which allow them to tightly control formularies and steer patients towards drugs for which they receive financial benefits, as well as to reap rewards from spread pricing. Large PBMs can also exclude other independent mail-order pharmacies from their networks and negotiate prices that allow them to undercut competitors, which raises antitrust questions.

PBMs were originally created to save consumers money, and increased regulation by states could theoretically drive up operating costs and reduce savings for consumers; however, extensive consolidation among PBMs has since tilted the balance of power away from consumers and obscured prices as well as the ability of outsiders to determine PBMs' real effect on the costs of the drug supply chain. States have little power to prevent future PBM mergers, thus increased regulation and transparency requirements may be their only effective tools.

~~RECOMMENDATIONS~~ AOA POLICY STATEMENTS

The AOA adopts the following statements as its official position on PBMs:

1. State and federal governments should work to ensure that PBMs function as originally intended; that is, to save patients money. In order to accomplish this goal, a multi-pronged approach that incorporates various elements below in order to

target PBMs' various revenue sources and address misaligned incentives should be considered.

2. PBMs should be required to publicly disclose any rebates or other "financial benefits" that they receive from other members of the drug supply chain and pass through a certain percentage to the plan sponsor. They should also be prevented from utilizing prior authorization requirements to steer patients to formulary drugs or mail-order pharmacies to which they have financial ties.

3. In order to improve the viability of independent pharmacies and preserve competition, PBMs should be prohibited from charging pharmacies retroactive DIR fees.

4. Capping patient copayments at the pharmacy reimbursement rate or the cost without insurance would help address PBM clawbacks.

5. The ~~aoa~~ AOA supports health policy which promotes making life saving medications (i.e. epinephrine for anaphylaxis, naloxone for drug overdose, and insulin/glucagon for diabetes) free for uninsured patients and a fully covered benefit for insured patients.

6. The U.S. Department of Justice should enforce antitrust protections to prevent additional PBM market consolidation, which is likely to lead to further drug formulary restrictions and reductions in the number of – and PBM reimbursement for – independent pharmacies.

7. Lastly, governmental action to improve PBM transparency is key. The Federal Trade Commission (FTC) has the unique power to shed light on the effect of PBMs on the drug supply chain through its Section 6(b) authority and accompanying subpoena power. Section 6(b) allows the FTC to "conduct wide-ranging economic studies that do not have a specific law enforcement purpose," and it could exercise this authority to obtain PBM rebate and fee information and to analyze PBMs' effects on drug pricing.[1]

References:

1. **OFFICE USGA. PRESCRIPTION DRUGS: U.S. PRICES FOR SELECTED BRAND DRUGS WERE HIGHER ON AVERAGE THAN PRICES IN AUSTRALIA, CANADA, AND FRANCE. PRESCRIPTION DRUGS: U.S. PRICES FOR SELECTED BRAND DRUGS WERE HIGHER ON AVERAGE THAN PRICES IN AUSTRALIA, CANADA, AND FRANCE | U.S. GAO. MARCH 29, 2021. HTTPS://WWW.GAO.GOV/PRODUCTS/GAO-21-282#:~:TEXT=WE%20ESTIMATED%20THE%20PRICES%20FOR,PRICES%20IN%20THE%20COMPARISON%20COUNTRIES.** ~~https://www.cnn.com/2015/09/28/health/us-pays-more-for-drugs/index.html~~

2. **SIX REASONS DRUG PRICES ARE SO HIGH IN THE U.S. DNYUZ. JANUARY 17, 2024. HTTPS://DNYUZ.COM/2024/01/17/SIX-REASONS-DRUG-PRICES-ARE-SO-HIGH-IN-THE-U-S/.** ~~https://health.usnews.com/health-care/for-better/articles/2019-02-06/why-are-prescription-drug-prices-rising~~

3. **AUGUSTINE NR, GURU MADHAVAN, NASS SJ. MAKING MEDICINES AFFORDABLE. *NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE*. PUBLISHED ONLINE MARCH 1, 2018. DOI:10.17226/24946.** ~~https://thehill.com/opinion/healthcare/369727-us-drug-prices-higher-than-in-the-rest-of-the-world-heres-why~~

4. **CARRIER MA. A SIX-STEP SOLUTION TO THE PBM PROBLEM. HEALTH AFFAIRS FOREFRONT. AUGUST 30, 2018. HTTPS://WWW.HEALTHAFFAIRS.ORG/DO/10.1377/HBLOG20180823.383881/FULL/.** ~~http://www.nap.edu/read/24946/chapter/5~~

5. **DIR FEES. PBM WATCH. HTTP://WWW.PBMWATCH.COM/DIR-FEES.HTML.** ~~http://www.ncpanet.org/advocacy/the-tools/pbm-resources~~

6. ***IBID*** ~~https://www.healthaffairs.org/do/10.1377/hblog20180823.383881/full/~~

7. **NASHP JR. STATE PHARMACY BENEFIT MANAGER LEGISLATION. NASHP. DECEMBER 20, 2023. HTTPS://NASHP.ORG/STATE-TRACKER/STATE-PHARMACY-BENEFIT-MANAGER-LEGISLATION/.** ~~http://www.pbmwatch.com/dir-fees.html~~

8. **WESLEY HILL JD. FROM TRANSPARENCY TO GOLD CARDING, 5 PBM STATE REGULATION TRENDS FROM '23. RXBENEFITS. NOVEMBER 22, 2023. HTTPS://WWW.RXBENEFITS.COM/BLOGS/5-PBM-STATE-REGULATION-TRENDS/.** ~~https://www.pharmacytimes.com/contributor/blair-thielemier-pharmd/2016/07/the-dirt-on-dir-fees~~

9. **HILL W. ANTI-STEERING LAWS GREW IN 2022. RXBENEFITS. SEPTEMBER 19, 2022. HTTPS://WWW.RXBENEFITS.COM/BLOGS/ANTI-STEERING-LAWS-GREW-IN-2022/.** ~~http://sourceonhealthcare.org/spotlight-on-2018-state-drug-legislation-part-6-pharmacy-benefit-manager-regulation/~~

10. **STAFF IN THE OFFICE OF TECHNOLOGY AND THE DIVISION OF PRIVACY AND IDENTITY PROTECTION. A BRIEF OVERVIEW OF THE FEDERAL TRADE COMMISSION'S INVESTIGATIVE, LAW ENFORCEMENT, AND RULEMAKING AUTHORITY. FEDERAL TRADE COMMISSION. AUGUST 10, 2022.** https://www.ftc.gov/about-ftc/mission/enforcement-authority.

11. ***IBID***

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic:
Medicare Plans – Misaligned Incentives In- Source: H-342-A/19

Prior Authorization- Source: H-602-A/21

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 20, 2024_____

SUBJECT: SUPPORT FOR OMT PRIVILEGES – SOURCE H349-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) support and advocate for ~~all~~ **QUALIFIED** physicians who ~~desire to~~ practice osteopathic manipulative treatment (OMT) within medical systems and hospitals **WHO HAVE COMPLETED AN AOA PATHWAY**.~~; and, that the AOA create guidelines that can be distributed upon request to hospitals, medical systems, and other interested entities that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2019

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to the Bureau of Osteopathic Education (BOE)

DATE: ___July 20, 2024_ _____

SUBJECT: DIVERSITY IN LEADERSHIP POSITIONS – SOURCE: H328-A/19

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset: and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and determined
3 that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Membership recommends the following policy be
5 REAFFIRMED.

6 The American Osteopathic Association (AOA) supports increased awareness of and
7 encourages diversity in its leadership positions and encourages its divisional and
8 specialty societies to do the same.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999, 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended 2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS – SOURCE: H307-A/19

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset: and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and determined
3 that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Membership recommends the following policy be
5 REAFFIRMED.

6 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS

7 The American Osteopathic Association (AOA) believes that, except in the case of
8 summary suspension necessary to protect patients from imminent harm, no adverse
9 action be taken against the staff privileges of a physician by a hospital, managed
10 care organization or insurer based on a claim of physician impairment without a
11 suitable due process hearing in accordance with medical staff bylaws to determine
12 the facts related to the allegations of impairment, and, where appropriate, a careful
13 clinical evaluation of the physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: NATIONAL PRACTITIONER DATA BANK-MEMBERSHIP ACTION – SOURCE: H312-A/19

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset: and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and determined
3 that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau of Membership recommends the following policy be
5 REAFFIRMED.

6 The American Osteopathic Association (AOA) believes that adverse membership
7 actions which do not involve professional competence or conduct such as
8 nonpayment of dues, CME deficiencies and other association matters shall not be
9 reported to the National Practitioner Data Bank (NPDB) unless otherwise required
10 by law; and that final actions of expulsion of members from the American
11 Osteopathic Association shall, when all appeal mechanisms have been exhausted
12 by the osteopathic physicians, be reported to the National Practitioner Data Bank.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; Reaffirmed 2004; 2009; 2014; Reaffirmed 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: __July 20, 2024_____

SUBJECT: PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP - SOURCE: H326-A/19

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset: and

WHEREAS, the Bureau of Membership has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of Membership recommends the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) reaffirms its commitment to promote diversity ~~underrepresented into~~ **WITHIN** the osteopathic profession; endorses programs to encourage increased diversity in enrollment at colleges of osteopathic medicine; and will work to identify and encourage such qualified individuals for participation in those osteopathic affiliate and national activities which foster leadership opportunities.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1979 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: CLARIFICATION ON THE TERMS "OSTEOPATHY, AND "OSTEOPATH" IN THE UNITED STATES (AMENDMENT TO POLICY H316-A/21)

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Professional Affairs

WHEREAS, the term "osteopathy" in common usage in the United States (U.S.), is often used interchangeably with "osteopathic manipulative treatment" and "osteopathic medicine,"; and

WHEREAS, in the U.S., the word "osteopath" is often used interchangeably with the terms "osteopathic physician" and “doctor of osteopathic medicine”; and

WHEREAS, accredited osteopathic medical schools in the United States may confer either the degree of Doctor of Osteopathy, or "Doctor of Osteopathic Medicine," (both abbreviated “D.O.”) yet, in meaning and practice, both terms apply to the exact same education and qualifications for postgraduate training and licensure; and

WHEREAS, the word, "osteopath," was first coined by our profession's founder, Andrew Taylor Still, to uniquely name the profession which he founded, and intended to encompass the complete scope practice of medicine, surgery, and obstetrics, and include osteopathic manipulative medicine[1]; and

WHEREAS, the profession of “osteopathy” progressed along non-medical lines in many countries outside of the U.S., and its practitioners possess scopes of practice that are limited to manual techniques, unlike the American osteopathic profession; and

WHEREAS, practitioners who train and practice outside of the US frequently use the terms "osteopathy" and "osteopath," to refer to themselves and their practice, leading to some confusion regarding the competencies and qualifications of U.S. trained D.O.s, despite the fact that there is no regulatory oversight body or pathway to licensure for non-medical “osteopaths” in the U.S.; and

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[1] "...Article III - The object of this corporation is to establish a College of Osteopathy, the design of which is to improve our present system of surgery, obstetrics, and treatment of diseases generally, and place the same on a more rational and scientific basis, and to impart information to the medical profession and to grant and confer such honors and degrees as are usually granted and conferred by reputable medical colleges..." A.T. Still, Autobiography, 1908.

WHEREAS, in the United States, the Commission on Osteopathic College Accreditation (COCA) is the sole authority for accreditation of osteopathic medical schools, and sets standards for conferral of the D.O. degree; and

WHEREAS, the AOA House of Delegates adopted a policy "Osteopathic Term Protection" in 2006 (most recently reaffirmed in 2021 as H316) to address use of osteopathic terminology; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) amend Policy H316-A/21 Osteopathic Term Protection as follows:

The American Osteopathic Association's policy regarding the preferential terms to be used in reference to the osteopathic **MEDICAL** profession has been updated over the years; **HOWEVER, WE SUPPORT RESTRICTING THE USE OF *ALL* OSTEOPATHIC TERMINOLOGY IN THE UNITED STATES TO STUDENTS AND GRADUATES OF OSTEOPATHIC MEDICAL SCHOOLS ACCREDITED BY THE COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION, OR THOSE PHYSICIANS HAVING COMPLETED AN ACGME ACCREDITED RESIDENCY WITH OSTEOPATHIC RECOGNITION OR OSTEOPATHIC NEUROMUSCULOSKELETAL MEDICINE**~~However we are mindful that there are osteopathic physicians practicing medicine who were granted degrees in "osteopathy."~~ **WE** will continue to advocate for ~~the~~ **TERM** protection ~~of the terms "osteopathic," "osteopathy" and "osteopath" as referenced~~ in state and federal laws and rules **IN THE INTEREST OF TRANSPARENCY AND PATIENT SAFETY.**

TERMS WHICH SHOULD BE PROTECTED INCLUDE "OSTEOPATHIC MEDICINE," "OSTEOPATHIC PHYSICIAN," "OSTEOPATHIC MANIPULATIVE TREATMENT," AND "OSTEOPATHIC MANIPULATIVE MEDICINE," AND RELATED ABBREVIATIONS. ADDITIONALLY, "OSTEOPATH", "OSTEOPATHY", AND OTHER TERMS DERIVED FROM THE WORD, "OSTEOPATHY," WHICH IMPLIES QUALIFICATION FOR THE COMPLETE PRACTICE OF MEDICINE IN THE US, SHOULD ALSO BE PROTECTED. DELIBERATE ALTERNATIVE USAGE OF THESE TERMS BY NON-PHYSICIANS MAY BE CONFUSING TO THE PUBLIC AND MAY CONSTITUTE UNPROFESSIONAL CONDUCT OR FRAUD.

Background Information: Provided by AOA Staff
Current AOA Policy: H316-A/21 Osteopathic Term Protection

Prior HOD action on similar or same topic: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: ___July 20, 2024_____

SUBJECT: INCREASED AWARENESS OF MENTAL HEALTH CONDITIONS IN NURSING HOME RESIDENTS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, behavioral health services have been unmet in 33% of nursing homes, and over 30% have reported inadequate coordination of care between nursing home staff and healthcare providers[1]; and

WHEREAS, the consequences of anxiety and depression are associated with premature mortality occurring up to 25 years earlier when compared to elderly individuals without the aforementioned disorders[2]; and

WHEREAS, early screening and identification of anxiety and depression can reduce morbidity and improve overall well-being of ~~elderly~~ nursing home residents[3]; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognize the ~~importance of~~ **PREVALENCE OF** mental health ~~within~~ **CONDITIONS AMONG** nursing home~~s~~ **RESIDENTS** and be it further

RESOLVED, that the AOA encourage physicians who practice in skilled nursing facilities and other long term care facilities to use evidence-based medicine to address ~~the increased prevalence of~~ mental health conditions among residents in these facilities.

Citations:

1. Orth, J., Li, Y., Simning, A., & Temkin-Greener, H. (2019). Providing behavioral health services in nursing homes is difficult: Findings from a national survey. Journal of the American Geriatrics Society, 67(8), 1713–1717. https://doi.org/10.1111/jgs.16017
2. Bucy, T., Moeller, K., Bowblis, J. R., Shippee, N., Fashaw-Walters, S., Winkelman, T., & Shippee, T. (2022). Serious mental illness in the nursing home literature: A scoping review. Gerontology and Geriatric Medicine, 8, 233372142211012. https://doi.org/10.1177/23337214221101260
3. Simning, A., & Simons, K. (2016). Treatment of depression in nursing home residents without significant cognitive impairment: a systematic review. International Psychogeriatrics, 29(2), 209–226. https://doi.org/10.1017/s1041610216001733

Background Information:
Current AOA Policy: H323-A/21

It is important to incorporate mental health training into physician education ensuring that all patients including nursing home residents receive comprehensive and holistic care that addresses both their physical and mental well-being. The mental health of patients is an AOA priority. The AOA participates with other leading medical organizations in the national Behavioral Health Integration (BHI) Collaborative and shares current resources and information on best practices and evidence-based medicine to increase osteopathic physicians' knowledge and skills in identifying and addressing mental health concerns.

Prior HOD action on similar or same topic: No

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended_____

DATE: _____July 21, 2024_____

SUBJECT: AIRLINE MEDICAL KITS - SOURCE: H302-A/18

SUBMITTED BY: Bureau on Federal Health Programs/American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Committee on Professional Affairs

WHEREAS, the 2023 House of Delegates referred sunset resolution H301-A/23 Airline Medical Kits that reviewed policy H302-A/18 Airline Medical Kits to the American Osteopathic College of Occupational and Preventive Medicine (AOCOPM); and

WHEREAS, as there have been significant aerospace medicine advancements in emergency inflight anaphylaxis treatment, airborne nausea treatment, and opioid overdose treatment; now therefore be it

RESOLVED, the current policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) supports the current Federal Aviation Administration (FAA) Final Rules on Airline Emergency Equipment.

THE AOA RECOMMENDS THAT THE FEDERAL AVIATION ADMINISTRATION (FAA) REVIEW AND UPDATE RULES ON AIRLINE IN-FLIGHT MEDICAL KITS (IFMK) EMERGENCY EQUIPMENT AND MEDICATIONS TO BETTER ADDRESS INFLIGHT MEDICAL EMERGENCIES SUCH AS ANAPHYLAXIS, NAUSEA, AND OPIOID OVERDOSE.

THE AOA RECOMMENDS A MANDATORY FIVE-YEAR REVIEW OF IFMK CONTENTS TO RESPOND TO ADVANCES AND EMERGING AEROMEDICAL TECHNOLOGIES AND PRACTICES.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Referred to AOCOPM)

H411-A/20 Aircraft Emergency Medical Supplies – The AOA supports the concept that airlines, under the control of the Federal Aviation Administration, maintain a policy for adequately equipping commercial aircraft of greater than 19 seats with at least minimal diagnostic and emergency medical supplies and supports legislation and regulation that any physician providing emergency service while on board aircraft be immune from any liability or legal action.

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: WHISTLEBLOWER POLICY - SOURCE: H346-A/19

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Committee on AOA Governance and Organizational Structure reviewed and amended the Whistleblower policy in January 2022 and the AOA Board of Trustees approved in February 2022 at its Midyear meeting; now therefore be it

RESOLVED, that the AOA Board of Trustees recommends that the following policy be REAFFIRMED AS AMENDED.

Whistleblower Policy

~~The AOA encourages its employees and members and/or volunteers to disclose and report concerns regarding perceived violations of federal and state laws and regulations and perceived financial irregularities.~~

~~Such reports may be made by any employee or member and/or volunteer openly, confidentially or anonymously, and they may be made in person, by telephone or in writing, including email.~~

~~Employees can report such concerns without fear of reprisal to any of the following individuals: department directors, the chief operations officer, the associate executive directors, the chief financial officer, the general counsel, the executive director or the AOA president. Employees can also report such concerns to the AOA Audit Committee.~~

~~Members and/or volunteers may report any concerns, charges or complaints to the AOA Committee on Ethics, including violations of the AOA Constitution & Bylaws, as per Article VII, Section 1(h).~~

~~Employees or members and/or volunteers who prefer to raise their concerns confidentially may do so by sending the appropriate executive or committee as outlined above a sealed envelope through US mail or interoffice mail and marking the envelope "Personal & Confidential" or by sending an email with the words "Personal & Confidential "in the subject line.~~

~~AOA employees or members and/or volunteers may also report their concerns about perceived violations of federal and state laws and regulations and perceived financial irregularities to appropriate governmental agencies without fear of adverse action.~~

~~The AOA complies with all applicable requirements of federal and state statutes and regulations concerning employee or member and/or volunteer "whistleblower" activity, including, without limitation, the Illinois Whistleblower Act [740 ILCS174/5, *et seq*].~~[3]

~~Among its provisions, the Illinois Whistleblower Act prohibits an employer from discharging or otherwise retaliating against an employee for any of the following actions:~~

- ~~disclosing to a law enforcement agency or other government agency information that the employer reasonably believes discloses a violation of any state or federal law, rule or regulation~~
- ~~refusing to participate in any activity that would result in the violation of any state or federal law, rule or regulation.~~

~~The Illinois Whistleblower Act also prohibits an employer from making, adopting or enforcing any rule, regulation or policy that prevents its employees from disclosing information to a government or law enforcement agency when employees have reasonable cause to believe that the information concerns a violation of a state or federal law, rule or regulation.~~

~~Likewise, the AOA extends these same protections for whistleblowing activity to its members and/ or volunteers. The AOA prohibits retaliation, or threat of retaliation, by or on behalf of the AOA, against members and/ or volunteers for making good faith complaints, reports or inquiries under this policy or for participating in a review or investigation under this policy. This protection extends to those whose allegations are made in good faith, but prove to be mistaken. The AOA reserves the right to discipline persons who make bad faith, knowingly false, or vexatious complaints, reports or inquiries.~~

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) REQUIRES TRUSTEES, OFFICERS, EMPLOYEES, AND VOLUNTEERS TO OBSERVE HIGH STANDARDS OF BUSINESS AND PERSONAL ETHICS IN THE CONDUCT OF THEIR DUTIES AND RESPONSIBILITIES. AS EMPLOYEES AND REPRESENTATIVES OF THE AOA, THEY MUST PRACTICE HONESTY AND INTEGRITY IN FULFILLING THEIR RESPONSIBILITIES AND COMPLY WITH ALL APPLICABLE LAWS AND REGULATIONS.

APPLICABILITY

THIS POLICY APPLIES TO ALL AOA EMPLOYEES, MEMBERS OF THE BOARD OF TRUSTEES, AND MEMBERS OF AOA BUREAUS, COMMITTEES, COUNCILS, AND TASK FORCES.

REPORTING RESPONSIBILITY

THIS WHISTLEBLOWER POLICY IS INTENDED TO ENCOURAGE AND ENABLE EMPLOYEES AND OTHERS WITH KNOWLEDGE OF MISCONDUCT TO RAISE CONCERNS INTERNALLY SO THAT THE AOA CAN ADDRESS AND CORRECT INAPPROPRIATE CONDUCT AND ACTIONS. IT IS THE RESPONSIBILITY OF ALL PERSONS AS OUTLINED ABOVE TO REPORT

CONCERNS ABOUT SUSPECTED VIOLATIONS OF LAW OR REGULATIONS THAT GOVERN THE AOA'S OPERATIONS.

<u>NO RETALIATION</u>
IT IS THE POLICY OF THE AOA THAT THERE SHALL NOT BE ANY PERSONAL OR PROFESSIONAL RETALIATION AGAINST ANY PERSON WHO IN GOOD FAITH REPORTS A SUSPECTED VIOLATION OF LAW OR OTHER SIGNIFICANT MISCONDUCT. ANY EMPLOYEE WHO RETALIATES AGAINST A WHISTLEBLOWER SHALL BE SUBJECT TO DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION OF EMPLOYMENT. ANY MEMBER WHO RETALIATES AGAINST A WHISTLEBLOWER SHALL BE SUBJECT TO DISCIPLINARY ACTION (CENSURE, PROBATION, SUSPENSION, EXPULSION) AS OUTLINED IN THE AOA BYLAWS (ARTICLE VII, SECTION 1, PART H).

<u>REPORTING PROCEDURE</u>
EMPLOYEES: THE AOA ENCOURAGES OPEN COMMUNICATIONS. EMPLOYEES ARE ENCOURAGED TO SHARE THEIR QUESTIONS AND CONCERNS, WITH THEIR SUPERVISOR AS AN INITIAL STEP. SUPERVISORS AND MANAGERS ARE REQUIRED TO REPORT COMPLAINTS OR CONCERNS ABOUT SUSPECTED LEGAL VIOLATIONS IN WRITING TO ANY OF THE FOLLOWING: THE AOA'S GENERAL COUNSEL, CHIEF FINANCIAL OFFICER, CHIEF EXECUTIVE OFFICER, THE HUMAN RESOURCES DEPARTMENT LEADER OR THE AOA PRESIDENT, WHO HAVE THE RESPONSIBILITY TO INVESTIGATE OR HAVE INVESTIGATED ALL REPORTED COMPLAINTS.

INDIVIDUALS UNCOMFORTABLE WITH REPORTING A CONCERN TO THEIR SUPERVISOR OR WHO ARE NOT SATISFIED WITH THE RESPONSE PROVIDED BY THEIR SUPERVISOR ARE ENCOURAGED TO REPORT THE CONCERN DIRECTLY TO ANY OF THE INDIVIDUALS LISTED ABOVE.

MEMBERS: MEMBERS ARE ENCOURAGED TO REPORT THEIR CONCERNS TO THE CHAIR OR SECRETARY OF THEIR BUREAU, COMMITTEE, COUNCIL, OR TASK FORCE OR TO A MEMBER OF THE BOARD OF TRUSTEES OR THE CHIEF EXECUTIVE OFFICER. BUREAU, COUNCIL, COMMITTEE OR TASK FORCE CHAIRS AND SECRETARIES OR TRUSTEES RECEIVING SUCH REPORTS OR COMPLAINTS ARE REQUIRED TO REPORT THEM IN WRITING TO ANY OF THE FOLLOWING: THE AOA'S COMPLIANCE OFFICER (GENERAL COUNSEL), CHIEF FINANCIAL OFFICER, CHIEF EXECUTIVE OFFICER, HUMAN RESOURCES DEPARTMENT LEADER OR THE AOA PRESIDENT. AOA'S COMPLIANCE OFFICER (GENERAL COUNSEL) WILL HAVE THE RESPONSIBILITY TO INVESTIGATE OR TO HAVE INVESTIGATED ALL WHISTLEBLOWER REPORTS OR COMPLAINTS.

THE AOA COMPLIES WITH ALL APPLICABLE REQUIREMENTS OF FEDERAL AND STATE STATUTES AND REGULATIONS CONCERNING "WHISTLEBLOWER" ACTIVITY, INCLUDING, WITHOUT LIMITATION, THE

ILLINOIS WHISTLEBLOWER ACT [1] AMONG ITS PROVISIONS, THE ILLINOIS WHISTLEBLOWER ACT PROHIBITS AN EMPLOYER FROM DISCHARGING OR OTHERWISE RETALIATING AGAINST AN EMPLOYEE FOR ANY OF THE FOLLOWING ACTIONS:

- **DISCLOSING TO A LAW ENFORCEMENT AGENCY OR OTHER GOVERNMENT AGENCY INFORMATION THAT THE EMPLOYEE REASONABLY BELIEVES DISCLOSES A VIOLATION OF ANY STATE OR FEDERAL LAW, RULE, OR REGULATION.**

- **REFUSING TO PARTICIPATE IN AN ACTIVITY THAT WOULD RESULT IN A VIOLATION OF ANY STATE OR FEDERAL LAW, RULE, OR REGULATION.**

THE ILLINOIS WHISTLEBLOWER ACT ALSO PROHIBITS AN EMPLOYER FROM MAKING, ADOPTING OR ENFORCING ANY RULE, REGULATION OR POLICY THAT PREVENTS ITS EMPLOYEES FROM DISCLOSING INFORMATION TO A GOVERNMENT OR LAW ENFORCEMENT AGENCY WHEN THE EMPLOYEES HAVE REASONABLE CAUSE TO BELIEVE THAT THE INFORMATION CONCERNS A VIOLATION OF A STATE OR FEDERAL LAW, RULE OR REGULATION.

<u>COMPLIANCE OFFICER</u>
THE AOA'S COMPLIANCE OFFICER IS THE GENERAL COUNSEL. THE COMPLIANCE OFFICER IS RESPONSIBLE FOR ENSURING THAT ALL COMPLAINTS ABOUT UNETHICAL OR ILLEGAL CONDUCT ARE INVESTIGATED AND RESOLVED. THE COMPLIANCE OFFICER WILL ADVISE THE CHIEF EXECUTIVE OFFICER AND BOARD OF TRUSTEES OF ALL COMPLAINTS AND THEIR RESOLUTION AND WILL REPORT AT LEAST ANNUALLY TO THE FINANCE COMMITTEE AND THE AUDIT COMMITTEE ON COMPLIANCE ACTIVITY RELATING TO ACCOUNTING OR ALLEGED FINANCIAL IMPROPRIETIES.

<u>ACCOUNTING AND AUDITING MATTERS</u>
THE AOA'S COMPLIANCE OFFICER SHALL IMMEDIATELY NOTIFY THE CHIEF EXECUTIVE OFFICER AND THE AUDIT COMMITTEE AND/OR FINANCE COMMITTEE OF ANY CONCERNS OR COMPLAINT REGARDING CORPORATE ACCOUNTING PRACTICES, INTERNAL CONTROLS OR AUDITING AND WORK WITH THE COMMITTEE UNTIL THE MATTER IS RESOLVED.

<u>ACTING IN GOOD FAITH</u>
TO QUALIFY FOR PROTECTION AS A WHISTLEBLOWER, ANYONE FILING A WRITTEN COMPLAINT CONCERNING A VIOLATION OR SUSPECTED VIOLATION MUST BE ACTING IN GOOD FAITH AND HAVE REASONABLE GROUNDS FOR BELIEVING THE INFORMATION DISCLOSED INDICATES A

[1] 740 ILCS 174/5, et seq.

VIOLATION. REPORTING OF ALLEGATIONS THAT PROVE (A) NOT TO BE SUBSTANTIATED, AND (B) HAVE BEEN MADE MALICIOUSLY OR KNOWINGLY TO BE FALSE WILL BE VIEWED AS A SERIOUS OFFENSE FOR WHICH APPROPRIATE DISCIPLINARY ACTION CAN BE TAKEN. PERSONS WHO MAKE ALLEGATIONS WITH MALICE OR KNEW THAT THE ALLEGATIONS WERE FALSE WHEN MADE DO NOT ENJOY ANY OF THE PROTECTIONS AFFORDED UNDER STATE OR FEDERAL LAW.

CONFIDENTIALITY

REPORTS OF VIOLATIONS OR SUSPECTED VIOLATIONS MAY BE SUBMITTED ON A CONFIDENTIAL BASIS BY THE COMPLAINANT. REPORTS OF VIOLATIONS OR SUSPECTED VIOLATIONS WILL BE KEPT CONFIDENTIAL TO THE EXTENT POSSIBLE, CONSISTENT WITH THE NEED TO CONDUCT AN ADEQUATE INVESTIGATION.

HANDLING OF REPORTED VIOLATIONS

ANY EMPLOYEE RECEIVING AN ALLEGATION OF VIOLATION OF ETHICS OR LAW SHALL REPORT THE ALLEGATION TO THE AOA COMPLIANCE OFFICER. THE COMPLIANCE OFFICER WILL NOTIFY THE PERSON WHO SUBMITTED A COMPLAINT AND ACKNOWLEDGE RECEIPT OF THE REPORT OF VIOLATION OR SUSPECTED VIOLATION. ALL REPORTS WILL BE PROMPTLY INVESTIGATED AND APPROPRIATE CORRECTIVE ACTION WILL BE TAKEN IF WARRANTED BY THE INVESTIGATION.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: LOCATIONS OF FUTURE MEETINGS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, more than two decades ago, the House of Delegates (HOD) of the American Osteopathic Association (AOA) met in various locations around the country; and

WHEREAS, due to the expenses of printing and transporting paper, multiple staff members and heavy equipment from Chicago to other areas of the country the decision was made to permanently locate the HOD to the Chicago area; and

WHEREAS, the State of Illinois, and the City of Chicago have been gracious hosts for the leadership of our profession for many years; and

WHEREAS, over the past decade technologic advances have substantially reduced the use of paper, and the need for heavy equipment in conducting a successful meeting; and

WHEREAS, the Osteopathic profession has grown and expanded widely over the past two decades with substantially more schools, students and physicians across a much wider geographic footprint; and

WHEREAS, while OMED is held in various cities featuring a wide variety of educational opportunities to engage Osteopathic physicians from across our profession; and

WHEREAS, many Divisional Societies of the AOA have expressed a desire to host these annual meetings; and

WHEREAS, there are opportunities for the AOA to have greater visibility of the work done on behalf of our members across our profession through scheduling these meetings throughout the country; and

WHEREAS, many hotels and meeting sites could service the needs of the AOA at equal or lesser costs by competing for bids; and

WHEREAS, we believe that the AOA, and the Delegates would be best served by moving the House around the country to various locations to allow Divisional Societies to host the HOD, and to facilitate greater visibility and engagement across the profession.

As many AOA staff members are housed in the meeting hotel already, and as we have seen that through technology a mixture of on site and off site staff can support the meeting, and with the substantial reduction of paper and equipment needed to conduct the business of the house we believe that any additional flight or ground transportation expenses could be offset by the ability to competitively bid for sites, and through greater member engagement as the house conducts business; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) should explore options for meeting sites outside of the city of Chicago; and, be it further

RESOLVED, that the AOA will consider cost, member engagement, and public visibility in the decisions for booking future meeting sites; and, be it further

RESOLVED, that the AOA will report these findings to the Board of Trustees for analysis and approval prior to finalizing contracts for future meetings of the House of Delegates.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $151K (plus increased risk with AOA having to ensure a specific number of hotel rooms were booked to avoid attrition and loss of concessions). The AOA Finance Committee has approved the fiscal impact.

The Annual Business Meeting and House of Delegates meetings are currently contracted at the Chicago Marriott through 2027. The House of Delegates should take into consideration the increased expense the AOA would incur if it is determined to rotate the Annual Business Meeting and House of Delegates annually beginning in 2028 versus continuing to host the Annual Business Meeting and House of Delegates in Chicago.

Increase in staff expenses:
There are a limited number of AOA staff who stay overnight at the hotel. These staff include those who are essential in executing the operations and production of the meeting. Additionally, there are staff from the Washington, D.C. office which incurs both travel and hotel room expense. The current budget for staff expenses is $28K.

Should the Annual Business Meeting and House of Delegates meeting rotate locations there will be 45 staff members (Senior Staff, operations/production staff and other supporting staff) that would incur travel expenses (flight, ground transportation, per diem, etc.). The anticipated budget for staff expenses would be $179K.

The variance between staff expenses from hosting the House of Delegates in Chicago ($28K) versus rotating locations ($179K) is $151K.

Increase in Meeting Related Expenses and Risk:
The Annual Business Meeting and House of Delegates has been hosted at the Chicago Marriott since 2016. There are many contractual cost-saving benefits to the AOA the hotel provides given AOA's partnership and repeat business history that would not be provided if moving locations, even if the venues selected were all under the same brand (i.e. Marriott).

There are cost savings for booking multi-year meetings at Marriott hotels. However, the savings are much deeper when hosting the same meeting at the same hotel. The additional benefits include:

- Favorable terms. The hotel can offer much more favorable terms, for example no hotel room attrition. Due to the deep history, the hotel can offer concessions like this and others as outlined by the Chicago Marriott leadership. These types of terms would not be acceptable for the same program at different hotels due to the risk it leaves for the hotel.
- Deeper discounts. Repeat meetings at the same hotel offers much deeper savings since it directly impacts one ownership group. Having the history year-over-year extends a much deeper discount than it would to any other program.
- Staff awareness: Hosting the same meeting at the same hotel creates hotel staff familiarity. For example, the Chicago Marriott staff understands the importance and schedule of the Annual Business Meeting and House of Delegates to the AOA. This supports the AOA staff in planning and provides the attendees with a welcoming experience.
- Chicago Marriott: The Chicago Marriot values the partnership with the AOA and the Annual Business Meeting and House of Delegates. The hotel leadership has provided a letter to be shared with the AOA House of Delegates.

ACTION TAKEN: Not Adopted

DATE: July 20, 2024

SUBJECT: OPIOID CRISIS , CAUSES

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, on October 26, 2017 the opioid crisis was officially declared a "public health emergency" [1]; and

WHEREAS, some in the medical profession [2] and government [3] have stated that physician over prescribing of opioids is the major cause of the opioid crisis; and

WHEREAS, according to a recent National Institutes of Health study, deaths linked to commonly prescribed opioid medications have fallen 26% since 2016 while over the same timeframe deaths related to illicitly manufactured fentanyl have increased nearly 60% [4]; and

WHEREAS, physicians have been blamed for the opioid crisis [5]; and

WHEREAS, this misconception of physicians as the cause of the opioid crisis has led to unintended consequences such as the under-treatment of pain, a failure to address the ~~true~~ **CONTRIBUTING** cause**S** of the problem, and the misallocation of resources; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) shall advocate to Congress and appropriate governmental **AND REGULATORY** agencies to identify the ~~true~~ **CONTRIBUTING** causes of the opioid crisis and to develop solutions which target those causes; and, be it further

~~RESOLVED, that the AOA encourage these same entities to stop blaming physicians for causing the opioid crisis and publicly acknowledge the true causes of the problem.~~

RESOLVED, THAT THE AOA EDUCATE MEMBERS OF THESE ENTITIES AROUND THE COMPREHENSIVE CAUSES OF THE PROBLEMS, AND ADVOCATE FOR POLICIES AND POSITIONS THAT SEEK TO IDENTIFY AND MITIGATE THE OPIOID CRISIS RECOGNIZING THAT PHYSICIANS AND OTHER HEALTH CARE RESOURCES ARE CRITICAL TO ADDRESS THE MANAGEMENT OF OPIOID ~~ADDICTION, AND SHOULD NOT BE VILIFIED OR DISPARAGED AS THE PROXIMATE CAUSE OF THE CURRENT CRISIS.~~ USE DISORDER.

References:

1. https://www.cms.gov/about-cms/what-we-do/emergency-response/current-emergencies/ongoing-emergencies accessed April 6, 2024
2. The Lancet Regional Health-Americas. Opioid crisis: addiction, overprescription, and insufficient primary prevention. Lancet Reg Health Am. 2023 Jul 12;23:100557. doi: 10.1016/j.lana.2023.100557. PMID: 37497399; PMCID: PMC10366477.
3. https://www.cdc.gov/opioids/basics/epidemic.html, accessed April 6, 2024
4. D'Orsogna MR, Böttcher L, Chou T. Fentanyl-driven acceleration of racial, gender and geographical disparities in drug overdose deaths in the United States. PLOS Glob Public Health. 2023 Mar 22;3(3):e0000769. doi: 10.1371/journal.pgph.0000769. PMID: 36962959; PMCID: PMC10032521.
5. Bump B. Are doctors to blame for opioid crisis? New Yorkers think so. Times Union. 2018 Apr 22 Published online at https://www.timesunion.com/local/article/Are-doctors-to-blame-for-opioid-crisis-New-12851255.php Accessed April 7, 2024

Background Information: Provided by AOA Staff

Current AOA Policy:

The resolved statements are covered by content in the following policies:

- H431-A/22 AOA Policies on Opioids and Substance Use – White Paper
- H429-A/22 Harm Reduction Modalities for People Who Inject Drugs – White Paper

The AOA has been providing education on "Pain Management and Opioids: Balancing Risks and Benefits" for 11 years through our participation with the Collaborative for REMS Education (CORE). CORE is a group of professional associations that include physicians, physician assistants, pain specialists, and nurse practitioners. CORE provides continuing education to healthcare professionals for safe opioid prescribing in alignment with the FDA's mission, following the FDA Blueprint. Since 2013, CORE has delivered in-person and online Opioid Analgesics REMS education to more than 452,000 clinicians via more than 700 CE/CME activities.

Prior HOD action on similar or same topic:

FISCAL IMPACT: No Financial Impact

ACTION TAKEN: _Adopted as Amended____

DATE: ___July 20, 2024_____

SUBJECT: SUPPORTING THE RIGHTS OF RESIDENTS TO UNIONIZE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, residents in medical training programs across the United States, including those in Michigan, often face challenges related to long work hours, inadequate compensation, lack of adequate supervision, insufficient resources, insufficient staff support and limited control over their work environments[2]; and

WHEREAS, these challenges can contribute to decreased quality of patient care, and/or adverse effects on the well-being and mental health of residents; and

WHEREAS, unionization has been shown to provide residents with a collective voice to negotiate for fair wages, reasonable working conditions, and improved patient safety standards[1]; and

WHEREAS, the American Osteopathic Association (AOA) is committed to promoting the welfare and professional development of osteopathic physicians and medical students within the state; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) supports the right of residents to form and join labor unions to advocate for their interests; and be it further

RESOLVED, that the AOA encourages all residency programs ~~to engage in constructive dialogue with their residents regarding their concerns and to~~ respect the rights of residents to organize and collectively bargain.~~; and, be it further~~

~~RESOLVED, that the AOA pledges to actively advocate for policies at the state and national level that support the rights of residents to unionize in order to promote fair and equitable working conditions in medical training programs.~~

References:

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Background Information: Provided by AOA Staff
Current AOA Policy: None.

Prior HOD action on similar or same topic: None.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_____

DATE: ____July 20, 2024_____

SUBJECT: EXPANDING ~~NALOXONE AND OTHER~~ OPIOID REVERSAL AGENT**S'** ~~OR ANTAGONIST~~ AVAILABILITY AND ACCESSIBILITY: PROMOTING EMERGENCY USE IN COMMUNITIES **TO TREAT OPIOID OVERDOSE**

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2018 more Michiganders (2,809) died from drug overdoses than car accidents[1], killing about 47,000 people per year nationwide[6]; and

WHEREAS**,** in 2020 142.8 million prescriptions of opioids were filled in Michigan[1]; and in 2021, the per capita cost of a fatal opioid overdose in Michigan was $2357[2]; and

WHEREAS, having ~~naloxone and other~~ opioid reversal agent**S** ~~or antagonist~~ accessible in public areas such as grocery stores, pharmacies, gas stations, libraries, and community centers has been suggested to allow community members to promptly reverse opioid overdoses and establish greater trust among individuals using opioids[6]; and

WHEREAS, facilitating access to ~~the~~ opioid **OV**reversal agent**S**~~, naloxone and other opioid reversal agent or antagonist~~ in areas of high need through agencies like Families Against Narcotics' HARM:LESS and Harm Reduction Michigan could work towards improving the safety of patients struggling with substance use[5,8]; and

WHEREAS, the implementation of naloxone –and other opioid reversal agent**S** ~~or antagonist~~ in local public buildings across Michigan counties has been met with a positive response from local communities[7,8]; and the implementation of increasing community access to ~~naloxone~~ **REVERSAL AGENTS** could decrease emergency room visit costs, deaths, and stigma around ~~addiction~~**OPIOID USE DISORDER;** and

WHEREAS**,** there is a significant financial barrier to obtaining naloxone and other ~~opioid reversal agent or antagonist as one-unit retails for about $135, and,~~ while a prescription is not needed to obtain naloxone, many pharmacies require the patient to be evaluated by a healthcare professional before selling naloxone and other opioid reversal **agentS** ~~or antagonist~~, thereby introducing a potential ~~financial and~~ logistical burden; and

WHEREAS, state-wide community focused support groups such as Families Against Narcotics work to provide evidence-based services to people affected by ~~addiction~~ **SUBSTANCE USE DISORDER** but continue to primarily be sustainable through inconsistent sources of funding; and

WHEREAS, ~~naloxone is shelf-stable for three years, therefore, most expenses related would be triennial; and~~, existing channels of funding for ~~naloxone and other~~ opioid reversal **agentS** ~~or antagonist~~ are already established through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Michigan Department of Health and Human Services (MDHHS); and

WHEREAS, additional funding can be acquired through partnerships with local cities and their police departments; now, therefore be it

RESOLVED**,** that the American Osteopathic Association (AOA) advocate for the implementation of ~~a~~ steady funding ~~program~~ for community programs to increase the accessibility of ~~naloxone and other~~ opioid reversal agent**S** ~~or antagonist~~ coming to market through federal, state, and local channels; and be it further

RESOLVED, that the AOA advocate for ~~consideration to~~ implement**ATION OF** such programs ~~across additional~~ **IN ALL** states.

RESOLVED, THE AOA ENCOURAGES STATES TO INCORPORATE PHYSICAN EXPERTISE IN DEVELOPING AND ADMINISTERING SUCH PROGRAMS.

References:

1. *Opioid Resources*. (2024). State of Michigan. Retrieved from https://www.michigan.gov/opioids
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Background Information: Provided by AOA Staff

Current AOA Policy:

H603-A/23 Increasing the Education and Availability of Naloxone Use for Opioid Overdose

The American Osteopathic Association (AOA) supports the continued availability of naloxone as an over-the-counter medication, and the education and training of its use for patients at risk of overdose, family members, and caregivers to prevent opioid / opiate related deaths.

Prior HOD action on similar or same topic: as noted above

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: GME EQUITY ANNUAL REPORT (POLICY H345-A/23 - AOA SUPPORT FOR GME EQUITY)

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, the 2023 House of Delegates adopted Policy H345-A/23 – AOA Support for GME Equity; and

WHEREAS, Policy H345-A/23 – AOA Support for GME Equity requires the AOA Board of Trustees to provide a report to the House of Delegates; now therefore be it

RESOLVED, that the 2024 House of Delegates accept the AOA Board of Trustees GME Equity 2024 Annual Report as outlined.

2024 GME Equity Annual Report

As the professional home for the nation's 148,000+ DOs and 38,000+ osteopathic medical students, the American Osteopathic Association (AOA) continually works to eliminate barriers that adversely impact access to training and employment opportunities for members of the osteopathic medical profession. Medical student parity is a top-of-mind concern for thousands of future DOs who are preparing for the next phase of their careers. The AOA is working tirelessly on behalf of the profession with partners across the House of Medicine to ensure full recognition.

Following 2023 AOA House of Delegates meeting, leaders from the AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) held a summit on student parity, during which AOA President Ira P. Monka, DO, and CEO Kathleen S. Creason, MBA, met with leaders from national organizations that oversee osteopathic and allopathic medical education and training, including the American Medical Association (AMA), the Association of American Medical Colleges (AAMC) and the National Resident Matching Program (NRMP).

During the summit, several outcomes and next steps were identified and are being advanced as part of a shared action plan that includes:

- A joint statement outlining the workforce benefits of including osteopathic physicians in residency programs.
- Meetings with program directors across various specialties to gain insights on current behaviors and attitudes.
- Further data analysis.
- Review of VSLO and ERAS filters and participation policies.

- Plans for future meetings to identify additional opportunities for collaboration.

The osteopathic profession (members, students and affiliate organizations) has been provided with updates March through end May 2024.

Past Updates:

- March 21, 2024: AOA Student Parity Advocacy Update: Student Parity Summit
- April 16, 2024: AOA Student Parity Advocacy Update: Collaborative partnerships
- May 13, 2024: AOA Student Parity Advocacy Update: Grassroots advocacy on parity issues

Future Updates:

- Week of May 27, 2024: AOA Student Parity Advocacy Update: Building awareness with stakeholders
- More updates to be provided as additional advocacy and wins take place

Background Information: Provided by AOA Staff
Current AOA Policy: AOA Support for GME Equity - Source: H345-A/23

Prior HOD action on similar or same topic: None.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted____

DATE: __July 20, 2024_____

SUBJECT: REMOVING INTRUSIVE MENTAL HEALTH QUESTIONS FROM LICENSURE AND CREDENTIALING APPLICATIONS

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, medical students, residents, fellows, and early-career physicians experience higher rates of burnout compared to peers of comparable age in the general U.S. population (1); and

WHEREAS, early-career physicians also report high rates of depressive symptoms and fatigue (1); and

WHEREAS, the “quadruple aim” of healthcare added a call for improvements in the quality of work lives of physicians and other health care providers (2); and

WHEREAS, since 2004, physician suicide prevalence has increased, with male physicians having a 40% higher rate of suicide and female physicians having a 130% higher rate of suicide than the general population (3); and

WHEREAS, in 2017, a national study found approximately 40% of sampled physicians were hesitant to pursue formal mental health treatment due to apprehensions about potential consequences to their medical licensure (4,5); and

WHEREAS, 32 state medical licensing bodies and 22 nursing licensure boards continue to ask mental health questions on applications (6-8); and

WHEREAS, in 2005, 51 state medical licensing applications were reviewed and 49 (96%) contained questions pertaining to the physical or mental health or substance use history of the applicant and 34 (69%) state applications contained at least one "likely impermissible" or "impermissible" item based on the Americans with Disabilities Act (ADA) and appropriate case law (9); and

WHEREAS, these questions about mental health are stigmatizing, discriminatory, violate personal privacy, and have not been shown to elicit responses by which professional competence can be judged (9); and

WHEREAS, the presence of these questions on licensing applications may cause physicians to avoid or delay treatment of personal illness (9) due to fear of negative consequences in the workplace, including retribution, exclusion, loss of license or even their job (4); and

WHEREAS, states in which neither the initial nor the renewal application were consistent with the Federation of State Medical Boards' (FSMB's) recommendations had physicians who were statistically significantly more likely to be reluctant to seek help (odds ratio, 1.21; 95% CI, 1.07-1.37; P=.002) (4); and

WHEREAS, reluctance to seek help was more prevalent in states where the initial and renewal medical licensure application forms were considered "inconsistent" with FSBM recommendations, defined as asking about *ever* having a history of mental health conditions and/or seeking treatment versus simply asking about current (within the last 12 months) mental health conditions and/or treatments (4); and

WHEREAS, the 2018 FSMB policy highlights the difference between impairment and illness by specifically attributing the "inability of a physician to provide medical care with reasonable skill and safety due to illness or injury" as impairment (10); and

WHEREAS, the 2018 FSMB recommendations are to use:

- "only if impaired": if mental health questions are asked, they are limited to conditions resulting in impairment
- "only current": if mental health questions are asked, they are limited to questions about conditions within the last 2 years
- "safe haven non-reporting": if mental health questions are asked, safe haven nonreporting is offered [i.e., allowing physicians to not report diagnoses or treatment history if they are being monitored by and are in good standing with a Physician Health Program]
- "supportive language": inclusion of supportive or normalizing language regarding seeking mental health care (10); and

WHEREAS, only 1 state licensing board application was consistent with all 4 areas of the FSMB's recommendations and 5 states in the United States were inconsistent in all areas (11); now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports the adoption of the 2018 Federation of State Medical Boards recommendations which limit licensing questions to current mental health conditions resulting in impairment by all states and territories; and, be it further

RESOLVED, that the AOA supports removing intrusive mental health questions from medical licensure and credentialing applications that are not compliant with the Americans with Disabilities Act (ADA).

Attachment:

https://jamanetwork.com/journals/jama/fullarticle/2780002?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jama.2021.2275 (2)

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2. Federation of State Medical Boards. *Physician Wellness and Burnout*. Published April 2018. Accessed March 16, 2021. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf
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9. Schroeder R, Brazeau CM, Zackin F, Rovi S, Dickey J, Johnson MS, Keller SE. Do state medical board applications violate the americans with disabilities act? Acad Med. 2009
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Background Information: Provided by AOA Staff

Current AOA Policy:

H362-A/19 Safe Haven Non-Reporting Protections for Physicians - White Paper

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Not Adopted___

DATE: ___July 20, 2024_____

AMERICAN OSTEOPATHIC ASSOCIATION

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (400 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Employee Retirement Income Security Act of 1974 (SR-Source-H414-A/19)	BFHP	Public Affairs	Adopted
H-401	Firearm Safety (SR-Source-H425-A/19)	BFHP	Public Affairs	Adopted
H-402	Protecting Patients with Private Insurance from Balance Billing (SR-Source-H426-A/19)	BFHP	Public Affairs	Referred to BFHP
H-403	Physician-Patient Relationship as Related to Proposed Gun Control Laws, Protection of the (SR-Source-H428-A/19)	BFHP	Public Affairs	Adopted
H-404	CMS Rules on Psychotropic Medications in Nursing Facilities (SR-Source-H429-A/19)	BFHP	Public Affairs	Adopted as Amended
H-405	Community Pharmacies; Required Notification of Primary Care Providers Regarding Vaccination Administration (SR-Source-H436-A/19)	BFHP	Public Affairs	Adopted
H-406	Discrimination in Healthcare (SR-Source-H406-A/19)	BFHP	Public Affairs	Adopted as Amended
H-407	Public Information – Correction of, About the Osteopathic Profession (SR-Source-H403-A/19)	BIOM	Public Affairs	Adopted as Amended
H-408	Pharmaceuticals – Support Efforts to Encourage the Proper Disposal of Unused and Expired (SR-Source-H408-A/19)	BORPH	Public Affairs	Adopted as Amended
H-409	Comparative Effectiveness Research (SR-Source-H410-A/19)	BORPH	Public Affairs	Adopted as Amended
H-410	Fluoridation (SR-Source-H412-A/19)	BORPH	Public Affairs	Adopted
H-411	Lead Exposure in Children – Prevention, Detection, and Management (SR-Source-H422-A/19)	BORPH	Public Affairs	Adopted as Amended
H-412	Hepatitis C Screening (SR-Source-H423-A/19)	BORPH	Public Affairs	Adopted as Amended
H-413	Raw Milk – Health Risks (SR-Source-H416-A/19)	BORPH	Public Affairs	Referred to BORPH

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (400 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-414	Vaccines (SR-Source-H417-A/19)	BORPH	Public Affairs	Adopted
H-415	Domestic and Intimate Partner Violence – Development of Programs to Prevent (SR-Source-H418-A/19)	BORPH	Public Affairs	Adopted
H-416	Alert Network – Silver and Gold (SR-Source-H404-A/19)	BORPH	Public Affairs	Adopted as Amended
H-417	Recognizing Food Insecurity as a Public Health Issue (SR-Source-H435-A/19)	BORPH	Public Affairs	Adopted
H-418	Alcohol Abuse (SR-Source-H405-A/19)	BORPH	Public Affairs	Adopted as Amended
H-419	Occupant Protection in Passenger Vehicles (SR-Source-H427-A/19)	BORPH	Public Affairs	Adopted as Amended
H-420	Sudden Infant Death Syndrome (SR-Source-H407-A/19)	BORPH	Public Affairs	Adopted as Amended
H-421	Patient Safety and use for Patients with Pain Conditions (SR-Source-H400-A/19)	BORPH	Public Affairs	Adopted as Amended
H-422	Human Trafficking – Awareness as a Global Health Problem (SR-Source-H401-A/19)	BORPH	Public Affairs	Adopted
H-423	Same-Sex Relationships and Healthy Families (SR-Source-H402-A/19)	BORPH	Public Affairs	Adopted as Amended
H-424	Maternal and Child Healthcare Block Grants (SR-Source-H413-A/19)	CERA	Public Affairs	Adopted as Amended
H-425	Health Care Fraud (SR-Source-H419-A/19)	CERA	Public Affairs	Adopted
H-426	Automated External Defibrillator Availability (SR-Source-H420-A/19)	CSHA	Public Affairs	Adopted
H-427	Enhanced Legislative Support for Behavioral and Mental Health Care	BEL	Public Affairs	Adopted
H-428	Recognition of Intellectual and Developmental Disabilities as a Health Disparity	BEL	Public Affairs	Adopted as Amended
H-429	Artificial Intelligence in Healthcare Report and Action Plan (Resolution H424-A/23 Artificial Intelligence in Healthcare)	BORPH	Public Affairs	Adopted as Amended
H-430	Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of (SR-Source-H424-A/18)	BORPH	Public Affairs	Adopted as Amended
H-431	Warning the Profession and Public about the Potential Dangers of Kratom Use	MOA (Michigan)	Public Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (400 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-432	Continuous Positive Airway Pressure (CPAP), Obstructive Sleep Apnea	OOA (Ohio)	Public Affairs	Referred to OOA
H-433	Against the use of High Fructose Corn Syrup	OOA (Ohio)	Public Affairs	Adopted as Amended
H-434	Recognizing Breast Implant Illness (BII) and Promoting Informed Consent for Breast Implant procedures	OOA (Ohio)	Public Affairs	Referred to BORPH
H-435	Addressing the compromised safety of Healthcare Workers practicing in areas of conflict and the resulting threat to Healthcare Infrastructure	SOMA	Public Affairs	Adopted as Amended
H-436	Childhood and Teenage Sexual Exposure (Amendment to Policy H420-A/21)	SOMA	Public Affairs	Adopted as Amended
H-437	Regulation of Cannabis Edibles	MOMA (Mississippi)	Public Affairs	Referred to MOMA

SUBJECT: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 – SOURCE: H414-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports federal legislation to reform
7 the Employee Retirement Income Security Act (ERISA) of 1974 to ensure the ability
8 of states to guarantee that clinical decisions be made by physicians and that
9 patients have legal remedies in state court. The American Osteopathic Association
10 also supports legislation that extends these protections to clinical decisions
11 impacting patient access to prescription drugs.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted____

DATE: _____July 20, 2024_____

SUBJECT: FIREARM SAFETY – SOURCE: H425-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recommends that physicians ask
7 patients and/ or caregivers about the presence of firearms in the home and counsel
8 patients who own firearms about the potential dangers inherent in gun ownership,
9 especially if vulnerable individuals' children and adolescents are present. The AOA
10 recommends strategies such as secure storage and the use of safety locks to
11 eliminate the inappropriate access to firearms by vulnerable individuals' children
12 and adolescents and recommends all physicians to educate families in the safe use
13 and storage of firearms.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1994; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING – SOURCE: H426-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports patients' right to access
7 emergency medical care at a reasonable cost; and, that the AOA, in emergency
8 medical care, supports a system in which patients are removed from the process of
9 resolving outstanding medical expenses that is beyond their cost sharing
10 responsibilities for in-network care; and, that disputes over the reasonable cost for
11 out of network emergency care be determined by an independent, third party or
12 arbitration.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to the Bureau on Federal Health Programs (BFHP)

DATE: ___July 20, 2024_____

SUBJECT: PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS – PROTECTION OF THE – SOURCE: H428-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 While the American Osteopathic Association (AOA) supports measures that save
7 the community at large from gun violence, the AOA opposes public policy that
8 mandates reporting of information regarding patients and gun ownership or use of
9 guns except in those cases where there is duty to protect, as established by the
10 Tarasoff ruling, for fear of degrading the valuable trust established in the physician-
11 patient relationship.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: __July 20, 2024_____

SUBJECT: CMS RULES ON PSYCHOTROPIC MEDICATIONS IN NURSING FACILITIES – SOURCE: H429-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) ~~petitioned~~ **ADVOCATES FOR** the
7 Centers for Medicare and Medicaid Services (CMS) to exclude hospice patients
8 from the CMS rules for use of psychotropic and antipsychotic medication in ~~NFs~~
9 **NURSING FACILITIES**; and, that the AOA work with CMS to refine the rules
10 governing the ~~PRN~~ **NECESSARY** use of antipsychotic and other psychotropic
11 medications for any nursing facility patient to improve the continuity of patient care,
12 decrease costs, and ease physician burden, based on scientific evidence and valid
13 clinical studies.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: COMMUNITY PHARMACIES; REQUIRED NOTIFICATION OF PRIMARY CARE PROVIDERS REGARDING VACCINATION ADMINISTRATION – SOURCE: H436-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports measures that would
7 require pharmacists to provide documentation of immunizations, administered in the
8 community-based pharmacy setting, to the patient's primary care physician in
9 appropriate registries.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: DISCRIMINATION IN HEALTHCARE – SOURCE: H406-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) adopts a zero-tolerance policy for all
7 forms of patient discrimination; and in concert with other healthcare organizations,
8 and the federal, state**,** and local governments will continue to monitor, correct, and
9 prevent any future negative bias ~~towards one or more patient groups~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999, 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ____July 20, 2024_____

SUBJECT: PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION – SOURCE: H403-A/19

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of International Osteopathic Medicine has reviewed the
3 policy; and

4 WHEREAS, the Bureau of International Osteopathic Medicine believes that the
5 policy remains relevant now, therefore be it

6 RESOLVED, that the Bureau of International Osteopathic Medicine recommends
7 that the following policy be REAFFIRMED.

8 The American Osteopathic Association (AOA) will work with online and public
9 information sites to ensure that content is accurate and unbiased and encourage
10 osteopathic physicians to notify the AOA Division of Media Relations to address
11 misinformation regarding **THE** osteopathic **PROFESSION** ~~medicine~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
AOA Rules and Guidelines on Physicians' Professional Conduct- Source: H505-A/19

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ____July 20, 2024_____

SUBJECT: PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED - SOURCE: H408-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association supports the development of educational
9 materials for the public by the appropriate regulatory/environmental and public
10 health agencies on the dangers of keeping unused and expired pharmaceuticals in
11 their possession; and ~~will~~ supports ~~that such materials also include~~ **INCLUSION OF**
12 education on the proper disposal of unused and expired pharmaceuticals.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: ____July 20, 2024_____

SUBJECT: COMPARATIVE EFFECTIVENESS RESEARCH – SOURCE: H410-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) ~~will continue to engage the osteopathic medical profession in Comparative Effectiveness Research (CER) projects and studies across private organizations and government agencies. The AOA will continue to disseminate CER findings to the osteopathic medical profession, consumers of medical information, patients, family members, and caregivers. The AOA~~ adopts the following principles regarding comparative effectiveness research:

Physicians and Patients

- Comparative effectiveness research should enhance the ability of osteopathic physicians (DOs) to provide the highest quality care to patients utilizing the best proven and widely accepted evidence based medical information at the time of treatment.

- Comparative effectiveness research should not be used to control medical decision-making authority, professional autonomy and should not be used to deny coverage or payment.

- Comparative effectiveness research should enhance, complement, and promote quality patient care, not impede it.

- Guidelines developed as a result of comparative effectiveness research studies should be advisory and not mandatory.

33 • Comparative effectiveness research should be viewed as a positive
34 development for patients and physicians and a useful tool in the physician's
35 armamentarium, working in concert with patients.
36
37 • Physicians in practice should be included in any discussions and decisions
38 regarding comparative effectiveness research.
39
40 • Comparative effectiveness research should focus on clinical effectiveness, not
41 cost effectiveness.
42
43 • The physician/patient relationship must be protected, and the needs of the
44 patients should be paramount.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: FLUORIDATION – SOURCE: H412-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, according to the Centers for Disease Control and Prevention (CDC), in
3 2020, only 72.7% of the US population receive fluoridated water, and many
4 research studies have proven the safety and benefits of fluoridated water;
5 and

6 WHEREAS, for 75 years, the United States population has been drinking water with
7 added fluoride and enjoying the benefits of better dental health; and

8 WHEREAS, community water fluoridation is recommended by nearly all public
9 health, medical, and dental organizations including the American Dental
10 Association, the American Academy of Pediatrics, the US Public Health
11 Service, and the World Health Organization; and

12 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
13 the policy and determined that it is current, now therefore be it

14 RESOLVED, that the Bureau of Osteopathic Research and Public Health
15 recommends that the following policy be REAFFIRMED.

16 The American Osteopathic Association (AOA) supports the fluoridation of fluoride-
17 deficient public water supply.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT – SOURCE: H422-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) encourages physicians and public
9 health departments to screen children for lead based ~~upon~~ **ON** current
10 recommendations and guidelines established by the U.S. Centers for Disease
11 Control and Prevention's Childhood Lead Poisoning Prevention **PROGRAM** ~~and~~,
12 encourages the reporting of all children with elevated blood lead levels to the
13 appropriate health department in their state or community in order to fully assess
14 the burden of lead exposure in children, and encourages public health policy
15 initiatives that identify exposure pathways for children and ~~develop~~ **THE**
16 **DEVELOPMENT OF** effective and innovative strategies to reduce overall childhood
17 lead exposure.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: HEPATITIS C SCREENING – SOURCE: H423-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

~~The American Osteopathic Association (AOA) publicly supports universal screening of **ADULTS AGED 18 TO 79 YEARS FOR HEPATITIS C VIRUS (HCV)** baby boomers (those born 1945-1964) in addition to, testing those at risk for HCV, and promote **PROMOTING HCV** public educational programs that educate their members about HCV, **ADDRESSING** testing strategies, and treatment. The AOA will work with public health entities to educate the public about the need for testing and treatment.~~**THE AOA SUPPORTS UNIVERSAL SCREENING AND APPROPRIATE PERIODIC TESTING FOR THOSE AT RISK FOR HEPATITIS C PER CURRENT CDC GUIDELINES AND SUPPORTS THE PROMOTION OF HCV PUBLIC EDUCATION PROGRAMS ADDRESSING TESTING STRATEGIES AND TREATMENTS.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: RAW MILK – HEALTH RISKS – SOURCE: H416-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) believes that all milk sold for human
7 consumption should be required to be pasteurized; and encourages osteopathic
8 physicians to educate their patients on the safety concerns and the health risks of
9 consuming raw milk.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau of Osteopathic Research and Public Health (BORPH)

DATE: July 20, 2024

SUBJECT: VACCINES – SOURCE: H417-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) will continue to promote evidence-
7 based information on vaccination compliance and safety.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As note above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: DOMESTIC AND INTIMATE PARTNER VIOLENCE DEVELOPMENT OF PROGRAMS TO PREVENT – SOURCE: H418-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will continue to support the efforts of
7 the United States Department of Health and Human Services to develop and foster
8 programs that prevent domestic and intimate partner violence.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1989; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: ALERT NETWORK – SILVER AND GOLD – SOURCE: H404-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **SUPPORTS** ~~endorses~~ the wide-spread state adoption of emergency response systems for missing mentally impaired adults throughout the United States, via “Silver Alert” and “Gold **(OR GOLDEN)** Alert” networks which are also known as “Endangered Person Advisory Networks.”

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: RECOGNIZING FOOD INSECURITY AS A PUBLIC HEALTH ISSUE – SOURCE: H435-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recognizes food insecurity as a
7 public health issue.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: ALCOHOL ~~ABUSE~~ **MISUSE** – SOURCE: H405-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) **SUPPORTS** ~~endorses~~ local, state,
9 and federal legislation that would control the consumption and purchase of alcohol
10 by individuals under the age of twenty-one~~,~~ and **SUPPORTS** ~~urges that~~ alcohol
11 ~~abuse~~ **MISUSE** prevention and treatment programs ~~be given~~ as a high national
12 priority.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1974; 1987 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1997 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: OCCUPANT PROTECTION IN PASSENGER VEHICLES – ~~WHITEPAPER~~ – SOURCE: H427-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) has reviewed the policy; and

WHEREAS, the current white paper provides consumer information from the websites of the National Highway Traffic Safety Administration and the National Safety Council; and

WHEREAS, in 2023, the National Safety Council updated its My Car Does What? website[1] to include an organized overview of the safety features available in specific vehicle types, simple explanations of what different technologies can and cannot do, and an extensive video library addressing automobile safety, all of which will be updated as needed; and

WHEREAS, the National Highway Traffic Safety Administration updates it's website[2] with annual statistics, and provides extensive information addressing Vehicle Safety including Car Seats and Booster Seats, Seat Belts, Tires, Air Bags, Driver Assistance Technologies, Electric and Hybrid Vehicles, Automated Vehicles for Safety, and Adapted Vehicles which is updated as needed; and

WHEREAS, the information from the National Safety Council and the National Highway Traffic Safety Administration is readily available to consumers and is updated regularly by these organizations; and

WHEREAS, after review of this information, the Bureau of Osteopathic Research and Public Health developed a policy statement supporting the ongoing work of the National Safety Council and the National Highway Traffic Safety Administration on Occupant Protection in Passenger Vehicles in lieu of a white paper, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA):

1) SUPPORTS THE ONGOING EFFORTS OF THE NATIONAL SAFETY COUNCIL AND THE NATIONAL HIGHWAY TRAFFIC AND SAFETY

ADMINISTRATION AND OTHER RESPONSIBLE SAFETY ORGANIZATIONS TO EDUCATE THE PUBLIC REGARDING THE PROPER USE OF ALL OCCUPANT PROTECTION EQUIPMENT IN PASSENGER VEHICLES AND THE BENEFITS AND POTENTIAL DANGERS OF ALL OCCUPANT PROTECTION EQUIPMENT AND ACCIDENT-AVOIDANCE SYSTEMS.

2) **URGES RESEARCH AND DEVELOPMENT OF SAFER AUTOMOBILES AND CONTINUED MONITORING OF INJURIES AND FATALITIES RESULTING FROM TRAFFIC ACCIDENTS AND FAULTY AND/OR IMPROPER USE OF ALL OCCUPANT PROTECTION DEVICES IN PASSENGER VEHICLES.**

References:

1. My Car Does What https://mycardoeswhat.org/
2. https://www.nhtsa.gov/

~~White Paper - Occupant Protection in Passenger Vehicles~~

~~INTRODUCTION~~

~~Today, almost every vehicle on the road has safety features that help drivers to be safer, either through protecting drivers and passengers involved in a crash or to preventing passenger vehicle crashes. This paper will provide information on all vehicle safety features and whether or not the feature is federally mandated, as well as recommend associated policy for adoption by the AOA.~~

~~OCCUPANT PROTECTION IN PASSENGER VEHICLES~~

~~Occupant protection includes safety belts, lower anchor and tethers for children (LATCH), airbags, and active head restraints. These features were designed to protect both drivers and passengers.~~

~~In 2016, National Highway Traffic Safety Administration (NHTSA) developed a fact sheet with information on passenger vehicle occupant protection, which included the use of restraints and benefits of safety belts, frontal airbags, and child restraints. According to the fact sheet, safety belts saved an estimated 14,668 lives of passenger vehicle occupants 5 years old and older in 2016, frontal air bags saved an estimated 2,756 lives, and car seats saved an estimated 328 lives of children under the age of 5 years.[1] NHTSA estimated that lap/shoulder safety belts, when used, reduce the risk of fatal injury among front-seat passenger vehicle occupants by 45%; moderate to critical injury to front-seat passenger vehicle occupants by 50%; fatal injury in front-seat light truck occupants by 60%, and moderate to critical injury to front-seat light truck occupants by 65%.[1]~~

~~Frontal airbags, combined with lap/shoulder bags offer effective safety protection for passenger vehicle occupants. NHTSA estimated that the use of frontal airbags without safety belts reduced the fatality risk by 11%, and when using safety belts, fatality drops further by 14%. In 2016, frontal airbags saved an estimated 2,756 lives. From 1987, when airbags first began to be installed in passenger vehicles, through 2016, 47,648 lives were saved.[1]~~

~~NHTSA estimated that car seat use in passenger vehicles reduce the risk of fatal injury by 71 % for infants younger than 1 year of age and 54 % for toddlers age 1 to 4 years. For infants and toddlers, the risk of fatal injury in light trucks is 58 % for infants younger than 1 year, and 59 % for toddlers ages 1 to 4 years. In 2016, car seat restraints saved an estimated 328 lives of children age 4 years and younger (313 associated with the use of car seats and 15 with the use of adult safety belts). NHTSA estimated that an additional 42 lives could have been saved (a total of 370 children age 4 and younger). Since 1975, the lives of 11,274 children 4 years old and younger involved in automobile accidents were saved because of child restraint use.[1]~~

~~There is an abundance of technology available to protect occupants of passenger vehicles. Most of the advancements have been in place for many years. As technology progressed, many of the features improved, resulting in more saved lives.~~

~~***Safety-Belt Features***~~

~~While the seat belt is the most important piece of automotive safety equipment, enhanced features have helped the seat belt do its job more efficiently.[2]~~

~~On March 1, 1967, the first Federal Motor Vehicle Safety Standard (FMVSS) mandate required that all passenger vehicles have safety belts. FMVSSs are United States federal regulations specifying the design, construction, performance, and durability requirements for passenger vehicles safety-related components, systems, and design features. FMVSSs are developed and enforced by the National Highway Traffic Safety Administration (NHTSA), pursuant to the National Traffic and Motor Vehicle Safety Act of 1966.~~

~~Safety belts now have belt tensioners; a device designed to pull a seat belt tight in an accident. This feature helps position passengers properly to take full advantage of a deploying airbag.[2]~~

~~Force limiters, companions to belt tensioners, reduce the force of the seat belt above a certain threshold and, in conjunction with belt tensioners and airbags, lessen the risk of upper body injuries to front seat passengers.[2]~~

~~Other seatbelt enhancements include inflatable seatbelts and adjustable shoulder anchors. Some car models have inflatable safety belts in the rear seat that reduces the force of the seat belt on passengers involved in an accident. Inflatable safety belts help protect the elderly and children who are the primary rear seat occupants.[2]~~

~~Safety belts also have adjustable shoulder anchors that help position the belt across the chest instead of the neck, which helps prevent neck injuries.[2]~~

~~***Latch (Lower Anchors and Tethers for Children)***~~

~~All passenger vehicles are now required to have the LATCH system. This system not only encourages the use of child safety seats but also integrates lower anchors and top tether attachment points. These anchors and attachment points allow the installation of the car safety seat to be effortless and eliminate the challenges and incompatibilities of installing a car safety seat. However, in some cars and trucks, the LATCH system is challenging to use correctly.[2]~~

~~NHTSA developed a traffic fact sheet that contains information on the fatal motor vehicle crashes and facilities, based on the Fatality Analysis Reporting System (FARS). Assuming that all passenger vehicle crashes have the LATCH system, in 2017, there were 23,351 passenger vehicle occupants killed in fatal crashes, 794 (3.3%) were infants (less than 1 year) to age 14. Of the 794 children killed, 244 (31%) were in a child restraint seat, 202 (25%) were in a lap belt only or shoulder, and lap belt and 103 (13%) were unknown. Of the 39,822 passenger vehicle occupants who survived in fatal crashes, 4,700 (11.8%) were infants (less than 1 year) to age 14 and 509 (11%) was unrestrained. Of the 63,373 passenger vehicle occupants involved in fatal crashes, 5,494 (8.7%) were infants (less than 1 year) to age 14, and 776 (15%) was unrestrained.[3]~~

~~***Airbags***~~

~~Since 1998, front airbags have been standard on all new cars, and since 1999, airbags have been standard on light trucks. The on-board computer-connected crash sensors detect a frontal collision and trigger the bags. In a few milliseconds, the bag inflates, then immediately deflates.[2]~~

~~Airbags have saved thousands of lives, but they also have the potential to cause children or occupants who do not use a seat belt to suffer injury or even death.[2] "From 1987 to 2015, frontal air bags saved 44,869 lives. That is enough people to fill a major league ballpark."[4] In 2016, the estimated number of lives saved by frontal airbags were 2,756.[4]~~

~~According to a Special Crash Investigations Report released in January 2009, from 1990 through January 1, 2009, there have been 296 airbag-related fatalities, (191 children, 92 adult drivers, and 13 adult passengers).[5] Also, the Takata airbag defection has caused 16 deaths in the U.S.; and 24 deaths and 300 injuries worldwide.[4]~~

~~Adaptive or dual-stage front airbags were introduced in 2003 and became the standard by 2007. Most airbag systems now have sensors that detect weight and the seat position of the driver and front passenger. The airbag system will deactivate if it senses that the driver is positioned too close to the wheel or the front passenger or child is out of position. This system minimizes injury from an accident.[2]~~

> ~~**Side Airbags.** Side-impact airbags protect the torso of front seat passengers. (Consumer Reports 2016) Depending on the passenger vehicle model, side airbags are offered as standard or optional equipment on many new passenger vehicles.[4]~~
>
> ~~**Side Curtain Airbags.** Side curtain airbags are designed to prevent occupants from hitting their heads and shielding them from flying debris. They remain inflated longer than other airbags to keep people from being ejected during a rollover or a high-speed side crash.[2]~~
>
> ~~A standard enacted late in 2007 and effective September 1, 2009, NHTSA mandated that all automakers phase in additional side-impact protection as a standard feature for their cars, trucks, and SUVs by 2013.[7]~~

~~***Active Head Restraints***~~

~~In a rear crash, active head restraints move up and forward to cradle the head and absorb energy to diminish whiplash injury.[2]~~

~~**ACCIDENT AVOIDANCE SYSTEMS**~~

~~The automotive industry is continually developing traffic safety technologies that will help drivers avoid crashes. Some of these technologies have a warning system and rely on the driver to take corrective action, while others are designed to automatically brake or steer, thus taking an active action approach to accident prevention. These features are expected to contribute to an overall improvement in traffic safety.~~

~~AAA Foundation for Traffic Safety developed a research brief that presented the probable safety benefits of various advanced driver assistance systems and provided estimates regarding the numbers of crashes, injuries, and deaths that such systems could have potentially helped to prevent based on the characteristics of the crashes that occurred on U.S. roads in 2016.[8]~~

~~According to the brief, the Forward Collision Warning (FCW) could theoretically have prevented an estimated 69-81% of all rear-end crashes, 76-81% of angle crashes, and 23-24% of single-vehicle crashes, totaling approximately 2.3 million crashes and 7,166 fatal crashes per year between 2002 and 2006. In 2016, there were an estimated 1,994,000 crashes, 884,000 injuries and 4,738 deaths that could have been prevented or mitigated by the FCW system if it were a standard feature in all vehicles.[8]~~

~~The brief estimated that Lane Departure Warning (LDW) and Lane Keeping Assistance (LKA) technology equipped in passenger vehicles could have theoretically addressed 179,000 crashes and 7,529 fatal crashes annually between 2004 and 2008. In 2016, there were an estimated 519,000 crashes, 187,000 injuries, and 4,654 deaths that could have been prevented or mitigated by LDW or LKA systems.[8]~~

~~The brief estimated that blind spot warning systems (BSW) could have prevented approximately 24% of all lane-changing crashes between 2004 and 2008. In 2016, there were an estimated 318,000 crashes, 89,000 injuries, and 274 deaths that could have been prevented by the BSW system.[8]~~

~~There is also an abundance of advanced driver assistance technology available. This technology is designed to prevent crashes. The features are relatively new; thus, they will have varying levels of NHTSA recognition.~~

~~***Forward Collision Prevention/Warning (FCW)***~~

~~**Adaptive Headlights.** Adaptive headlights are primarily intended to move side-to-side to help illuminate curves and corners. "These headlights use electronic sensors that can detect your steering angle to swivel based on the direction your car is heading."[9]~~

~~**Bicycle Detection.** The bicycle detection feature alerts the driver to a potential collision with a bicyclist ahead. NHTSA has not set any performance specifications for this feature.[10]~~

~~**Forward-Collision Warning (FCW).** Forward-collision warning utilizes cameras, radar or laser to scan for autos ahead and alert the driver that they are moving toward a vehicle in their path excessively quick and an accident is inescapable. Most Forward-Collision warning systems alert the driver with a visual and or audible signal to a potential accident, allowing time for a reaction.[2]~~

~~This system meets NHTSA performance specifications but is an option on many new cars, SUVs, and trucks.[11]~~

~~**Left Turn Crash Avoidance.** Left turn car avoidance feature monitors traffic when the driver turns left at low speeds. The sensor automatically activates warning sounds, dash lights, and brakes when a driver turns left into another car's path. NHTSA has not set any performance specifications for this feature.[12]~~

~~**Obstacle Detection.** Obstacle detection uses sensors mounted on the front and/or rear bumpers to determine the distance between the car and a nearby object. If an object is detected, the sensor automatically slows down the passenger vehicle. NHTSA has not set any performance specifications for this feature.[13]~~

~~**Pedestrian Detection.** This system utilizes the features of the Forward-Collision Warning system and automatically initiates the car's braking system to protect pedestrians from being hit. The car's camera or radar looks for a pedestrian in the path of the vehicle. Some systems will alert the driver with an audible or visual alert, and some systems will automatically initialize the emergency braking system if the collision is deemed high.[2]~~

~~NHTSA has not set any performance specifications for this feature but recognized that this is a promising technology. This system is currently an option on many new cars, SUVs, and trucks.[2]~~

~~***Breaking, Tire Pressure, and Anti-Rollover***~~

~~**Brake Assist.** Brake Assist helps detect when a driver is braking to maximum strength. In conjunction with anti-lock brakes, the system allows braking without locking the wheels. Studies have shown that most drivers are not braking as hard as they can, so Brake Assist intervenes to reach the shortest stop distance possible.[2]~~

~~**Traction Control.** Traction control electronically controls the wheels spinning motion during acceleration to obtain the maximum traction. This system is useful in wet, icy, or snowy conditions.[2]~~

~~**Electronic Stability Control (ESC).** Electronic stability control (ESC) is a step beyond traction control. In order to avoid sliding or skidding, this system helps keep the vehicle on its intended path during a turn. ESC uses a series of sensors connected to a computer to detect wheel speed, steering angle, side movement, and yaw (rotation). If the car drifts outside the intended path, the stability control system momentarily brakes one or more wheels and reduces the power of the engine to pull the car back on track depending on the system.[2]~~

~~ESC is particularly useful for tall, heavy-duty vehicles such as sports equipment pickups; helping to keep the vehicle from rollover.[2]~~

~~The federal government required stability control on all vehicles by the 2012 model.[2]~~

~~**Anti-Lock Braking System (ABS).** Before the invention of the anti-lock braking system (ABS), car wheels easily locked during hard braking which caused the front tires to slide and made steering impossible; which is dangerous on slippery surfaces. ABS prevents this from occurring. ABS uses sensors that are controlled by a computer on each wheel. The system maximizes the breaking action on each wheel to avoid locking the wheel which results in the driver maintaining control of the car to avoid hitting obstacles.[2]~~

~~"Over the past 10 years, most car manufacturers have made ABS standard in their vehicles. The federal government required all new cars to have ABS by September 1, 2011."[14]~~

~~**Automatic Emergency Braking (AEB).** AEB adds to the advantages of forward-crash cautioning. AEB will detect a potential crash, and if the response time is moderate, the vehicle will start braking.[2] This system engages Dynamic Brake Support and Crash Imminent Braking technology.~~

> ~~**Dynamic Brake Support (DBS) and Crash Imminent Braking (CIB).** If the driver does not brake hard enough to evade a crash, the DBS system will automatically supplement the driver's breaking to avoid the collision. If the driver does not take any action to prevent the accident, the CIB system will automatically apply the car's brakes to slow or stop the vehicle. (National Highway Traffic Safety Administration n.d.) This system has been available on some car models since 2006 but is typically an optional feature on many new cars, SUVs, and trucks.[15] NHTSA does recommend the CIB and DBS system if it meets NHTSA's performance specifications.~~

~~**Temperature Warning.** Temperature warning alerts the driver when the outside temperature is detected to be at or below freezing, which can affect road conditions. NHTSA has not set any performance specifications for this feature.[16]~~

~~**Hill Descent Assist.** Hill descent assist works with the passenger vehicle's existing braking systems to block the driver from going past a certain speed while traveling downhill or on treacherous terrain. If the vehicle begins accelerating past a safe downhill speed, this feature further applies the brakes. NHTSA has not set any performance specifications for this feature.[17]~~

~~**Hill Start Assist.** Hill start assist uses sensors in the vehicle to detect when a vehicle is on an incline. For a set time, the system maintains the brake pressure as the driver switches from the brakes to the gas pedal. Once the driver presses the accelerator, it releases the brake. In cars with a manual transmission, the Hill Start Assist also maintains brake pressure until the driver lets up on the clutch. NHTSA has not set any performance specifications for this feature.[18]~~

~~***Driver State Monitoring***~~
~~**Tire-Pressure Monitor System.** Tire pressure monitoring systems (TPMS) warn drivers of under or overinflated tires. The system helps to increase the car's fuel economy and potentially prevent a tire blowout which can be dangerous at high speeds and lead to a car accident. The federal government required all new vehicles to include this system starting in late 2007.[19]~~

~~**Curve Speed Warning.** Curb speed warning uses Global Positioning System (GPS) to alert the driver of upcoming sharp turns. This feature tracks the passenger vehicle speed and location and warns the driver to slow down when approaching curves and exits. NHTSA has not set any performance specifications for this feature.[20]~~

~~**High-Speed Alert.** High-speed Alert uses a built-in speed sensor and GPS to compare a database of known road speed limit against the driver's actual speed and alerts the driver if they are speeding. Some versions may track school and work zones. Future versions may be able to read limits through a camera. NHTSA has not set any performance specifications for this feature.[21]~~

~~**Adaptive Cruise Control (ACC).** ACC utilizes lasers, radar, cameras, or a blend of these to keep a steady distance between the driver and the vehicle ahead. If the traffic slows, some systems automatically stop the car and automatically accelerate to full speed when the traffic returns to normal. The system allows the driver to lose their focus on driving, which is a hazard.[2]~~

~~**Push Button Start.** Push Button Start simplifies turning the passenger vehicle on and off using a key fob unique to the vehicle. NHTSA has not set any performance specifications for this feature.[22]~~

~~**Drowsiness Alert.** Drowsiness alert borrows some of the sensors from lane departure warning systems to track lane markings and the automobile's lane position. Many versions of this feature will track how often the driver departs from the lane over a short period to determine if the driver may be drowsy. This feature may alert the driver using a coffee cup or other symbol on the dash suggesting that the driver take a break and when it will be safe to pull over. NHTSA has not set any performance specifications for this feature.[23]~~

~~Automatic High Beams. Automatic high beam lights switch from high to low and back again to improve nighttime visibility and as conditions warrant.[2]~~

~~***Parking and Backing Assistance***~~
~~**Backup Camera.** The backup camera assistance system is activated when the driver of a passenger places the gear in reverse. The monitor is in the center console of the passenger vehicle and displays items behind the car. This system is primarily used as a parking aid or spotting a child or pedestrian concealed in the blind zone.[2]~~

~~NHTSA required this life-saving technology on all new vehicles in May 2018.[11]~~

~~**Back-up Warning.** Back-up warning uses sensors mounted to the rear bumper. These sensors detect objects in the path of the vehicle. The system may beep or vibrate if an object is in the way.[24]~~

~~At this time, this is not a new car standard. As stated above, NHTSA required this life-saving technology on all new vehicles in May 2018.[15] In the future, manufacturers are expected to pair the back-up warning and the back-up camera systems in new cars.~~

~~**Parking Assist System.** Parking assist incorporates sensors in the car's front, rear, or both bumpers. The system alerts the driver that light poles, walls, shrubbery, and other obstacles are close when the passenger vehicle is moving at a slow speed (parking speed).[2]~~

~~**Automatic Parallel Parking.** Automatic parallel parking can detect objects in front and back of a car while parking. It provides audible warnings when detecting one or more objects. Advanced sensors read the gaps between vehicles in the area where the driver chooses to park. The feature will not activate if there is insufficient room to parallel park, which helps ensure that the car does not bump into any nearby vehicles. When initiated, this feature takes over some of the vehicle's steering and acceleration functions needed to park.[25]~~

~~Rear Cross-Traffic Alert. Rear cross-traffic alerts sense traffic crossing the path of a passenger vehicle as the driver backs out of a parking space or driveway. Some systems automatically brake to prevent an accident.[2]~~

~~The Rear cross-traffic alert system is not a standard feature for passenger vehicles, but the federal government does mandate the feature for such vehicles as buses and trucks. However, manufacturers often pair rear cross traffic alert with back-up cameras; so the mandate may increase the popularity of rear cross traffic alert features soon.[26]~~

~~***Lane and Side Assistance***~~
~~**Lane-Departure Warning (LDW).** Lane-departure warning alerts the driver when the car drifts out of its lane without activating the turn signal. The system uses a camera or lasers to monitor lane markers. The system will chime, the dashboard will blink, or the steering wheel or seat will vibrate~~

~~to warn the driver that they are drifting into another lane.[2] This system meets NHTSA's performance specifications and is an option on many new cars, SUVs, and trucks.[15]~~

~~**Lane-Keeping Assist (LKA).** Lane-keeping assist will generate mild steering to put the driver back in their lane. This system also senses when the driver leaves their lane.[2]~~

~~NHTSA has not set performance specifications for this technology, but this technology may be available on new cars, SUVs, and trucks.[15]~~

~~**Blind-Spot Warning (BSW) or Blind Spot Detection (BSD).** BSW utilizes radars or cameras and shines a light or symbol in or adjacent to the outside mirrors to warn the driver that another vehicle is driving in the parallel lane in an area that the drivers outside mirrors cannot detect. This system will sound an audible warning if the driver attempts to change lanes or uses their turn signal to indicate that they plan to change lanes. There are additional advanced systems that can initiate the braking system or the steering system in order to move the vehicle back towards the center of the lane.[2]~~

~~NHTSA has not set performance specifications for BSW, but NHTSA recognizes this as a promising technology. On many new cars, SUVs, and trucks, this system is an option and can help avoid a crash.[14]~~

~~**Side View Camera.** Side view cameras improve visibility on the passenger side, and in some cases provide the driver with a circuit view of the surrounding area of the car. The driver can use this feature to protect bumpers, side mirrors, trim, and wheel rims from damage at low speeds. This camera also provides an expanded view of a lane beside the driver when the driver uses their turn signal or when the driver manually activates this feature. This feature is similar to the blind spot monitor.[27]~~

~~***Communication***~~

~~**911 Notification - Automatic Crash Notification (ACN).** ACN is technology designed to notify emergency responders that an accident has occurred and provide the location. This system uses sensors to detect a deployed airbag or detect a dramatic and sudden deceleration. Once this is detected, the system will automatically connect to an operator who will be able to talk with the accident victims.[15]~~

~~This system has the potential to reduce death and disability by reducing the time it takes for emergency medical services to reach an accident scene and transport victims to a hospital.[15]~~

~~NHTSA has not set performance specifications for this technology. This system is available as an option on many new cars, SUVs, and trucks.[15]~~

~~**Telematics.** Telematics is the use of cellular, Global Positioning Satellite (GPS), and other technology (e.g., GM OnStar, BMW Assist, Hyundai Bluelink, Kia UVO, Lexus Safety Connect, Mercedes-Benz's mBrace, and Toyota Safety Connect) to gather and transmit data. "This system allows the driver to communicate with a central dispatch center at the touch of a button. This center knows the location of the vehicle and can provide route directions"[28] of emergency aid on request.[2]~~

~~**CONCLUSION**~~

~~There are many safety features to prevent automobile accidents and protect drivers. Because some do carry the potential risk of harm, these features continue to evolve. Research is regularly conducted to ensure that passenger vehicles are able to lessen the impact of crashes, reduce injuries and help drivers prevent crashes. However, consumer education is needed on the proper use of existing safety features. NHTSA, for example, not only conducts research and establish standards, but insurance companies and not-for-profit agencies such as AAA Foundation for Traffic Safety conduct research.~~

~~Although some crashes are unavoidable, the probability that passenger vehicle crashes,~~ ~~**INJURIES, AND DEATH** will continue to decrease is high because of the ongoing research, available educational opportunities, and existing and future advanced technologies.~~

~~After review of the existing literature on automotive safety, including airbags, the American Osteopathic Association (AOA) adopts the following policies: The American Osteopathic Association:~~

~~(1) supports the ongoing efforts of the National Safety Council (NSC), the National Highway Traffic and Safety Administration (NHTSA), the National Transportation Safety Board (NTSB) and other responsible safety organizations to educate the public regarding the proper use of all occupant protection devices in passenger vehicles, including safety belts, child safety seats, and airbags;~~

~~(2) urges continued corporate development and research into safer airbags and monitoring of adult and child fatalities resulting from airbag deployment; and~~

~~(3) encourages the National Safety Council, the National Highway Traffic and Safety Administration, the National Transportation Safety Board, and other responsible safety organizations to educate the public regarding the benefits and potential dangers of all occupant protection equipment and accident avoidance systems.~~

~~(4)~~

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: _____July 20, 2024_____

SUBJECT: SUDDEN INFANT DEATH SYNDROME – SOURCE: H407-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **SUPPORTS** ~~urges~~: continued research into the causes and prevention of sudden infant death syndrome (SIDS); ~~that~~ **ENCOURAGES THE AVAILABILITY OF** information based on current medical literature ~~be made available~~ to the public on the nature of sudden infant death syndrome and proper counseling ~~be available~~ to families who lose infants to this disease; and supports the US Department of Health and Human Services and Centers for Disease Control and Prevention campaigns by encouraging its members to educate ~~the~~ parents and care-givers of infants on strategies to reduce the risk of SIDS.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1974; 1980 Reaffirmed; 1985 Reaffirmed; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: PATIENT SAFETY AND **OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)** USE FOR PATIENTS WITH PAIN CONDITIONS – SOURCE: H400-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) affirms that **OSTEOPATHIC**
9 **MANIPULATIVE TREATMENT** (OMT) is a safe intervention and should be
10 considered as first-line treatment for patients with pain associated with Somatic
11 Dysfunction and other appropriate conditions.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM – SOURCE: H401-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) acknowledges human trafficking as
7 a violation of human rights and a global public health problem; encourages
8 osteopathic physicians to be aware of the signs of human trafficking and the
9 resources available to aid them in identifying and addressing the needs of victims
10 of human trafficking, including appropriate medical assessment, and reporting to
11 law enforcement.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: ~~SAME-SEX~~ **LGBTQIA+** RELATIONSHIPS AND HEALTHY FAMILIES – SOURCE: H402-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy and determined that it is current, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) recognizes the need of ~~same-sex~~ **LGBTQIA+** households to have the same access to health insurance and health care as ~~opposite-sex~~ **HETEROSEXUAL/CISGENDER** households and supports measures to eliminate discrimination against ~~same-sex~~ **LGBTQIA+** households in health insurance and health care. The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for ~~same-sex~~ **LGBTQIA+** marriages and civil unions and the children of those families.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended____

DATE: ____July 20, 2024_____

SUBJECT: MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS – SOURCE: H413-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) supports government expenditures
7 for the Title V Maternal and Child Healthcare Block Grant Program and the efficient
8 use of its resources. ~~The AOA supports ensuring sufficient funding for this program.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1988; 1993 Reaffirmed; 1998 Reaffirmed; 2003 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: HEALTH CARE FRAUD – SOURCE: H419-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) urges the Center for Medicare and
7 Medicaid Services (CMS) to: (1) disclose to the public and the medical community
8 the actual amount of "fraud" in dollars, based on the reasonable definition of “fraud”
9 omitting all denied and resubmitted claims and all honest mistakes by physicians
10 and the Medicare carriers; and (2) strongly opposes the use of law enforcement
11 agencies and auditors to enter physicians’ offices without prior request, warning or
12 due process under the law for the purpose of confiscating records.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: AUTOMATED EXTERNAL DEFIBRILLATOR AVAILABILITY
-SOURCE: H420-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) recommends an Automated External
8 Defibrillator (AED) be placed in as many public places as possible and supports
9 legislation that will limit the liability for installing an AED for use by the public.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic:
Promotion for the Requirement of All Sporting Events to Have Access to An Automated External Defibrillator (AED) - Source: H410-A/22

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: ENHANCED LEGISLATIVE SUPPORT FOR BEHAVIORAL AND MENTAL HEALTH CARE

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Public Affairs

WHEREAS, seeking care for mental health disorders is becoming increasingly common, with the number of visits to emergency departments for mental, behavioral, and neurodevelopmental diagnoses amounting to 5.8 million visits per year[1]; and

WHEREAS, the COVID-19 pandemic exacerbated mental health issues for both adults and children with rates of depression and anxiety increasing by greater than 60% following the onset of the pandemic[2]; and

WHEREAS, there are limited resources, staff and training for mental health conditions in local communities, schools, emergency departments and urgent care facilities, which leads to restricted mental healthcare access, even in emergency situations[3]; and

WHEREAS, the cost of accessing mental health resources contributes to health disparities across different socioeconomic backgrounds[3]; and

WHEREAS, addressing the shortage of mental health professionals, particularly in rural and underserved areas, requires greater legislative support to enhance comprehensive access to mental health initiatives regardless of geographic location or socioeconomic status; and

WHEREAS, the American Osteopathic Association (AOA) supports access and affordability for various medical services but has no comprehensive legislative policy on mental health care; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports legislative and other efforts to enhance access to behavioral and mental health care resources in local communities, schools, emergency departments and urgent care facilities.

Citations

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Background Information: Provided by AOA Staff
Current AOA Policy:

Prior HOD action on similar or same topic:
Healthy Life Styles - H406-A/18
Firearm Violence - H442-A/20
Homeless Support - H449-A/20

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted____

DATE: __July 20, 2024_____

SUBJECT: RECOGNITION OF INTELLECTUAL AND DEVELOPMETAL DISABILITES AS A HEALTH DISPARITY

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Public Affairs

WHEREAS, it is well recognized that individuals with intellectual and developmental disabilities (IDD) face ~~attitudinal, communicative, physical, political, programmatic, social, and transportational~~ barriers[1]; and

WHEREAS, people with disabilities often experience a wide range of health conditions that lead to poorer health and shorter lifespan, along with barriers to timely and comprehensive health care[2]; and

WHEREAS, the American Osteopathic Association (AOA) has a policy statement in place with a call to action to address health disparities through various methods; and

WHEREAS, in September 2023, the National Institute of Health (NIH) officially recognized people with disabilities as a population with health disparities, in an effort to support health equity research for this population; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes people with Intellectual and Developmental Disabilities (IDD) as a population with health disparities; and, be it further

RESOLVED, that the AOA includes the IDD population in health disparity education, research, and legislative efforts to enhance health equity in this population.

Citations:

1. Centers for Disease Control and Prevention. (2020, September 16). Disability and health disability barriers. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html

2. Lagu T, Griffin C, Lindenauer PK. Ensuring access to health care for patients with disabilities. JAMA Intern Med. 2015 Feb;175(2):157-8. doi: 10.1001/jamainternmed.2014.6740. PMID: 25486022; PMCID: PMC4545487.

Background Information: Provided by AOA Staff

Current AOA Policy:

Prior HOD action on similar or same topic:
Minority Health Disparities – Source: H428 – A/20

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 20, 2024_____

SUBJECT: ARTIFICIAL INTELLIGENCE IN HEALTHCARE REPORT AND ACTION PLAN

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the 2023 House of Delegates approved Resolution H424-A/23 Artificial Intelligence in Healthcare which resolved that AOA will provide a report and action plan to the House of Delegates at its meeting in 2024; and

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) developed the attached report and action plan in response to Resolution H424-A/23 Artificial Intelligence in Healthcare; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) approve the report and action plan.

Artificial Intelligence in Healthcare

The use of Artificial Intelligence (AI) in healthcare has grown exponentially over the last few years. In October 2023, President Biden released a comprehensive Executive Order on the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence which addresses AI in Healthcare.[1] In December 2023, the European Union (EU) released a draft regulation which aims to ensure that AI systems placed on the European market and used in the EU are safe and respect fundamental rights and EU values.[2] Numerous professional associations have developed policies around the use of AI in healthcare.[3, 4, 5] While AI promises great benefits to physicians and their patients, there are enormous risks if AI is not appropriately deployed.

In July 2023, the AOA House of Delegates requested that the AOA study the impact of AI in healthcare pertaining to five issues. The AOA was directed to present a report and action plan to the House of Delegates for the July 2024 HOD meeting. The five issues outlined in the resolution are presented below with accompanying commentary. The action plan/recommendations are then presented.

NOTE: Some professional associations refer to AI as Augmented Intelligence.[3] Augmented Intelligence seeks to enhance human capabilities by providing AI-powered tools and assistance. Artificial Intelligence aims to create autonomous systems that can perform tasks without human intervention. The use of the term “AI” in this document refers to both Artificial and Augmented Intelligence.

1. The potential benefits and risks of AI in healthcare for patients, healthcare professionals, and healthcare organizations.

The benefits of AI can be numerous. For osteopathic physicians and other healthcare professionals, AI can be used to assist with administrative tasks such as creating office notes, producing patient messages, and responding to document requests.[6] Other clinical applications include chart reviews, clinical decision support (CDS) tools, medical imaging analysis, development of patient resources, and research applications including literature review, document drafting, and data analysis.[7]

By removing administrative barriers for physicians, AI can benefit patients through increased time for engagement with physicians. AI can also improve patient education by providing clearer information on medical treatments which can lead to better outcomes.[8]

For healthcare organizations, AI can produce cost savings by streamlining operations, reducing inefficiencies, and enhancing resource allocation.

However, there are also numerous risks, such as generation of biased outcomes due to training on poor quality data, generation of inaccurate results through flaws in data sources used for model training, violation of patient privacy, and harm resulting from insufficient training on use of tools. One category of new technology where these risks are pronounced is in Large Language Models (LLMs). These are a relatively new type of AI that can generate text and perform other natural language processing tasks. LLMs are trained on large sets of data, such as programming languages, and can learn patterns and connections between words and phrases. Datasets used in training the LLM may be biased, out of date or otherwise flawed, which can result in the AI system producing unreliable or inaccurate information. If an LLM cannot find the correct answer to a query, it may falsify information and generate errors.[6] If not designed and implemented appropriately, AI systems can contribute to patient harm. LLMs are not currently regulated. Rules need to be developed to address data privacy, security, and transparency.

However, risks also exist in a broad range of AI technologies used in healthcare, both for treatment and in administrative functions. AI software that are “intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease…or are intended to affect the structure or any function of the body” are regulated as medical devices by the U.S. Food and Drug Administration.[9] Over 600 such tools are approved and used in clinical practice, improving patient care across the country.[10] These technologies include Clinical Decision Support (CDS), such as imaging analysis and predictive tools, as well as digital therapeutics, among other technologies. However, while these tools can significantly improve outcomes, their use also entails risk, such as biased outcomes through training on insufficient data or misuse through improper training.

Use of AI without appropriate clinician oversight may also result in liability for physicians. Physicians should be cautious with their reliance on AI tools for clinical uses.[6,11]

2. The ethical, legal, and social implications of AI in healthcare, including issues related to data privacy, bias, and transparency.

Issues of transparency, patient privacy and compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must be addressed in AI systems to protect patient data. In the case of LLMs, a key concern is whether patient information entered into an LLM will remain secure and not subject to cybersecurity threats. It is also unclear if LLMs are covered by HIPAA. If use of patient medical information violates HIPAA compliance, this could result in penalties to physicians.[6]

Across all AI software, including FDA regulated software and other software, bias in the development of products poses risk to patient care AI models which are trained on biased data may increase existing biases in healthcare resulting in discriminatory outcomes.[7,12] Use of biased AI modules along with existing cultural and language barriers and bias may also worsen health outcomes for certain populations.[13] It is important to continue to provide culturally competent care to all patients with the widespread adoption of AI.

AI algorithms must be transparent and easy to interpret, so physicians and patients understand how decisions are being made. It is imperative that AI companies guarantee the confidentiality of patient data and provide policies on how data is collected, stored, and used.[4]

3. The impact of AI on the roles and responsibilities of healthcare professionals and the potential need for new training and education.

AI can automate routine tasks (such as data entry, administrative work, managing appointments and documentation) which will allow healthcare professionals to focus on patient care. Physicians and other healthcare professionals need to become more proficient in AI to understand its concepts, limitations, and ethical considerations. Training programs should cover AI applications, model interpretation, and responsible use. Combining medical knowledge with data science and technology expertise will become essential.

Medical education, training~~,~~ **AND** assessment ~~and licensure requirements~~ should incorporate AI literacy moving forward.

4. The potential impact of AI on healthcare costs and the healthcare system as a whole.

Studies predict that adoption of AI in healthcare can potentially lead to reductions in spending of 5-10%.[14] As outlined in the sections above, AI adoption could also improve healthcare quality, increase patient access, enhance patient experiences, and provide greater physician satisfaction. However, it will be crucial to overcome obstacles related to data privacy, liability, bias, transparency, interoperability, and regulatory compliance, and

ensure that AI use by insurers and others does not result in patient harm through delayed care or additional burden on physicians and patients.

5. The potential impact of AI on the practice of osteopathic medicine.

AI is uniquely positioned to help osteopathic medicine reach its full potential, as it can remove barriers to the patient-centered, hands-on approach DOs are trained to provide. As trusted sources of health information and guidance, osteopathic physicians will play an integral role in addressing the use of AI with their patients.

Osteopathic physicians:

- Focus on understanding the patient as a complete individual including body, mind, and spirit.
- Believe there is more to good health than the absence of pain or disease and provide a holistic and comprehensive approach to treating patients.
- Support each patient in achieving a high level of wellness by focusing on physical and behavioral health and the individual's environment.[15]

The incorporation of the tenets of osteopathic medicine,[16] Osteopathic Principles & Practice (OPP), and Osteopathic Manipulative Medicine (OMM) into AI tools will ensure that the osteopathic philosophy of treatment is applied to each patient encounter. To the extent that AI can "re-humanize" medicine by reducing administrative burden and the intrusion of technology upon the physician-patient relationship, osteopathic medicine is poised to thrive in this new environment.

Action Plan/Recommendations

1. The AOA will develop a comprehensive policy paper addressing the AOA's position on use of AI in healthcare.

2. The AOA, in partnership with other osteopathic organizations, will investigate partnerships with existing AI software development companies to integrate osteopathic data, language, and terminology, Osteopathic Principles & Practice (OPP) and Osteopathic Manipulative Medicine (OMM) into mainstream AI tools.

3. The AOA will monitor new and existing federal and state regulations/legislation on AI and provide comments on AOA's positions.

4. The AOA, working with other osteopathic partners, will create educational programs, materials, and tools to assist osteopathic students, residents, and physicians with navigating AI.

5. The AOA will develop member resources addressing comprehensive data management and security protocol such as guidelines on data collection, storage, processing, and sharing, ensuring compliance with HIPAA and other relevant privacy laws.

6. The AOA will maintain a list of experts in AI (DOs and others) to provide insights to the AOA on the status of AI implementation and issues affecting the ~~practice of~~ osteopathic **PROFESSION** ~~medicine~~ as they arise.

7. The AOA will continue to monitor AI use in healthcare and advocate for appropriate human oversight at all stages of AI development and use.

8. Th AOA will provide regular updates to the osteopathic profession on the use of AI in healthcare and its impact on the ~~practice of~~ osteopathic **PROFESSION** ~~medicine~~.

AI Use Disclosure: Microsoft Copilot was used in the development of some sections of this report, to confirm references and, in some cases, generate additional references. All references and text produced by Copilot were reviewed and edited by AOA Staff.

References

1. Executive Order on the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence, October 30, 2023. https://www.whitehouse.gov/briefing-room/presidential-actions/2023/10/30/executive-order-on-the-safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence/ Accessed 11-1-2023.
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10. U.S. Food & Drug Administration. “Artificial Intelligence and Machine Learning (AI/ML)-Enabled Medical Devices.” October 19, 2023. https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-and-machine-learning-aiml-enabled-medical-devices
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16. H608-A/23 Tenets of Osteopathic Medicine – AOA Policy Statements. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H608-A-23_Tenets_of_Osteopathic_Medicine_(H617-A18).pdf Accessed 3-15-2024

Background Information: Provided by AOA Staff
Current AOA Policy: N/A

Prior HOD action on similar or same topic:
Action Item: Resolution H424-A/23 Artificial Intelligence in Healthcare

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: ____July 20, 2024_____

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING – CLINICAL AND PUBLIC HEALTH APPLICATION OF - SOURCE: H424-A18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted sunset resolution H413-A/23-SR-Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of for policy H424-A/18 to the 2023 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2023 House of Delegates referred this policy back to BORPH to update the policy to address current guidelines; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy and added references to current CDC guidelines, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED**.**

~~The American Osteopathic Association supports widespread application of HIV testing in the clinical setting particularly for those at risk for HIV infection as determined by physician evaluation; supports continued anonymous testing and counseling programs in public health facilities to maximize individual participation; supports mandatory HIV testing only for source patients, in cases of rape or incest, or in cases of an accidental exposure in patients who are at risk for HIV/AIDS; and supports the following recommendation of the American College of Osteopathic Obstetricians and Gynecologists.~~

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS THE U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) RECOMMENDATIONS THAT EVERYONE AGED 13-64, RECEIVE AT LEAST ONE HIV TEST AS A PART OF ROUTINE HEALTH CARE AND MORE FREQUENT TESTING, AT LEAST ANNUALLY, FOR THOSE AT HIGHER RISK.[1] PER THE CDC[2], INDIVIDUALS WHO MAY BENEFIT FROM AT LEAST ANNUAL SCREENING INCLUDE:

- **SEXUALLY ACTIVE GAY OR BISEXUAL MEN (SOME OF WHOM MAY BENEFIT FROM MORE FREQUENT TESTING, SUCH AS EVERY 3 TO 6 MONTHS)**
- **INDIVIDUALS WHO HAVE HAD SEX WITH AN HIV-POSITIVE PARTNER**
- **INDIVIDUALS WHO HAVE HAD MORE THAN ONE PARTNER SINCE THEIR LAST HIV TEST**

- **THOSE WHO HAVE SHARED NEEDLES OR ~~WORKS~~ EQUIPMENT TO INJECT DRUGS**
- **PEOPLE WHO HAVE EXCHANGED SEX FOR DRUGS OR MONEY**
- **INDIVIDUALS WHO HAVE ANOTHER SEXUALLY TRANSMITTED DISEASE, HEPATITIS, OR TUBERCULOSIS**
- **THOSE WHO HAVE HAD SEX WITH SOMEONE WHO HAS PARTICIPATED IN ANY OF THE ABOVE ACTIVITIES OR WITH SOMEONE WITH AN UNKNOWN SEXUAL HISTORY.**

A. Healthcare Workers

1. Healthcare workers have a minimal risk of acquiring HIV infection from patients[3, 4]~~;~~.~~however, this risk is much greater than the extremely remote possibility of transmission to patients~~.

2. Properly used universal precautions are effective in the prevention of transmission of bodily fluids between healthcare workers and patients and diminish the risk of infection.[3] Serologic testing of patients and/or healthcare workers for the purposes of infection control does not prevent the transmission of HIV infection nor enhance the effectiveness of universal precautions. The AOA supports and encourages patients who know they are HIV positive to inform their physician that they are HIV positive prior to receiving medical care.

3. CDC recommends that all HIV screening be voluntary, and opt-out (patient is notified that the test will be performed and consent is inferred unless the patient declines) vs. opt-in (test is offered to the patient who must explicitly consent to an HIV test, often in writing).[1, 5] The AOA opposes mandatory testing of patients and healthcare workers as there is no scientific data supporting the efficacy of such testing in the prevention of HIV transmission in the healthcare setting. ~~Should any state or the federal government legislate mandatory HIV testing for any group, the AOA is opposed to any such legislation which does not include the entire population because such legislation discriminates against certain groups.~~ The AOA affirms the right of HIV-infected individuals to practice their occupations in a manner which does not present any identifiable risk of transmission of disease and pledges itself to promote the ability of these individuals to continue productive careers so long as they can do so responsibly and safely.

4. The AOA supports programs for effective education and implementation of universal precautions in all healthcare settings.

B. Public and Patient Education

1. Although studies have demonstrated an improved awareness of HIV infection and its modes of transmission, myths and misconceptions persist.

2. The AOA supports public education programs that provide accurate, up-to-date and clearly stated information regarding HIV transmission. The AOA urges increased governmental appropriations for implementing public health measures to assist in halting the increasing incidence of HIV and AIDS.

3. Primary care physicians ~~occupy~~ **FILL** a central role in education of patients regarding preventative healthcare in general and are in an ideal position to serve a central role in HIV prevention.

4. The AOA encourages all osteopathic physicians to be knowledgeable in HIV risk evaluations and to incorporate candid and nonjudgmental assessment of related risk behaviors in routine patient care.

C. Medical Education

1. Osteopathic medical students and physicians in training are particularly vulnerable to the socioeconomic consequences of occupationally acquired HIV infection. The osteopathic profession bears a unique responsibility to provide for their maximum protection and social wellbeing.

2. All osteopathic medical schools and postdoctoral training programs should make available: life, health and disability insurance including coverage for occupationally acquired HIV infection; effective education and training in AIDS, infection control and universal precautions.

REFERENCES

1. **REVISED RECOMMENDATIONS FOR HIV TESTING OF ADULTS, ADOLESCENTS, AND PREGNANT WOMEN IN HEALTH-CARE SETTINGS (CDC.GOV) HTTPS://WWW.CDC.GOV/MMWR/PREVIEW/MMWRHTML/RR5514A1.HTM . ACCESSED 2-29-2024.**
2. **GETTING TESTED | TESTING | HIV BASICS | HIV/AIDS | CDC HTTPS://WWW.CDC.GOV/HIV/BASICS/HIV-TESTING/GETTING-TESTED.HTML ACCESSED 3-8-2024.**
3. **HIV AND OCCUPATIONAL EXPOSURE | HIV IN THE WORKPLACE | HIV/AIDS | CDC HTTPS://WWW.CDC.GOV/HIV/WORKPLACE/HEALTHCAREWORKERS.HTML ACCESSED 3-5-2024.**
4. **HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN HEALTHCARE SETTINGS | HAI | CDC HTTPS://WWW.CDC.GOV/HAI/ORGANISMS/HIV/HIV.HTML ACCESSED 3-5-2024.**
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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1991; revised 1992; reaffirmed 1997, revised 2003; reaffirmed 2013; reaffirmed 2018; Referred to BORPH 2023)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_ ___

DATE: ____July 20, 2024_____

SUBJECT: WARNING THE PROFESSION AND PUBLIC ABOUT THE POTENTIAL DANGERS OF KRATOM USE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, Kratom is a substance derived from a tropical tree, Mitragyna speciosa, native to Southeast Asia traditionally used to alleviate pain, fatigue, enhance mood (1,2,4); and

WHEREAS, Kratom acts as an opioid agonist that acts on the mu opioid receptor, leading to stimulant effects (in low doses) and sedative effects (in high doses), which can lead to psychotic symptoms, and psychological and physiological dependence (1); and

WHEREAS, the use of Kratom in the United States increased 10-fold from 2010 to 2015 and is easily accessible without a prescription at smoke shops, gas stations, or on the internet; and

WHEREAS, according to the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, an estimated 1.7 million Americans aged 12 and older used Kratom in 2021 to treat pain, anxiety, depression, opioid use disorder, and opioid withdrawal (2); and

WHEREAS, there is limited scientific evidence to support its safety and efficacy, and concerns have been raised about its potential for addiction, abuse, and adverse effects, including seizures, liver damage, and death; and

WHEREAS, in ~~2017~~ **2019** the ~~FDA~~ **CDC** issued a public health advisory about Kratom and the Drug Enforcement Administration (DEA) identified Kratom as a drug of concern, although it is still not classified or regulated as a controlled substance (3); and

WHEREAS, the Centers for Disease Control (CDC) recognizes Kratom as a potential ~~source~~ **CONTRIBUTOR** of fatal overdose (3); and

WHEREAS, ~~the American Medical Association (AMA) has a policy statement noting~~ it is inappropriate to authorize the sale, marketing or distribution of Kratom given there is no Federal Drug Administration (FDA) approval for any prescription or over-the-counter drug products containing Kratom or its two main chemical components mitragynine and 7-hydroxymitragynine (7-OH-mitragynine) (2,4); now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) promote learning opportunities for its members about Kratom, its current accessibility,

CULTURAL BACKGROUND AND CONSIDERATIONS, ~~and~~ use by the public, and concerns regarding safety and efficacy or lack thereof; and

RESOLVED, that the American Osteopathic Association (AOA) ~~write a policy statement~~ oppos**ES**~~ing~~ Kratom being available for marketing, purchase, or prescription until such time that the FDA and other relevant regulatory agencies evaluate its safety and appropriateness for sale; ~~and, be it further~~

~~RESOLVED, that this resolution be considered at the American Osteopathic Association (AOA) 2024 House of Delegates.~~

References:

1. Synthetic and Receptor Signaling Explorations of the *Mitragyna* Alkaloids: Mitragynine as an Atypical Molecular Framework for Opioid Receptor Modulators. Andrew C. Kruegel, Madalee M. Gassaway, Abhijeet Kapoor, András Váradi, Susruta Majumdar, Marta Filizola, Jonathan A. Javitch, and Dalibor Sames. *Journal of the American Chemical Society* 2016 *138* (21), 6754-6764 DOI: 10.1021/jacs.6b00360.<https://pubs.acs.org/doi/10.1021/jacs.6b00360>.
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Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP), OBSTRUCTIVE SLEEP APNEA

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, obstructive sleep apnea is a sleep disorder in which a person's breathing stops and starts during sleep caused by obstruction in the airway; and

WHEREAS, the estimated prevalence in North America obstructive sleep apnea is 15 to 30% in males and 10 to 15% in females; and

WHEREAS, the obstruction leads to decreased oxygen levels in the blood, causing fragmented sleep; and

WHEREAS, if left untreated, obstructive sleep apnea may worsen or even lead to multiple disease processes, including hypertension, heart disease, stroke, diabetes, and depression and the resulting daytime fatigue and somnolence negatively impacts our patients' quality of life; and

WHEREAS, unlike other medical conditions, such as infections or elevated blood pressure that are diagnosed when hospitalized, sleep apnea is not able to be treated at discharge with effective life-saving CPAP or BiPAP due to the current requirement for a completed polysomnogram or "sleep study"; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocates for measures to minimize the barriers to obtain life-saving CPAP or BiPAP at the time of hospital discharge for patients newly diagnosed with obstructive sleep apnea; and, be it further

RESOLVED, that the AOA advocates for an emergency grace period in which a CPAP or BiPAP machine could be provided until the sleep study is completed; and, be it further

RESOLVED, that the AOA pledges advocacy for discharge procedures that ensure access to needed treatments for our patients.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Ohio Osteopathic Association (OOA)

DATE: July 20, 2024

SUBJECT: AGAINST THE USE OF HIGH FRUCTOSE CORN SYRUP

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association (AOA) is dedicated to improving public health and advocating for evidence-based policies; and

WHEREAS, High Fructose Corn Syrup (HFCS) is a highly processed sweetener derived from corn and commonly used in various food and beverage products; and

WHEREAS, the increased consumption of HFCS has been associated with various adverse health effects, ~~including obesity, metabolic syndrome, NASH (Nonalcoholic steatohepatitis), and an increased risk of chronic diseases such as type 2 diabetes and heart disease~~; and

WHEREAS, excessive consumption of added sugars, including HFCS, contributes to the rising rates of obesity and related health issues in the United States; and

WHEREAS, promoting healthier nutrition and reducing the intake of added sugars is crucial in preventing chronic diseases and improving overall public health; and

WHEREAS, there is a need for public awareness and education regarding the potential health risks associated with high fructose corn syrup; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocates for evidence-based policies that promote the reduction of high fructose corn syrup consumption and advocate for initiatives aimed at improving nutrition and public health; and, be it further

RESOLVED, that the AOA will collaborate with other medical organizations, public health agencies, and stakeholders regarding educational campaigns and resources to inform the public about the potential health risks of high fructose corn syrup

References:

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Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended___

DATE: _____July 20, 2024_____

SUBJECT: RECOGNIZING BREAST IMPLANT ILLNESS (BII) AND PROMOTING INFORMED CONSENT FOR BREAST IMPLANT PROCEDURES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, breast augmentation procedures involving the insertion of breast implants have become increasingly common; and

WHEREAS, the American Osteopathic Association (AOA) recognizes the importance of ensuring patient safety and informed decision-making in all medical procedures; and

WHEREAS, recent evidence has emerged regarding the risks associated with breast implants, including the development of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and systemic symptoms collectively referred to as Breast Implant Illness (BIL); and

WHEREAS, the Food and Drug Administration (FDA) has issued a boxed warning advising patients and health care professionals about the risks associated with breast implants, including the potential for complications over time, the increased likelihood of additional surgeries, the association with BIA-ALCL, and the occurrence of systemic symptoms; and

WHEREAS, the AOA acknowledges the importance of providing patients with comprehensive information regarding the risks and benefits of breast implants to facilitate informed decision-making; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes Breast Implant Illness (BII) ~~as a legitimate concern~~ and encourages health care professionals to educate patients about the potential risks associated with breast implants, including the risk of developing BIA-ALCL and systemic symptoms; and, be it further

RESOLVED, that the AOA emphasizes the importance of obtaining informed consent from patients considering breast implant procedures, including a thorough discussion of the risks outlined in the FDA **LABELING RECOMMENDATIONS AND** boxed warning; and, be it further

RESOLVED, that the AOA advocates for efforts to enhance patient awareness of the risks associated with breast implants ~~and advocates for transparent communication between patients and health care providers throughout the decision-making process~~; and, be it further

~~RESOLVED, that the AOA calls upon health care professionals to prioritize patient safety and well-being by staying informed about emerging research and guidelines related to breast implant procedures; and, be it further~~

~~RESOLVED, that the AOA encourages health care professionals to engage in shared decision-making with patients, taking into account individual preferences, medical history, and the latest evidence-based recommendations; and, be it further~~

~~RESOLVED, that the AOA reaffirms its commitment to promoting ethical and patient-centered care in all aspects of medicine, including cosmetic procedures such as breast augmentation with implants~~.

References:

1. Cohen Tervaert JW, Mohazab N, Redmond D, van Eeden C, Osman M. Breast implant illness: scientific evidence of its existence. Expert Rev Clin Immunol. 2022 Jan;18(1):15-29. doi: 10.1080/1744666X.2022.2010546. Epub 2022 Jan 5. PMID: 34882509Suh LJ,

2. Khan I, Kelley-Patteson C, Mohan G, Hassanein AH, Sinha M. Breast Implant-Associated Immunological Disorders. J Immunol Res. 2022 May 4;2022:8536149. doi: 10.1155/2022/8536149. PMID: 35571560; PMCID: PMC9095406.

3. https://www.fda.gov/medical-devices/implants-and-prosthetics/breast-implants.

4. Serena TJ, Habib P, Derosa A. Breast Implant Illness: A Cohort Study. Cureus. 2023 Apr 24;15(4):e38056. doi: 10.7759/cureus.38056. PMID: 37228535; PMCID: PMC10208020.

5. Magnusson MR, McGuire P. Commentary on: Understanding Breast Implant Illness: Etiology is the Key. Aesthet Surg J. 2022 Mar 15;42(4):378-380. doi: 10.1093/asj/sjab191. PMID: 33864368.

6. Bascone CM, McGraw JR, Couto JA, Sulkar RS, Broach RB, Butler PD, Kovach SJ 3rd. Exploring Factors Associated with Implant Removal Satisfaction in Breast Implant Illness Patients: A PRO BREAST-Q Study. Plast Reconstr Surg Glob Open. 2023 Sep 25;11(9):e5273. doi: 10.1097/GOX.0000000000005273. PMID: 37753329; PMCID: PMC10519512.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau of Research and Public Health (BORPH)_

DATE: __July 20, 2024_____

SUBJECT: ADDRESSING THE COMPROMISED SAFETY OF HEALTHCARE WORKERS PRACTICING IN AREAS OF CONFLICT AND THE RESULTING THREAT TO HEALTHCARE INFRASTRUCTURE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, over the last two decades, military powers have attacked healthcare workers and infrastructure with increasing impunity in violation of the regulations set forth by the Geneva Convention, the Rome Statute and International Humanitarian Law (IHL) that specify the protection of healthcare workers and infrastructure[1]; and

WHEREAS, Article 17 of the Fourth Geneva Convention declares the right of passage of medical personnel and medical equipment to occupied areas, while Article 20 demands respect and protection for any personnel involved in the operation and administration of civilian hospitals, including the transport of wounded civilians[2]; and

WHEREAS, there have been over 6,600 violent attacks against health care systems within the last ten years leading to destruction or damage of 3,420 medical facilities, 1,732 healthcare transportation units, and 1,367 medical supply units as well as injury or death to 1,334 patients and 3,404 medical personnel during wartime conflicts across 21 countries and territories[3]; and

WHEREAS, deliberate destruction of healthcare infrastructure has resulted in decreased availability of adequate healthcare services and chronic medical management leading to even further civilian death, disease, and epidemic outbreak[4]; and

WHEREAS, the AOA supports the protection of physicians and healthcare workers through advocating for congressional endorsement of the Safety from Violence for Healthcare Employees (SAVE) Act; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) affirms~~, and advocates for~~ the right of physicians globally to ethically practice medicine without fear of persecution or personal danger in any and all situations, including but not limited to wartime and civil unrest; and, be it further

RESOLVED, that the AOA ~~urge~~ **ADVOCATE** for the unimpeded delivery of humanitarian aid, highlight the need for security of medical personnel

36 across all conflict zones, and denounce the targeting of healthcare
37 systems including the denial of medical services in conflict zones.

References:

1. UN General Assembly, Rome Statute of the International Criminal Court (last amended 2010), ISBN No. 92-9227-227-6, UN General Assembly, 17 July 1998, https://www.refworld.org/legal/constinstr/unga/1998/en/64553
2. International Committee of the Red Cross. (1949). Geneva Convention Relative to the Protection of Civilian Persons in Time of War of 12 August 1949, https://ihl-databases.icrc.org/assets/treaties/380-GC-IV-EN.pdf
3. World Health Organization. (n.d.). World Health Organization. https://extranet.who.int/ssa/Index.aspx
4. Abbara, A., Atassi, B., Badr, S., et al. (2015). War is the Enemy of Health. Pulmonary, Critical Care, and Sleep Medicine in War-Torn Syria. Annals of the American Thoracic Society. 13(2):147-155. https://doi.org/10.1513/AnnalsATS.201510-661PS

Background Information: Provided by AOA Staff

Current AOA Policy:

H343-A/23 - Workplace Violence Against Healthcare Providers

A324-A/20 - Violence Against Healthcare Staff

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: _____July 21, 2024____

SUBJECT: CHILDHOOD AND TEENAGE SEXUAL EXPOSURE (AMENDMENT TO POLICY H420-A/21)

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, numerous studies have shown that sex education that prioritizes abstinence does not reduce rates of teen sexual activity, unprotected sex, teen pregnancy, or sexually transmitted infections [1,2,3]; and

WHEREAS, the American College of Obstetricians and Gynecologists has committed to sexuality education that is age appropriate, comprehensive, inclusive, and based in science and evidence[4]; and

WHEREAS, the American College of Osteopathic Pediatricians has published research regarding abstinence-only education in which the final recommendation stated that allocating resources to fund abstinence-only curriculum would be medically irresponsible, as abstinence-only education has significant challenges in effectively changing adolescent sexual behavior[5]; and

WHEREAS, AOA policy H418-A/23 Patient Education supports the advancement of patient education to promote a better understanding of personal health and wellness; now therefore be it

RESOLVED, that the AOA strike ~~preferably abstinence~~; **AND REPLACE WITH INCLUDING ABSTINENCE** from line 11 of policy H420-A/21 Childhood and Teenage Sexual Exposure so that section (2) now reads **ENCOURAGES OSTEOPATHIC PHYSICIANS TO SUPPORT THE DEVELOPMENT OF CURRICULUM BY LOCAL, STATE AND NATIONAL EDUCATIONAL ORGANIZATIONS THAT WILL LEAD TO THE PREVENTION OF ~~UNWANTED~~ PREGNANCY AND TRANSMISSION OF DISEASE, USING MEDICALLY APPROPRIATE MEASURES AND AVOIDANCE OF HIGH-RISK SEXUAL BEHAVIOR**;

References:

1. Atkins DN, Bradford WD. The Effect of State-Level Sex Education Policies on Youth Sexual Behaviors. Arch Sex Behav. 2021 Aug;50(6):2321-2333. doi: 10.1007/s10508-020-01867-9. Epub 2021 Feb 3. PMID: 33537882.
2. Society for Adolescent Health and Medicine. Abstinence-Only-Until-Marriage Policies and Programs: An Updated Position Paper of the Society for Adolescent Health and

Medicine. J Adolesc Health. 2017 Sep;61(3):400-403. doi: 10.1016/j.jadohealth.2017.06.001.
3. Rabbitte M, Enriquez M. The Role of Policy on Sexual Health Education in Schools: Review. The Journal of School Nursing. 2019;35(1):27-38. doi:10.1177/1059840518789240
4. American College of Obstetricians and Gynecologists. 2024. Comprehensive Sexuality Education [Policy Brief]. https://www.acog.org/advocacy/policy-priorities/adolescent-health/comprehensive-sexuality-education
5. Marriott, O. B. (2014). *Abstinence-Only Education: Implications for Policy Development*. ACOP eJournal. https://www2.acopeds.org/forms/site/ejacop/2014spring/patient-education.html

Background Information: Provided by AOA Staff

Current AOA Policy: H420-A/21 Childhood and Teenage Sexual Exposure

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: _____July 21, 2024_____

SUBJECT: REGULATION OF CANNABIS EDIBLES

SUBMITTED BY: Mississippi Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Association of Poison Control Centers shows more than 7,000 confirmed cases of kids younger than six years old who have eaten cannabis edibles were reported to the nation's poison control centers between 2017 and 2021; and

WHEREAS, edibles are often packaged to look like candy or cookies and children unaware of the risks may find them appealing; and

WHEREAS, consuming too much cannabis can lead to serious health problems in children including confusion, hallucinations, tachycardia and vomiting, and in severe cases children can experience trouble breathing or even coma; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with the Food and Drug Administration to strengthen how cannabis manufacturers can advertise their products, including regulations that ensure the packaging does not appeal to children; and, be it further

RESOLVED, that the AOA propose public awareness campaigns aimed at informing the general population, especially parents and guardians, about the risks associated with edible cannabis and the importance of safe storage and handling; and, be it further

RESOLVED, that the AOA emphasize the importance of childproof packaging for all cannabis products, along with advocating for stricter regulations to enforce this requirement.

Background Information: Provided by AOA Staff
Current AOA Policy:

Prior HOD action on similar or same topic:

FISCAL IMPACT: $

ACTION TAKEN: Referred to the Mississippi Osteopathic Medical Association (MOMA)

DATE: July 20, 2024

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (500 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Constitution and Bylaws (500 series)
This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-500	Articles of Incorporation	CAGOS	Constitution & Bylaws	Adopted as Amended
H-501	Amendments to the American Osteopathic Association Constitution – Article IX – Amendments ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-502	Amendments to the American Osteopathic Association Constitution – Article VII: Section 2 - Officers ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-503	Amendments to the American Osteopathic Association Constitution - Article VIII: Section 1 C, D and E - Board of Trustees and Executive Committee ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-504	Amendments to the American Osteopathic Association Constitution – Article X – Gender Disclaimer ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-505	Amendments to the American Osteopathic Association Bylaws – Article VIII: Section 9 – Officers and New Article XI: Section 1 and 2	CAGOS	Constitution & Bylaws	Adopted as Amended
H-506	Amendments to the American Osteopathic Association Bylaws – Article XII – Gender Disclaimer	CAGOS	Constitution & Bylaws	Adopted as Amended
H-507	Amendments to the American Osteopathic Association Bylaws – Article I: Section 1 and 3 – Divisional Societies and Affiliate Organizations	CAGOS	Constitution & Bylaws	Adopted as Amended
H-508	Amendments to the American Osteopathic Association Bylaws – Article V: Section 11 - Representation of Osteopathic Postdoctoral Trainees and/or New Physicians In Practice	BEL	Constitution & Bylaws	Adopted as Amended
H-509	Support for Unlicensed Delegates to the House	FOMA (Florida)	Constitution & Bylaws	Adopted as Amended
H-510	AOA Board, Bureau, Committee and Council Member Representation	AMOPS	Constitution & Bylaws	Not Adopted

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (500 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-511	AOA Rules and Guidelines on Physicians' Professional Conduct (SR-Source-H505-A/19)	Ethics Review and Board Appeals Committee	Constitution & Bylaws	Adopted as Amended
H-512	Ethics of Publicly Supporting Violence – Amendment to the AOA Code of Ethics	FOMA (Florida)	Constitution & Bylaws	Not Adopted

SUBJECT: AOA ARTICLES OF INCORPORATION

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: Constitution and Bylaws

WHEREAS, the AOA's Articles of Incorporation were first filed in 1923 and last updated in 1938;

WHEREAS, the AOA's Committee on AOA Governance and Organizational Structure (CAGOS) was tasked with reviewing the AOA Articles of Incorporation to align with current practices and requirements;

WHEREAS, CAGOS' work, which was done in conjunction with internal and external legal counsel, reviewed the Articles of Incorporation and recommended the following: (a) the purposes clause be expanded to clarify that board certification activities of AOA were related to AOA's tax-exempt mission; (b) that the language on the size of the Board of Trustees be directed to the AOA's Constitution and Bylaws; and (c) that other updates be made to conform to current legal requirements or IRS best practices that had evolved since the Articles of Incorporation were last updated; and

WHEREAS, the above recommendations have been incorporated into the attached Amended and Restated Articles of Incorporation of the American Osteopathic Association; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) approve and adopt the attached Amended and Restated Articles of Incorporation of the American Osteopathic Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_____

DATE: _July 20, 2024_____

Amended and Restated Articles of Incorporation
of
American Osteopathic Association

Article 1. Name of Corporation
American Osteopathic Association (the "Organization")

Article 2. Registered Agent
Corporate Creations Network, Inc.
1320 Tower Road
Schaumburg, IL 60173

Article 3. Board of Trustees
The Organization shall be managed by members of a governing board of directors known as the Board of Trustees ("Board"). The number of members of the Board shall be as set forth in the Constitution and Bylaws of the Organization.

Article 4. Purposes
The purposes for which the Organization is organized shall be to improve and promote public health and improve public health outcomes by (i) maintaining high standards of osteopathic education and advancing the profession's knowledge of the prevention, diagnosis, and treatment of disease; (ii) facilitating the continuous education of osteopathic physicians to advance their knowledge, practice, skill, compassion, and professionalism; (iii) stimulating original research and investigation and disseminating the results of such work for the education and improvement of the profession and the ultimate benefit of the general public; (iv) certifying physicians in medical specialties to ensure that such physicians have the necessary knowledge, education, and clinical experience, as well as to ensure that such physicians continue to have the necessary competence to practice medicine for the benefit of the general public; and (v) promoting the continual evolution and advancement of the osteopathic principles and the research of Andrew Taylor Still regarding osteopathic medicine. The Organization also shall be permitted to pursue other related purposes permissible for organizations exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code (the "Code") (or the corresponding section of any future federal tax code).

Article 5. Other Provisions
The Organization shall not have authority to issue capital stock.

No part of the net earnings of the Organization shall inure to the benefit of, or be distributable to, its Directors, officers, employees, or other private persons, except that the Organization shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article 4 hereof. Notwithstanding any other provision of these Articles of Incorporation, the Organization shall not carry on any other activities not permitted to be carried on by an Organization exempt from federal income tax under Section 501(c)(3) of the Code (or the corresponding section of any future federal tax code).

Upon the termination or dissolution of the Organization, any assets lawfully available for distribution, after paying or adequately providing for the debts and obligations of the

Organization, shall be distributed to one or more qualifying organizations described in Section 501(c)(3) of the Code (or the corresponding section of any future federal tax code), such organization(s) have purposes which, at least generally, include one or more purposes similar to the Organization.

Article 6. Miscellaneous

The Organization is not a Condominium Association as established under the Illinois Condominium Property Act, a Cooperative Housing Corporation as defined in Section 216 of the Code (or the corresponding section of any future federal tax code), or a Homeowner's Association which administers a common-interest community as defined in subsection (c) of Section 9-102 of the Illinois Code of Civil Procedure.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE IX ***(Second Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

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1 WHEREAS, the procedure for amending the Constitution of the American
2 Osteopathic Association (AOA), as described in Article IX of the Constitution
3 requires that all proposed amendments be presented to the House of
4 Delegates and filed with the Chief Executive Officer at the annual meeting in
5 the year prior to its presentation to the House of Delegates for action; and

6 WHEREAS, the Board of Trustees Committee on AOA Governance and
7 Organizational Structure has undertaken a review of the AOA's Constitution
8 and Bylaws and intends to present proposed changes to Article IX -
9 Amendments - of the Constitution at the 2024 House of Delegates annual
10 meeting; now, therefore be it

11 RESOLVED, that the official meeting record reflect that a first reading of the
12 following amendment has been presented at the July 2023 annual meeting of
13 the AOA House of Delegates and filed with the Chief Executive Officer of the
14 AOA so that it can be presented for action at the 2024 House of Delegates:

15 **AOA Constitution**

16 Article IX – Amendments
17 This Constitution may be amended by the House of Delegates at any annual
18 meeting by a two-thirds vote of the total number of delegates accredited for voting,
19 provided that such amendments shall have been presented to the House and filed
20 with the Chief Executive Officer at a previous annual meeting, who shall cause them
21 to be distributed by U.S. mail or electronic communication to each divisional
22 **SOCIETY** and **AFFILIATED ORGANIZATION** ~~specialty society~~ entitled to ~~and~~
23 send[1] voting representatives to the House of Delegates, posted on the AOA's
24 website, and **COMMUNICATED IN AN OFFICIAL PUBLICATION OF THE**
25 **ASSOCIATION** ~~published ON-LINE in the on-line edition of *THE DO* *The Journal of*~~
26 ~~*Osteopathic Medicine*~~ not less than two months nor more than four months prior to
27 the meeting at which they are to be acted upon.

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[1] The word 'and' in line 22 was a typo and should have been 'send' to make the sentence grammatically correct with no additional wording. The editorial amendment has been made for the second read.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_____

DATE: ____July 20, 2024_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE VII: SECTION 2 ***(Second Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the role of the Editor will exist however not as an Administrative Officer. The proposed updated definition of the role of the Editor has been updated in the Bylaws; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VII – Officers – Section 2 Administrative Officers - of the Constitution at the 2024 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

Article VII – Officers
Section 2 – Administrative Officers
The administrative officers shall be Chief Executive Officer, a Chief Financial Officer[1], **AND** a General Counsel~~, and an Editor~~ who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None
FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended
DATE: July 20, 2024

[1] The title of Controller to Chief Financial Officer was approved at the 2023 House of Delegates and has been updated.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION - ARTICLE VIII: SECTION 1 C, D AND E ***(Second Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VIII – Board of Trustees and Executive Committee – Section 1 Board of Trustees, Part C, Part D and Part E - of the Constitution at the 2024 House of Delegates annual meeting; and

WHEREAS, Section 1-C are grammatical correction; Section 1-D is a grammatical correction and the AOA no longer has these programs; and Section 1-E is a grammatical correction; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

Article VIII – Board of Trustees and Executive Committee
Section 1 – Board of Trustees
The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-eight members.

C. One new physician in practice member elected by the House of Delegates to serve for **A** one year **TERM**. Candidates for the new physician in practice position **SHALL BE** osteopathic physicians who have completed their postdoctoral training within the past five years ~~shall be~~ **AND BE** nominated by Bureau of Emerging Leaders. Candidates must be members in good standing of the AOA;

D. One postdoctoral trainee, to include intern, resident, or a fellow, member elected by the House of Delegates to serve for one year. Candidates for the postdoctoral trainee position shall be enrolled in an **ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION** (ACGME) ~~or AOA-approved~~ internship, residency or fellowship. Candidates for the postdoctoral trainee position shall be nominated by the Bureau of Emerging Leaders. Candidates should be members in good standing of the AOA; and

E. One student member elected by the House of Delegates to serve for one year. Candidates for the student position shall be nominated, in ~~altering~~ **ALTERNATING** years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA).

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: ____July 20, 2024_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE X – GENDER DISCLAIMER
(Second Read)

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article X – Gender Disclaimer - of the Constitution at the 2024 House of Delegates annual meeting; and

WHEREAS, the pronouns within the Constitution and Bylaws to be updated to 'their', 'them', 'they' to be gender neutral to show inclusivity. The usage of these pronouns would eliminate the need for a gender disclaimer; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

~~Article X - Gender Disclaimer~~
~~The American Osteopathic Association is open to persons of both sexes and does not discriminate against any persons because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic:
H439-A20 Gender Identity
H406-A19 Discrimination in Healthcare

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended____

DATE: __July 20, 2024_____

[1] Should this section be approved for removal, all references to 'his' within the Constitution will be adjusted to 'they', 'them', 'theirs' as appropriate.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VIII: SECTION 9 AND NEW ARTICLE XI: SECTION 1 AND 2

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is not common business practice to have the Editor-in-Chief as an administrative officer as this position is not intricately involved in the daily operations of the Association; and

WHEREAS, it is common business practice to have an Editor-in-Chief oversee a scholarly journal and report to the Board of Trustees and Chief Executive Officer; and

WHEREAS, if approved any reference to the Editor-In-Chief under the Administrative Officers sections will be removed; and

WHEREAS, it is necessary to amend the AOA's Bylaws to reflect common business practice; and

WHEREAS, in 2023 the House of Delegates determined to postpone Resolution H520-A/23 until the 2024 House of Delegates to align with the AOA Constitution second read amendment Resolution H502-A/24; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VIII - Duties of Officers

~~Section 9-Editor-in-Chief~~

~~The Editor-in-Chief shall:~~

~~a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of *The Journal of Osteopathic Medicine*, other periodical publications of the Association under the general supervision of the Chief Executive Officer and shall cooperate with all departments of the central office.~~

~~b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.~~

ARTICLE XI PUBLICATIONS

SECTION 1 — SCHOLARLY JOURNAL

THE ASSOCIATION SHALL MAINTAIN A SCHOLARLY JOURNAL, *THE JOURNAL OF OSTEOPATHIC MEDICINE*, ALONG WITH ANY OTHER SCIENTIFIC PUBLICATIONS AS THE BOARD OF TRUSTEES MAY DEEM APPROPRIATE. ANY SUCH PUBLICATIONS SHALL BE OVERSEEN BY AN EDITOR, APPOINTED BY THE BOARD OF TRUSTEES, WHO SHALL BE RESPONSIBLE FOR OVERSEEING THE EDITORIAL DECISIONS OF ANY SUCH PUBLICATIONS.

SECTION 2 – EDITOR

THE EDITOR SHALL:

a. **HAVE THE EDITORIAL DIRECTION, IN ACCORDANCE WITH THE ESTABLISHED POLICIES OF THE BOARD OF TRUSTEES AND HOUSE OF DELEGATES, OF *THE JOURNAL OF OSTEOPATHIC MEDICINE*, OTHER PERIODICAL PUBLICATIONS OF THE ASSOCIATION UNDER THE GENERAL SUPERVISION OF THE CHIEF EXECUTIVE OFFICER AND SHALL COOPERATE WITH ALL DEPARTMENTS OF THE CENTRAL OFFICE.**

b. **BE PROVIDED WITH SUCH ASSISTANCE AS IS NECESSARY TO THE PROPER CONDUCT OF THEIR OFFICE, SUBJECT TO THE DIRECTIVES OF THE BOARD OF TRUSTEES THROUGH THE CHIEF EXECUTIVE OFFICER**.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above.

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 20, 2024_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE XII

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it has been recommended that the pronouns within the Bylaws be updated to 'their', 'them', 'they' to be gender neutral, show inclusivity, and eliminate implicit bias.

WHEREAS, the usage of such gender neutral pronouns would eliminate the need for a gender disclaimer; and

WHEREAS, in 2023 the House of Delegates determined to postpone Resolution H523-A/23 until the 2024 House of Delegates to align with the AOA Constitution second read amendment Resolution H504-A/24; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

~~Article XII Gender Disclaimer~~
~~The American Osteopathic Association is open to all persons and does not discriminate against any person because of their gender identity; therefore, the wording herein importing the masculine or feminine gender is inclusive of all gender identities and imports no such discrimination.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above.

Prior HOD action on similar or same topic:
H439-A20 Gender Identity
H406-A19 Discrimination in Healthcare

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE I: SECTION 1 AND 3

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is necessary that AOA's Bylaws provide a clear definition for both when a Charter may be issued and when it may likewise be suspended or revoked; and

WHEREAS, the Bylaws currently do not detail when a Charter may be suspended or revoked and for the purposes of clarifying this process; and

WHEREAS, the Committee on AOA Governance and Organizational Structure developed a Charter Suspension and Revocation process outlined within this resolution in response to the 2023 House of Delegates referred Resolution H511-A/23; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article I – Divisional AND District SOCIETIES and Affiliated ~~Societies~~ ORGANIZATIONS

Section 1-Divisional Societies

Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its Constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given **GEOGRAPHICAL** area**. THE ASSOCIATION ALSO HAS THE AUTHORITY TO REVOKE OR SUSPEND THE CHARTER OF ANY DIVISIONAL SOCIETY. THE BOARD OF TRUSTEES, UPON TWO-THIRDS AFFIRMATIVE VOTE, MAY SUSPEND A CHARTER FOR A PERIOD OF TIME UNTIL THE NEXT REGULARLY SCHEDULED MEETING OF THE HOUSE OF DELEGATES. THE HOUSE OF DELEGATES MAY, BY A TWO-THIRDS CONSENT OF THOSE MEMBERS PRESENT, PROVIDED TWO-THIRDS OF THE SEATED DELEGATES ARE IN ATTENDANCE, REVOKE A CHARTER. THE AOA SHALL OUTLINE POLICIES AND PROCEDURES FOR ANY SUCH SUSPENSIONS**

AND/OR REVOCATIONS. SUCH POLICIES MUST, AT A MINIMUM, PROVIDE THAT A SUSPENSION OR REVOCATION SHALL NOT TAKE PLACE UNLESS THERE IS GOOD CAUSE SHOWN AND THAT THE AFFILIATED ORGANIZATION MUST FIRST BE PROVIDED WITH NOTICE AND DUE PROCESS PRIOR TO ANY SUCH SUSPENSION AND/OR REVOCATION DECISION.

Section 3-Affiliated Organizations

Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any present affiliated organization. ~~All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.~~ **THE ASSOCIATION ALSO HAS THE AUTHORITY TO REVOKE OR SUSPEND THE CHARTER OF ANY AFFILIATED ORGANIZATION. THE BOARD OF TRUSTEES, UPON TWO-THIRDS AFFIRMATIVE VOTE, MAY SUSPEND A CHARTER FOR A PERIOD OF TIME UNTIL THE NEXT REGULARLY SCHEDULED MEETING OF THE HOUSE OF DELEGATES. THE HOUSE OF DELEGATES MAY, BY A TWO-THIRDS CONSENT OF THOSE MEMBERS PRESENT, PROVIDED TWO-THIRDS OF THE SEATED DELEGATES ARE IN ATTENDANCE, REVOKE A CHARTER. THE AOA SHALL OUTLINE POLICIES AND PROCEDURES FOR ANY SUCH SUSPENSIONS AND/OR REVOCATIONS. SUCH POLICIES MUST, AT A MINIMUM, PROVIDE THAT A SUSPENSION OR REVOCATION SHALL NOT TAKE PLACE UNLESS THERE IS GOOD CAUSE SHOWN AND THAT THE AFFILIATED ORGANIZATION MUST FIRST BE PROVIDED WITH NOTICE AND DUE PROCESS PRIOR TO ANY SUCH SUSPENSION AND/OR REVOCATION DECISION.**

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

AOA Charter for Suspension and/or Revocation Process
Component 4 of the Organizational AOA Charter Process
Policy Number: P6-10/2022

- Develop the process for suspending and/or revoking a charter and reference the process document in the AOA Administrative Guide
    - The AOA charter of an Affiliate Organization or Divisional Society may be suspended and/or revoked when done (a) according to the procedures outlined below and in AOA Bylaws; and (b) when doing so is in the best interests of the profession, including the remaining Affiliate Organizations and Divisional Societies collectively.
    - Suspension:
        - A suspension may only occur when the Affiliate Organization or Divisional Society's continuation of their charter is detrimental to the profession.
        - A suspension should only occur when there is an imminent need for AOA to act that cannot be extended to the next House of Delegates meeting.
        - A suspension may only occur if the Affiliate Organization or Divisional Society is first provided written notice of the reason for the suspension and provided a reasonable opportunity to respond (both in writing and through a presentation to the AOA Board of Trustees).
        - Only after the above process has been followed, the AOA Board of Trustees may vote to suspend the charter of an Affiliate Organization or Divisional Society upon the affirmative vote of two-thirds (2/3) of the Board of Trustees.
        - The Affiliate Organization or Divisional Society may appeal this decision to the House of Delegates at the next regularly scheduled meeting. In the interim, the Affiliate Organization or Divisional Society can continue to hold its seat at the House of Delegates and remain a CME sponsor, if applicable.

    - Revocation:
        - A revocation should only occur when the Affiliate Organization or Divisional Society's continuation of their charter is detrimental to the profession.
        - A revocation should only occur if the Affiliate Organization or Divisional Society is first provided written notice of the reason for the revocation and provided a reasonable opportunity to respond (both in writing and through a presentation to the AOA House of Delegates).
        - Only after the above process has been followed, the AOA House of Delegates may vote to revoke the charter of an Affiliate Organization or Divisional Society upon the affirmative vote of the House of Delegates by a two-thirds (2/3) consent of those members present, provided two-thirds of the seated delegates are in attendance.
        - Once an Affiliate Organization or Divisional Society's charter has been revoked, it shall cease its affiliation as such and any related benefits on account of that status.

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE V: SECTION 11 - REPRESENTATION OF OSTEOPATHIC POSTDOCTORAL TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Constitution and Bylaws Committee

WHEREAS, Article V - Section 11 of the American Osteopathic Association (AOA) Bylaws designates that three seats in the House of Delegates represent. Osteopathic postdoctoral trainees and/or new physicians in practice; and

WHEREAS, the AOA Bylaws require these three delegates be selected by the Bureau of Emerging Leaders (BEL); and

WHEREAS, the AOA Bylaws further require that one of these three delegate positions be reserved for physicians who are in a fellowship postdoctoral training program; and

WHEREAS, the position designated for a physician who is a fellowship program has only been filled twice since 2019 due to multiple barriers which include but are not limited to the timing of the AOA's House of Delegates, leaving postdoctoral trainees and new physicians in practice with less representation in the House of Delegates ; and

WHEREAS, The BEL was formed in 2015 after the merger of the Council of Student Affairs, Council of Interns and Residents, and the Council of New Physicians in Practice. Subsequently, three seats at the HOD were granted to the BEL. In 2018 it was approved by the House of Delegates with resolution number H503-A/18 to have a reserved spot specifically for physicians who are in a fellowship postdoctoral training program. Since 2019, only 2 fellows have participated as delegates for the BEL. Potential barriers include timing of the House of Delegates which coincides with the start of many fellowship programs or those in fellowships recently completed their fellowships in June. Furthermore, individuals serving as a BEL delegate shall not concurrently serve as a delegate for any other group at the AOA House of Delegates. Given these potential barriers, it has proven difficult to secure a fellow for the dedicated delegate position. The BEL will continue attempting to fill the third seat with a fellow, but backup processes need to be in place. As the number of Osteopathic Postdoctoral Trainees and New Physicians in Practice continue to grow, it would continue to benefit the BEL constituents to have three delegates present at the Annual House of Delegates; now, therefore be it

RESOLVED, that the AOA approves the following proposed amendments to the AOA's governing documents and requests that the AOA Chief Executive Officer take the necessary steps to arrange for publication of this proposed amendment and submission of a resolution to the July 2024 House of Delegates meeting that, if approved, would amend the AOA's Bylaws as follows:

AOA Bylaws

Article V - House of Delegates
Section 11- Representation of Osteopathic Postdoctoral Trainees and/or New Physicians in Practice

Osteopathic postdoctoral trainees and/or new physicians in practice may be represented in the House of Delegates by three individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs or currently a new physician in practice as defined by the association. At least one of the three individuals shall be **A NEW PHYSICIAN IN PRACTICE, AND AT LEAST ONE SHALL BE** enrolled ~~in an accredited fellowship training program and at least one of the three individuals shall be enrolled~~ in an accredited residency program.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above.

Prior HOD action on similar or same topic: Resolution H503-A/18

FISCAL IMPACT: $0
The BEL currently has a budgeting allowance for three delegates.

ACTION TAKEN: __Adopted as Amended

DATE: ____July 20, 2024_____

SUBJECT: SUPPORT FOR ~~UNLICENSED~~ **SOMA** DELEGATES TO THE HOUSE

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Constitution and Bylaws Committee

The American Osteopathic Association House of Delegates declares the following:

WHEREAS, the Student Osteopathic Medical Association (SOMA) hosts a valued delegation to the American Osteopathic Association (AOA) House of Delegates with all the rights and privileges of any delegation including the ability to introduce resolutions, serve on committees, and make motions from the floor; and

WHEREAS, the delegates from the SOMA comprise the only delegation within the House of Delegates who are not able to seat fully licensed Osteopathic Physicians within their delegation; and

WHEREAS, to better serve delegates who are in training the AOA should leverage resources, such as graduates of the Health Policy Fellowship to provide support, guidance and mentorship to the future of our profession; and

~~WHEREAS, the delegates from SOMA may have limited experience within the operations of the House of Delegates, and Roberts Rules of Order; now, therefore be it~~

~~RESOLVED, that the Speaker of the House annually designate one or more licensed Osteopathic Physicians with expertise and experience to serve as an advisor to the SOMA delegation, and to be available to any trainees who are seated as a delegate for the purpose of assisting and guiding them through the business of the House.~~

RESOLVED, THAT THE AOA BOARD OF TRUSTEES AND THE AOA HOUSE OF DELEGATES WORK WITH SOMA TO MAKE AVAILABLE TO SOMA TWO TRUSTEES AND TWO LEADERS OF THE HOUSE OF DELEGATES TO SERVE AS LIAISONS AND MENTORS. THESE INDIVIDUALS MUST BE FULLY LICENSED IN THEIR STATE TO PRACTICE OSTEOPATHIC MEDICINE AND ARE ~~ENCOURAGED~~ PREFERRED TO BE AOA BOARD CERTIFIED.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: The AOA currently provides a training session at the HOD that addresses some of these items.

FISCAL IMPACT: $0

ACTION TAKEN __Adopted as Amended___

DATE ____July 20, 2024_____

SUBJECT: AOA BOARD, BUREAU, COMMITTEE AND COUNCIL MEMBER REPRESENTATION

SUBMITTED BY: Association of Military Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Constitution and Bylaws

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1 WHEREAS, the AOA currently requires AOA Membership for participation on any
2 national AOA Board, Bureau, Committee and Council; and

3 WHEREAS, currently there are members of the Board of Trustees, Bureaus,
4 Committees and Councils representing the Military, State Affiliates, and
5 Specialty Colleges, who are not members of said Military Affiliate, State
6 Affiliate or Specialty College; therefore, be it

7 RESOLVED, that the American Osteopathic Association (AOA) ensures that all
8 appointed/elected Board, Bureau, Committee and Council members who are
9 representing a specific Affiliate, State Affiliate or Specialty College be a
10 member of the respective Affiliate/State Affiliate/Specialty College.

Background Information: Provided by AOA Staff
Current AOA Policy:

AOA Bylaws at Article IX – Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association's departments shall include the Departments of Affiliate Relations, Finance, Education, Governmental Affairs, Membership, and Research and Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

Except where positions are designated for public members (i.e., non-physicians serving on a bureau or committee who are intended to represent and speak for the interests of the public and consumers of osteopathic medical services), membership in both the AOA and a divisional society shall be a requisite for qualification for service on a bureau, council, or committee of the Association, however selected, if the incumbent shall be an osteopathic or allopathic physician.

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: _____Not Adopted___

DATE: _July 20, 2024___

SUBJECT: AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT (H505-A/19)

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Ethics Review and Board Appeals Committee have reviewed the policy; and

WHEREAS, the Ethics Review and Board Appeals Committee recommends the policy be amended by updating the name of the committee that reviews the policy; now, therefore be it

RESOLVED, that the Ethics Review and Board Appeals Committee recommends that the following policy be REAFFIRMED AS AMENDED**.**

AOA Rules and Guidelines on Physicians' Professional Conduct

Policy Statement

The American Osteopathic Association (AOA) supports the AOA Rules and Guidelines on Physicians' Professional Conduct and recognizes that it is a separate and distinct document from the AOA's Code of Ethics.

American Osteopathic Association: Rules and Guidelines on Physicians' Professional Conduct

<u>Professionalism and Physician Responsibilities</u>

Professionalism is a core competency expected of all physicians. Physicians are among the most highly educated and trained professionals in our society and should enjoy the respect of their peers and the community. Society expects them to perform various roles. As healthcare providers, they diagnose and treat patients; as advisors, they provide patients with an understanding of their health status and the potential consequences of decisions regarding treatment and lifestyles; as advocates, physicians communicate with patients, their caregivers, and their health insurers the needs of the patient; and as counselors, they listen to their patients and discuss their condition with family members and others involved in health-care decision-making. Physicians are entrusted by their patients and their patients'

families with private and confidential information, much of which is related to healthcare, but frequently includes other personal details.

Osteopathic physicians, in order to enjoy the continued respect and trust of society, recognize the responsibilities and obligations they bear and in order to maintain their status as professionals, must act accordingly. Medical ethics includes many tenets that should guide osteopathic physicians in their professional and personal activities. Although ethics and professionalism encompass broad concepts, some of the recognized elements are:

- Non-maleficence – first, do no harm
- Acting as a positive role-model
- Displaying respect in interactions with others
- Legal and ethical behavior
- Appropriate management of potential conflicts of interest
- Beneficence – a physician should act in the best interest of the patient/altruism/placing the needs of the patient first
- Autonomy – the patient has the right to refuse or choose their treatment
- Dignity – the patient (and the medical professional involved with their care) has the right to dignity, truthfulness and honesty
- Participation in self-evaluation programs and acceptance of constructive criticism from others.

The AOA's Code of Ethics offers rules to guide physicians in their interactions as physicians with their patients, with society, and with the AOA. This document is intended to supplement the Code of Ethics by providing rules and guidance for physicians' conduct as professionals in the broader context beyond the traditional role in the delivery of care. Some of the Rules and Guidelines are mandatory (i.e., "shall" or "shall not"), while others are permissive (i.e., "may," "should," "should not" or "may not") and recognize a physician's discretion to assess the specific context and situation and exercise professional judgment.

Finally, the Rules and Guidelines are designed by the AOA to provide guidance to physicians in appropriate professional behavior and to provide a structure for regulating conduct. Any assessment of a physician's conduct must be made with due consideration to the facts and circumstances that existed at the time of the conduct in question and recognize that a physician may have had to act based upon uncertain or incomplete information. The Rules and Guidelines are not intended to be a basis for civil liability. Rather, perceived failure of a physician to comply with an obligation or prohibition imposed by the Code of Ethics or these Rules and Guidelines is a basis for invoking the AOA's ~~disciplinary process through the Bureau of Membership's Subcommittee on Ethics.~~ **ETHICS REVIEW AND BOARD APPEALS COMMITTEE.**

1. A physician's conduct shall be consistent with the requirements of the law, whether providing medical/professional service to patients or in conducting business and personal affairs.

2. Physicians should use their status as professionals only for legitimate purposes and not to take advantage of economic or social opportunities or to harass or intimidate others.
3. A physician has an obligation to pursue a patient's best interests and to be an advocate for the patient. In so doing, physicians shall conduct themselves in a civil manner. When appropriate, physicians should disclose and resolve any conflict of interest that might influence decisions regarding care.
4. Patients may come from any of a broad spectrum of cultures and beliefs. Physicians should conduct themselves with appropriate respect for their patients' social and cultural needs and provide necessary care without regard to gender, race, color, religion, creed, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, gender identity or sexual orientation.
5. Physicians are allowed limited autonomy to govern conduct within their own profession through participation on state licensing boards, hospital credentialing committees and in peer review processes. Physicians should fully participate in self-regulation by setting, maintaining, and enforcing appropriate practice standards. Regulations and rules with respect to healthcare delivery shall be developed with the best interests of patient care in mind rather than advancing private interests or protecting friends or colleagues from adverse action.
6. Physicians are responsible for observance of the Code of Ethics and these Rules and Guidelines on Professional Conduct. While compliance depends primarily upon understanding of and voluntary compliance with these obligations, physicians should also make efforts to secure their observance by other physicians through expression of formal or informal peer opinion or, when necessary, invocation of disciplinary proceedings. Where a protected peer review process is available, adverse events and medical errors should be fully disclosed.
7. Physicians should be aware of disparities in medical care within the United States and internationally. Where possible, physicians should assist those less fortunate in securing access to appropriate medical care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: ETHICS OF PUBLICLY SUPPORTING VIOLENCE – AMENDMENT TO THE AOA CODE OF ETHICS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, on October 7, 2023 thousands of people were murdered by the efforts of a known terrorist organization; and

WHEREAS, in response to this event many organizations, including physician organizations denounced the intentional targeting and killing of persons on the basis of their religion or national origin; and

WHEREAS, some individual physicians publicly announced their support for these acts under the idea that the acts were justified political actions; and

WHEREAS, as leaders in society the words that physicians speak matter. While we recognize and value freedom of speech, the use of speech to foment violence is not, and should not be protected; and

WHEREAS, the Osteopathic Oath, to which all members of our profession pledge, notes that, “I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession”; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) Code of Ethics shall be amended to read:

Section 13: A physician shall respect the law. When necessary, a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health. **IT IS NOT ETHICAL FOR A PHYSICIAN TO COMMIT, ENDORSE, OR LEND SUPPORT TO VIOLENCE OR COMMIT, ENDORSE, OR LEND SUPPORT TO ORGANIZATIONS THAT COMMIT, ENDORSE OR SUPPORT VIOLENCE IN ORDER TO ENACT CHANGES IN THE LAW OR TO PROMOTE OTHER POLITICAL CHANGE.**

Background Information: Provided by AOA Staff
Current AOA Policy:

H505-A/19-AOA Rules and Guidelines on Physicians' Professional Conduct
The American Osteopathic Association (AOA) supports the AOA Rules and Guidelines on Physicians' Professional Conduct and recognizes that it is a separate and distinct document from the AOA's Code of Ethics.

AOA Code of Ethics

AOA Rules and Guidelines on Physicians' Professional Conduct

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN: Not Adopted

DATE: July 20, 2024

AMERICAN OSTEOPATHIC ASSOCIATION

600 Series Ad Hoc Resolutions w/Action

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (600 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Cooperation of the Veterans Administration and Non-VA Clinicians (SR-Source-H634-A/19)	BFHP	Ad Hoc	Adopted
H-601	Addressing the Gender Pay Gap in the Medical Profession (SR-Source-H638-A/19)	BFHP	Ad Hoc	Adopted
H-602	Investment Tax (SR-Source-H610-A/19)	BFHP	Ad Hoc	Adopted
H-603	Family Medical Leave Act Employee Relationship Modification (SR-Source-H603-A/19)	BFHP	Ad Hoc	Adopted
H-604	Industry Transparency Standards (SR-Source-H622-A/19)	BFHP	Ad Hoc	Adopted as Amended
H-605	OMT – Osteopathic Manipulative Treatment (SR-Source-H611-A/19)	BORPH	Ad Hoc	Adopted
H-606	Drug Therapy Surveyor Guidelines for Nursing Homes (SR-Source-H607-A/19)	BORPH	Ad Hoc	Adopted
H-607	Beer's Criteria for Potentially Inappropriate Medication Use in Older Adults - Use Of (SR-Source-H625-A/19)	BORPH	Ad Hoc	Adopted
H-608	Latex Allergy (SR-Source-H618-A/19)	BORPH	Ad Hoc	Adopted
H-609	Pharmaceutical Packaging/ Environmental Responsibility (SR-Source-H621-A/19)	BORPH	Ad Hoc	Adopted
H-610	Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S. (SR-Source-H628-A/19)	BORPH	Ad Hoc	Adopted as Amended
H-611	Third-Party Payers and Utilization Review Firms – Accountability (SR-Source-H612-A/19)	CERA	Ad Hoc	Adopted as Amended
H-612	Local Coverage Determination (SR-Source-H617-A/19)	CERA	Ad Hoc	Adopted
H-613	Mergers and Buy-Outs of Third-Party Payers (SR-Source-H615-A/19)	CERA	Ad Hoc	Adopted

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (600 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-614	Federal Health Information Technology Incentives – AOA Support (SR-Source-H616-A/19)	CERA	Ad Hoc	Adopted as Amended
H-615	Electronic Health Records Software – Reporting Errors to Physicians (SR-Source-H623-A/19)	CERA	Ad Hoc	Adopted as Amended
H-616	Government Intervention in Private Practice (SR-Source-H606-A/19)	CERA	Ad Hoc	Adopted
H-617	Patient Matching of Electronic Health Record Data (SR-Source-H632-A/19)	CERA	Ad Hoc	Adopted as Amended
H-618	Centers For Medicare and Medicaid Communications with Physicians (SR-Source-H608-A/19)	CERA	Ad Hoc	Adopted
H-619	Mandated Patient Care – Assignment of (SR-Source-H609-A/19)	CERA	Ad Hoc	Adopted as Amended
H-620	Hospice – Federal Reimbursement for Required Face-to-Face Visits (SR-Source-H600-A/19)	CERA	Ad Hoc	Adopted
H-621	Palliative Care – Federal Funding for Support Services (SR-Source-H601-A/19)	CERA	Ad Hoc	Adopted
H-622	Regulation of Health Information Technology Software (SR-Source-H603-A/19)	CERA	Ad Hoc	Adopted as Amended
H-623	Emerging States – Assistance by Other States and the AOA (SR-Source-H604-A/19)	CSHA	Ad Hoc	Adopted as Amended
H-624	Mail Order Pharmacy (SR-Source-H613-A/19)	CSHA	Ad Hoc	Adopted
H-625	Maintenance of Licensure (SR-Source-H627-A/19)	CSHA	Ad Hoc	Adopted
H-626	Osteopathic Terminology - Glossary of (SR-Source-H605-A/19)	BOM	Ad Hoc	Adopted as Amended
H-627	Taser Safety – Referred Sunset Resolution H609-A/23 (SR-Source-H615-A/18)	BORPH	Ad Hoc	Adopted as Amended
H-628	Physician Payment Adjustments for Budget Neutrality	FOMA (Florida)	Ad Hoc	Adopted as Amended
H-629	House of Delegates Committees	FOMA (Florida)	Ad Hoc	Not Adopted

AMERICAN OSTEOPATHIC ASSOCIATION

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (600 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-630	Preventing the Criminalization of Medical Decision Making	MOA (Maine)	Ad Hoc	Referred to Maine
H-631	Approved Resolutions Status	OPSC (California)	Ad Hoc	Adopted as Amended
H-632	Appeal CMS Physician Payment Rule for Medicare	OPSC (California)		Withdrawn
H-633	OMT Coverage Determination Guidance - Amendment to Policy H635-A/20	BFHP	Ad Hoc	Referred to BFHP
H-634	Prior Authorization Requirement for Reimbursement for Osteopathic Manipulative Treatment	AAO	Ad Hoc	Adopted as Amended

SUBJECT: ADDRESSING THE GENDER PAY GAP IN THE MEDICAL PROFESSION – SOURCE: H638-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) acknowledges the existence of the
7 "gender pay gap" between male and female physicians in the United States; and,
8 that AOA shall support the adoption of policies and practices that ensure the
9 equitable compensation of physicians who work the same job regardless of gender.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: INVESTMENT TAX – SOURCE: H610-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) notes that it is the responsibility of all
7 osteopathic associations with 501{c}(6) tax status to urge their state legislators, U.S.
8 senators and representatives, to defeat any proposed expansion of the tax on
9 unrelated business income to include dividends, capital gains and/or interest
10 income on reserves and current operational funds, under the 501{c}(6) tax status.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: FAMILY MEDICAL LEAVE ACT EMPLOYEE RELATIONSHIP MODIFICATION – SOURCE: H603-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports legislation amending the
7 Family Medical Leave Act (FMLA) Basic Leave Entitlement 'to care for the
8 employee's spouse, son or daughter, or parent, who has a serious health condition'
9 to include responsible designee; and requests the Department of Labor to include
10 these changes at the federal level.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 20, 2024

SUBJECT: INDUSTRY TRANSPARENCY STANDARDS – SOURCE: H622-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be **REAFFIRMED.**

6 The American Osteopathic Association AOA: (1) acknowledges the contributions
7 made by pharmaceuticals, biologics, and medical devices to the improved health,
8 management of disease, and enhanced life function for millions of patients cared
9 for by physicians ~~as distinguished in H327-A21 and as outlined in H626-A/23~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: OMT – OSTEOPATHIC MANIPULATIVE TREATMENT – SOURCE: H611-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) urges that in all forms of
7 communication the term OMT shall always be "Osteopathic Manipulative
8 Treatment."

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: __July 20, 2024_____

SUBJECT: DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES – SOURCE: H607-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports drug therapy surveyor
7 guidelines regarding inappropriate drug use in nursing facilities be developed in
8 collaboration with professional organizations possessing clinical expertise in
9 geriatrics and long-term care medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: BEER'S CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS-USE OF – SOURCE: H625-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recognizes the limitations of the
7 Beer's Criteria, as published by the American Geriatrics Society, as guidelines and
8 not mandates to limit or prohibit access to medications deemed appropriate by the
9 patient's physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: LATEX ALLERGY – SOURCE: H618-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) strongly encourages hospitals and
7 other healthcare facilities to provide non-latex alternatives.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY- SOURCE: H621-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that it is current, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports environmentally
7 responsible packaging of pharmaceutical samples.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1991, 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 20, 2024_____

SUBJECT: STANDING AGAINST RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS IN THE US -SOURCE: H628-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has updated statistics and references now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED**.**

Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the US

Policy Statement - White Paper

Opposing Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S.

Introduction

Every day ~~approximately~~ ~~53,000~~ **~~48,000~~** **AN ALARMING NUMBER OF** youth under the age of 18 are ~~sent to~~ **PLACED IN** correctional facilities as a result of juvenile or criminal justice involvement.[1] Correctional facilities generally offer limited medical and mental health care, resulting in harmful health outcomes, such as increased violence, mental illness, cognitive impairment, and increased risk of disease. It is not uncommon for incarcerated youth to be housed in solitary confinement or restrictive housing while in these facilities. The use of solitary confinement further compromises the quality of the health care detainees receive, and results in long-lasting, adverse physical, psychological, and social effects. Thus, the use of such housing has become a major public health concern in the U.S.

For many individuals who are committed to improving health outcomes for juvenile youth, there has been an urgent need for interventions and reformation programs that encourage humane alternatives and movement towards the abolishment of juvenile solitary confinement in the U.S. In fact, several professional and human rights organizations have taken positions in favor of limiting or eliminating solitary confinement.

The purpose of this paper is to discuss the frequency and impact of solitary confinement (isolation) on juvenile well-being and to present the AOA's position opposing restrictive housing and solitary confinement for juvenile inmates in the U.S.

Solitary Confinement

The term, solitary confinement, is often used interchangeably with the terms segregation, isolation, and restrictive housing. The National Commission on Correctional Health Care refers to solitary confinement, or isolation, as the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals. Additionally, the United States Department of Justice defines restrictive housing as any type of detention that involves one of the following:[2]

1. Removal from the general inmate population, whether voluntary or involuntary.
2. Placement in a locked room or cell, whether alone or with another inmate.
3. Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.

There are several forms of restrictive housing. High security facilities that contain solitary confinement units are called supermaximum ("supermax") facilities.[3] These facilities house inmates who have engaged in violent behavior aimed at other inmates or staff in another institution or those who were not compliant at lower-security prisons. Some supermax facilities also house inmates in protective custody or those considered to be a "special population", such as prisoners on death row. In addition to these facilities, there are facilities that contain solitary confinement cells, known as segregated housing or secured housing units, in institutions that are not considered supermax facilities.[3]

By design, solitary confinement restricts human contact and environmental simulation. The facilities commonly have minimal natural light, leaving detainees exposed to constant artificial light, and inmates experience punitively distasteful meals, have limited personal items, and are denied opportunities to communicate with others.[3]

Public Health Implications

Though data on the frequency and duration of solitary confinement is scant, the Office of Juvenile Justice and Delinquency Prevention reports that half of the individuals in the juvenile penal system were isolated for more than four hours at a time.[4] Exact statistics are not readily available, since the federal government does not require prisons to report the number of juveniles in solitary confinement, the frequency, or the amount of time they are isolated.[3]

In some jurisdictions, youth may be detained in solitary confinement for several weeks or months. In addition to the harms associated with adults in solitary confinement, youth may also lack educational options or interaction with their families, and they may experience the beginning of mental illnesses that commonly occur during late adolescence.[5]

Many studies have underscored the troubling realities of physical and mental health outcomes directly related to the increase of solitary confinement. While incarceration alone yields unintentional but inevitable consequences on wellness, especially mental health issues, solitary confinement amplifies the risk of anxiety, depression, psychosis and self-harm, as supported by both the American Psychological Association and American Academy of Child and Adolescent Psychiatry.[6]

The practice of placing youth in solitary confinement is especially troubling since children and young adults are still developing physically, mentally, and socially and are more vulnerable to the noted long-lasting negative effects of solitary confinement. Accordingly, mental health problems are more prevalent among youth inmates compared to adult inmates, with 95% of youth in the juvenile penal system having at least one mental health problem, and 80% of youth developing more than one mental health illness.[7]

Furthermore, the Centers for Disease Control and Prevention reports that **IN 2021,** suicide **WAS THE 2ND LEADING CAUSE OF DEATH FOR PEOPLE AGED 10-14, AND 20-34.**[8] ~~is the 3rd leading cause of death for youth, resulting in approximately 4,600 deaths per year.~~[8] However, young people in prisons are 18 times more likely to commit suicide than their counterparts in the community.[7] Thus, isolation of juveniles increases the risk of both mental illness and suicide for adolescents and young adults. Thus, concerns about the use of solitary confinement have mounted.

In a July 14, 2015 speech at the NAACP National Convention, President Barack Obama announced that he had asked Attorney General Loretta Lynch to conduct a review of "the overuse of solitary confinement across American prisons." The President directed that the focus not only on understanding how, when, and why correctional facilities isolate certain prisoners from the general inmate population, but also that it includes strategies for reducing the use of this practice throughout our nation's criminal justice system.

Among other findings, the study report summary noted that the implementation of solitary confinement and the length of time an inmate is isolated is the discretion of correctional officers, not decided by a court or jury. The report also recommended that the Bureau end the practice of placing juveniles in restrictive housing, pursuant to the standards proposed in the Sentencing Reform and Corrections Act of 2015.[2]

The United Nations has also taken a stance against solitary confinement and considers isolation within juvenile facilities a form of torture. The U.N. has encouraged the U.S. to create federal and state legislature ratifying the Convention on the Rights of the Child, an international agreement set forth by the U.N. to protect children from abuse. To date, only seven U.S. states have placed any prohibition on juvenile solitary confinement.[3]

The American Academy of Child and Adolescent Psychiatry highlights the code of ethics surrounding the psychiatrist's responsibility to not only reduce the harmful impacts of the behavior of others but the community and social effects as well.[7] Often, correctional facilities have a culture of their own that produces a different code of ethics for the survival and safety of juvenile inmates; this can create a dilemma for clinicians as it relates to providing quality care to inmates.

~~**Racial and Gender Disparities**~~

Within the issue of solitary confinement in juvenile detention facilities, there is a concern that certain races/ethnicities are disproportionally exposed to these practices than youth from other races/ethnicities. ~~Across the nation, the youth rate of incarceration is **74**152 per 100,000. However, the Black youth placement rate is nearly three times higher than the national rate at **228** 433 per 100,000. Comparatively, the White youth placement rate is **49** 86 per 100,000 nationally. According to the Department of Justice, Black youth are five times more likely to be detained compared to Whites. When examining the system further, Black males and Native American females are an over-represented population in the U.S. juvenile prison system. Currently, in the U.S., Black males under the age of 18 make up~~

~~**15%**14% of the total population; however, **42%**43% of Black males under 18 years of age are in juvenile facilities.[9] Nationally, Native Americans make up less than 1% of all youth, but 3% of Indian females are in juvenile facilities.[7]~~

~~Over the last decade, the racial disparity in youth placed in the juvenile penal system has increased by nearly 22%.[9] As a result of disparities in the number of justice-involved juveniles, minority youth detainees are more likely to suffer severe psychological/mental health issues and live in restrictive facilities away from home. Black juveniles, specifically, are experiencing worse health outcomes, especially mental health outcomes, due to disparities in the juvenile penal system.[9]~~

Social and Societal Impact

~~Family support and love are essential for the development of juveniles social identity.[9] However, visits, phone calls, and sometimes even letters are prohibited during solitary confinement, creating additional separation between inmates, their families, and the outside world in general.~~

Isolation due to incarceration creates separation from society that makes it very difficult to form a social identity. Solitary confinement exacerbates the social complexities and behaviors of re-entering into society by aggravating preexisting depression or anxiety due to separation from home or the community. Consequently, isolation hinders the development of juveniles, making it extremely difficult for them to reintegrate into the community easily or productively.[3]

Additionally, author, Jessica Lee, highlights that solitary confinement also negatively impacts the physical growth of juveniles by restricting much needed exercise and nutrition.[3]

Reformation Efforts

The impact of juvenile solitary confinement has led to a call for reform by legislators and scientific scholars.[3] Although some states have been successful in abolishing or reducing solitary confinement, it is still practiced within the juvenile penal system.[4] This call for reform regarding solitary confinement has the potential to shift the juvenile justice system toward a more ethical and just model.

- **Federal Reformation Efforts**

U.S. Representative Cedric Richmond presented a bill calling for a study across the nation on the impacts that solitary confinement has on mental health. The intent of this bill, known as the Solitary Confinement Study and Reform Act of 2014, was to reduce the use of solitary confinement.[3] The bill died and was reintroduced to the House in 2015.

In 2015, Senator Cory Booker introduced “Maintaining Dignity and Eliminating Unnecessary Restrictive Confinement of Youth”, commonly known as the Mercy Act. The Mercy Act entails the following:

1. Prohibits the use of solitary confinement of juveniles in federal custody, except for a maximum of three hours, if the juvenile harms any individual.
2. Requires that facilities first use less restrictive measures to control behavior before placing the juvenile into solitary.
3. If, after the maximum three hours of solitary have ended, the juvenile still poses a risk of physical harm to themselves or anyone else, then the juvenile can be

transferred to a different juvenile facility or "internal location" where he or she can be treated without the use of solitary.

The Mercy Act was introduced to the Senate in 2017, but no further action has been taken.[3]

- **State & Local Reformation Efforts**

In the state of New York, legislators agreed to ban solitary confinement for inmates younger than 21 at Riker's Island and implement a practice where inmates between the ages of 18-21 undergo counseling and classes in a different facility as an alternative.[3] The reason for this reform was to combat the psychological effects that solitary confinement has on young adults and youth. Other states have joined in on State and Local reformation with varying approaches to the public health issue. For instance, in Pennsylvania mentally ill inmates will no longer be placed in solitary confinement; instead, they will be placed in special treatment units.

Although these laws are progressive, they do not address all of the concerns about solitary confinement among youth. There has been a huge push by activists and researchers for Congress and the U.S. Department of Justice to bring forth uniformity across the nation's legislation to provide a standard and just approach to juvenile inmates regarding solitary confinement in the U.S. prison system.[10]

- **Educational Efforts**

Many medical and research organizations, such as the National Alliance for Suicide Prevention, have developed recommendations and interventions for "improving the level and quality of collaboration between the juvenile and mental health systems, primarily for suicide prevention."[11] These collaborative efforts are tailored to promoting education, awareness, and prevention support and services for youth in the juvenile prison system. In these educational programs, organizations and researchers identify protective factors to decrease mental illness and suicide. In so doing, many organizations also are promoting data collection and inmate screening/assessment tools to increase information on solitary confinement in an effort to better understand and combat the psychological and social impacts of solitary confinement. More information and knowledge will allow health care professionals and public health practitioners to monitor the social development and health outcomes for inmates in juvenile facilities.[13]

Opposition To Reformation Efforts

Despite evidence of deleterious effects of solitary confinement in the juvenile penal system, there is still some opposition to reformation efforts. Opponents suggest that solitary confinement serves pragmatic purposes. For example, when prisons are overloaded with inmates, there is no physical space for them, or enough staff to run the prison. In this instance, solitary confinement provides additional housing space for inmates.[12] Others contend that solitary confinement aids in the rehabilitation of character as it becomes a means of reflection for inmates. Another viewpoint is that solitary confinement offers prison safety for inmates who are a threat to staff, other inmates, or the public.[13] Finally, some believe that solitary confinement provides guards/officers with the means to discipline and maintain order within the prison walls.[13]

Conclusion

Nearly half of juveniles placed in the U.S. Prison system experience solitary confinement. As a result, the majority of these juveniles also have detrimental, long-lasting, physical and psychological health outcomes. Education, counseling, and rehab programs are all positive alternatives to solitary confinement that raises health outcomes for youth. Increased State and Federal legislation that actively opposes juvenile solitary confinement will not only positively impact youth outcomes but society as well when inmates reintegrate into their communities. Opposing solitary confinement and restrictive housing would be a significant step forward in saving lives and improving health and well-being outcomes.

American Osteopathic Association Policy

Given the research surrounding the negative impacts of restrictive housing and solitary confinement, the American Osteopathic Association adopts the following policy statements as its official position on opposing restrictive housing and solitary confinement for juvenile inmates of the prison system in the U.S.:

1. The official position of the American Osteopathic Association (AOA) is that youth incarceration is meant to be rehabilitation and that the use of juvenile solitary confinement and/or restrictive housing imparts serious psychological and physical harm.
2. The American Osteopathic Association encourages increased research and data collection surrounding the prevalence of the use of solitary confinement /restrictive housing among juveniles.
3. The American Osteopathic Association opposes the use of solitary confinement and/or restrictive housing among juveniles in the penal system and supports the abolishment of the use of solitary confinement and isolation for incarcerated youth set forth at the United Nations Convention on the Rights of the Child.

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: ___July 20, 2024_____

SUBJECT: THIRD-PARTY ~~PAYERS~~ **PAYOR** AND UTILIZATION REVIEW FIRMS – ACCOUNTABILITY -SOURCE: H612-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED**.**

6 The American Osteopathic Association (AOA) supports the disclosure of the origin
7 of utilization review criteria used by ~~third-party~~ ~~payers~~ **PAYOR AND WILL**
8 **ADVOCATE TO ENSURE THAT UTILIZATION MANAGEMENT CRITERIA ARE**
9 **EVIDENCE-BASED AND DEVELOPED WITH PUBLICLY AVAILABLE**
10 **EVIDENCE. THE AOA OPPOSES THE USE OF CRITERIA OR ALGORITHMS**
11 **THAT RELY ON PROPRIETARY INFORMATION HELD BY THE PLAN THAT**
12 **CANNOT BE RESEARCHED OR EXTERNALLY VALIDATED.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1994; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: ___July 20, 2024_____

SUBJECT: LOCAL COVERAGE DETERMINATION – SOURCE: H617-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that this policy is duplicative of other AOA policy; and

4 WHEREAS, current policy H635-A/20 OMT Coverage Determination Guidance has
5 been revised by the Bureau of Federal Health Programs, approved by the
6 AOA Board of Trustees and has been submitted to the 2024 House of
7 Delegates via Resolution H633-A/24-OMT Coverage Determination
8 Guidance Amendment to policy H635-A/20; and

9 WHEREAS, the guidance established within the current policy and the proposed
10 amendments cover the content in H617-A/19; now, therefore be it

11 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
12 the following policy be ~~SUNSET~~.REAFFIRMED.

13 The American Osteopathic Association (AOA) encourages public and private
14 insurance carriers, as well as the Centers for Medicare and Medicaid Services to
15 utilize the local coverage determination (LCD) adopted in the State of Florida as a
16 guide when determining coverage requirements for osteopathic manipulative
17 treatment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009; Reaffirmed 2014; Reaffirmed 2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: MERGERS AND BUY-OUTS OF THIRD PARTY ~~PAYERS~~ PAYORS – SOURCE: H615-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) advocates that all third party ~~payers~~
7 **PAYORS** automatically enrolling physicians in all products of an acquiring company
8 should notify the physician of the products offered and permit physicians to reject
9 one or all of the products of the acquiring company.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: FEDERAL HEALTH INFORMATION TECHNOLOGY ~~INCENTIVES~~ **INITIATIVES** – AOA SUPPORT – SOURCE: H616-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED**.**

The American Osteopathic Association (AOA) **ADVOCATES FOR** ~~supports the~~ federal Health Information Technology (HIT) initiatives **SEEKING TO PROMOTE INTEROPERABILITY AND DATA EXCHANGE** by assisting its members through education and other services necessary for them to adopt the appropriate technology which would be cost effective for their practices. **THE AOA ALSO SUPPORTS FEDERAL EFFORTS TO HELP PHYSICIAN PRACTICES MAKE INVESTMENTS IN TECHNICAL INFRASTRUCTURE THAT BETTER ENABLES THEIR PARTICIPATION IN VALUE-BASED CARE AND QUALITY INITIATIVES.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: ____July 20, 2024_____

SUBJECT: ELECTRONIC HEALTH RECORDS SOFTWARE – REPORTING ERRORS TO PHYSICIANS – SOURCE: H623-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED**.**

The American Osteopathic Association (AOA) supports prompt notification by Electronic Health Record (EHR) vendors to physician clients of reported software errors and provisions of software updates that correct these errors, in a systematic~~,~~ ~~cost-effective~~ ~~and timely~~ fashion **AS SOON AS POSSIBLE** at no cost to the EHR **END** user.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended

DATE: _____July 20, 2024_____

SUBJECT: GOVERNMENT INTERVENTION IN PRIVATE PRACTICE – SOURCE: H606-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) strongly recommends that any
7 intervention by federal, state or private third-party payers shall not impose a
8 financial penalty on any physician without proper peer review and opportunity for
9 appeal, and encourages the continued availability of judicial review of claims.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1985; 1990 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: PATIENT MATCHING OF ELECTRONIC HEALTH RECORD DATA SOURCE: H632-A19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

Policy Brief on Patient Matching

Overview:
As patient electronic health information can be more easily shared between physicians, health information exchanges, and payers, patient identification (patient matching) remains a persistent problem in ensuring that electronic health record (EHR) data is complete and accurate. **ACCORDING TO A 2019 NATIONAL SURVEY, 20% OF PROVIDERS AND HEALTH INFORMATION EXCHANGES REPORTED THAT MORE THAN 10% OF THEIR STORED RECORDS ARE DUPLICATES, WITH SOME RESPONDENTS REPORTING MORE THAN 50% DUPLICATION IN THEIR RECORDS[1]**. ~~Errors and missing information remain common in the electronic health record ecosystem, with approximately 8% of all records being split or duplicate. This error rate is higher (14% to 16%) within large health systems that store vast amounts of data for a large number of patients.1 When excluding matching within organizations to analyze patient matching rates between organizations, the match rate can drop to 50%.2~~ These high duplication and mismatch rates often translate into unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate information**. THE SAME STUDY FOUND THAT ABOUT 38% OF HEALTHCARE PROVIDERS EXPERIENCED AN ADVERSE EVENT IN THE LAST TWO YEARS BECAUSE OF PATIENT MATCHING ISSUES. ADDITIONALLY, 45% OF LARGE HOSPITALS REPORTED DIFFICULTY MATCHING OR IDENTIFYING THE CORRECT PATIENTS BETWEEN SYSTEMS[2]**~~. A 2016 report indicated that 4% of duplicate records result in negative clinical care and outcomes.~~

Robust and accurate information exchange is central to delivering high quality, cost effective care. Although it requires significant investment, improving patient matching rates will provide benefits to the greater healthcare system that extend far beyond individual encounters.

THE OFFICE OF THE NATIONAL COORDINATOR (ONC) PUBLISHED THE TRUSTED EXCHANGE FRAMEWORK, A COMMON SET OF PRINCIPLES DESIGNED TO INCREASE TRUST ACROSS HEALTH INFORMATION NETWORKS, IN 2022 TO SUPPORT IMPROVED DATA SHARING ACROSS HEALTHCARE ENTITIES. THESE PRINCIPLES, COMBINED WITH THE COMMON AGREEMENT, A LEGAL CONTRACT FOR DEFINING TECHNICAL REQUIREMENTS FOR PARTICIPATION, (KNOWN TOGETHER AS TEFCA), WERE DEVELOPED WITH THE GOAL OF SIMPLIFYING CONNECTIVITY TO SECURELY EXCHANGE INFORMATION TO IMPROVE PATIENT CARE. THESE NATIONWIDE EXCHANGE EFFORTS MAKE THE NEED FOR EFFECTIVE RECORD MATCHING ESPECIALLY IMPORTANT.

Being able to effectively capture, track, and share data relating to patients' social determinants of health is crucial to delivering high-value care management and promoting well-being outside of a hospital. Not only would accurate capture and sharing of patient data promote better care coordination once a patient is back in their community, but it also supports better population level analytics.[3] Despite the need to improve patient matching, no clear standards for patient matching exist, and there are numerous legal and operational barriers to driving standardization across the healthcare landscape.

Past and Current Proposals

Policy efforts to improve the matching of patient records in an increasingly digital health care system date back to the mid-1990s. As part of the Health Information Portability and Accountability Act (HIPAA) in 1996, Congress directed the Department of Health and Human Services (HHS) to develop a unique identifier for each individual, employer, provider, and plan within the US healthcare system. However, following the passage of HIPAA, there was significant pushback against this provision due to privacy and security concerns. As a result, Congress walked back the proposal by inserting language into appropriations bills that prohibited HHS from using federal funds to develop unique patient identifiers (UPIs) for individuals.

As the number of digital patient records across the US health care system proliferates, it is becoming increasingly important that providers can de-duplicate records and effectively match them to the proper patient. **IN RESPONSE TO PUBLIC COMMENTS DESCRIBING "PATIENT ADDRESS" AS A USEFUL DATA ELEMENT FOR ACCURATE PATIENT MATCHING IN LIEU OF A UPI, ONC COLLABORATED WITH STANDARDS DEVELOPMENT ORGANIZATIONS TO CREATE PROJECT US@, AN INITIATIVE INTENDED TO ESTABLISH CONSISTENT PATIENT ADDRESS FORMATTING TO SUPPORT PATIENT MATCHING BY ISSUING A UNIFIED TECHNICAL SPECIFICATION FOR HEALTH RECORDS. RESEARCHERS ESTIMATE THAT FORMATTING ADDRESSES ACCORDING TO THE U.S. POSTAL SERVICE SPECIFICATIONS WILL AID IN MORE ACCURATELY LINKING RECORDS[4]. "PATIENT ADDRESS" AND "PATIENT FORMER ADDRESS" ARE INCLUDED AS DATA ELEMENTS IN THE UNITED STATES CORE DATA FOR INTEROPERABILITY (USCDI) AS A STANDARD, FINALIZED IN 2020. WHILE THIS EFFORT IS IMPORTANT TO SUPPORT PATIENT MATCHING, ADDITIONAL DEMOGRAPHIC DATA IS NECESSARY TO EFFECTIVELY MATCH PATIENT RECORDS. CERTAIN INDIVIDUALS, INCLUDING UNHOUSED INDIVIDUALS, WOULD BE NEGATIVELY IMPACTED BY EFFORTS THAT RELY EXCLUSIVELY ON ADDRESSES.**

~~As of March of 2019, as part of the HHS Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator's (ONC) Proposed Rule on Interoperability and Information Blocking, HHS is proposing to improve patient matching by establishing standards for EHR developers regarding demographic data elements necessary within EHRs for patient matching. The rule also includes a request for information on what data elements would be useful in ensuring accurate patient matching and whether national standards for patient identification would be useful.~~

Without a UPI, the ~~most effective way to ensure accuracy of matched patient records is through the~~ use of social security numbers **COULD ALSO HELP MATCH RECORDS, ALONG WITH OTHER DATA ELEMENTS**. A study published in Perspectives in Health Information Management asserts that creating a field for at least the last 4 digits of a patient's social security number, and capturing a patient's full middle name, would increase match accuracy substantially.[5]~~[4]~~

Challenges of Each Approach

While there is a great amount of discussion around national standards for patient demographic data and the need for additional identifying information, there is disagreement on whether it would be more appropriate to encourage the use of social security numbers or to seek legislative action to create unique patient identifiers.

Inclusion of social security numbers in patient records would improve patient matching, and standards that require fields for social security numbers in EHRs would not require legislative action. However, various challenges exist to achieving widespread adoption of this practice. First, individuals are often reluctant to provide SSNs out of concern for identity theft. Under this approach, patients would likely have various records with different providers containing their SSNs, increasing their exposure to identity theft risk. Although this perceived risk may be marginal, the fear is likely to be a deterrent to patients offering this information. Second, many states outlaw the collection of social security numbers for health care purposes, and a federal standard that included SSN collection would not apply in these states. Third, as a result of federal legislation, Medicare now provides patients with Medicare cards **TO** ~~and is actively~~ shift~~ing~~ away from having patients provide social security numbers. Alternatively, the use of Medicare cards can improve patient matching for this particular population.[6]~~[5]~~

As an alternative to social security numbers, various groups have proposed using different unique patient identifiers, including numbers that would be issued by CMS, encouraging the use of biometrics as an additional authenticator, or incorporating additional personal authenticators within patient records that patients would then confirm (personal questions or text message authentication). However, these changes would be costly to implement and there is no consensus on what approach would be best.

Position of the AOA

In light of the current debate regarding the most effective way to match patient data that does not present privacy and security risks, the AOA supports efforts to develop national standards with appropriate safe guards for authentication, and collection of patient demographic data. In order to make the sharing of patient data more efficient and

accurate, all health care organizations must collect the same information and enter it in a standardized format. The AOA will support policies that will achieve standardization of identifying data in patient records.

Additionally, because patient health data is particularly sensitive information and patient records contain large amounts of identifying information, the AOA will support the strengthening of privacy and security standards for the certification of EHRs and application programming interfaces.

REFERENCES

1. ~~Hillestad, Richard, James H. Bigelow, Basit Chaudhry, Paul Dreyer, Michael D. Greenberg, Robin Meili, M. Susan Ridgely, Jeff Rothenberg, and Roger Taylor, Identity Crisis: An Examination of the Costs and Benefits of a Unique Patient Identifier for the U.S. Health Care System. Santa Monica, CA: RAND Corporation, 2008. https://www.rand.org/pubs/monographs/MG753.html.~~ **THE STATE OF PATIENT MATCHING IN AMERICA: A 2019 NATIONAL SURVEY. HTTPS://WWW.EHIDC.ORG/SITES/DEFAULT/FILES/RESOURCES/FILES/NEXTGATE-EHI%20PATIENT%20MATCHING%20SURVEY%20RESULTS.PDF**
~~2.http://perspectives.ahima.org/why-patient-matching-is-a-challenge-research-on-master-patient-index-mpi-data-discrepancies-in-key-identifying-fields/~~
2. **AHA, TRENDWATCH: SHARING HEALTH INFORMATION. A LARGE HOSPITAL IS ONE WITH GREATER THAN 300 BEDS. HTTPS://WWW.AHA.ORG/SYSTEM/FILES/2018-03/SHARING-HEALTH-INFORMATION.PDF**
3.**HTTPS://WWW.PEWTRUSTS.ORG/EN/RESEARCH-AND-ANALYSIS/REPORTS/2018/10/02/ENHANCED-PATIENT-MATCHING-CRITICAL-TO-ACHIEVING-FULL-PROMISE-OF-DIGITAL-HEALTH-RECORDS**
~~3.~~**4. DIGITAL MEDICINE. 2020. BETTER PATIENT IDENTIFICATION COULD HELP FIGHT THE CORONAVIRUS. HTTPS://WWW.NCBI.NLM.NIH.GOV/PMC/ARTICLES/PMC7264357/**
~~4.~~**5. HTTPS://WWW.PEWTRUSTS.ORG/EN/RESEARCH-AND-ANALYSIS/REPORTS/2018/10/02/ENHANCED-PATIENT-MATCHING-CRITICAL-TO-ACHIEVING-FULL-PROMISE-OF-DIGITAL-HEALTH-RECORDS**
~~5.~~**6. HTTPS://WWW.MANAGEDHEALTHCAREEXECUTIVE.COM/HEALTH-MANAGEMENT/WHY-ADDRESSING-SDOH-STARTS-PATIENT-MATCHING/PAGE/0/1**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2019)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 20, 2024

SUBJECT: CENTERS FOR MEDICARE AND MEDICAID COMMUNICATIONS WITH PHYSICIANS – SOURCE: H608-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED**.**

6 The American Osteopathic Association (AOA) supports the distribution of thorough
7 and current written information by all Medicare administrative contractors on the
8 correct preparation and coding of Medicare claims to all physicians and supports
9 communication to the physician of the complete justification for the denial of any
10 Medicare claims.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: MANDATED PATIENT CARE – ASSIGNMENT OF – SOURCE: H609-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED**.**

The American Osteopathic Association strongly opposes any attempt by a **WORKMAN'S COMPENSATION PAYER, OR ANY OTHER** third-party payer, business, institution or government to mandate a patient be seen and managed by any individual~~, including a hospitalist, or anyone other than the patient and their physician~~ in any setting without the **TIMELY NOTIFICATION OF AND** concurrence of the patient's physician **AND THE INFORMED CONSENT OF THE PATIENT.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended__

DATE: _____July 20, 2024_____

SUBJECT: HOSPICE – FEDERAL ~~REIMBURSEMENT~~ **PAYMENT** FOR REQUIRED FACE-TO-FACE VISITS – SOURCE: H600-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED**.**

6 HOSPICE – FEDERAL ~~REIMBURSEMENT~~ **PAYMENT** FOR REQUIRED FACE-TO-
7 FACE VISITS

8 The American Osteopathic Association (AOA) supports reasonable federal payment
9 to hospice organizations for federally required face-to-face visits for patients enrolled
10 in hospice.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 20, 2024_____

SUBJECT: PALLIATIVE CARE – FEDERAL FUNDING FOR SUPPORT SERVICES – SOURCE: H601-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports federal funding for chaplain,
7 social work, and home health aide provider services for palliative care patients.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE – SOURCE: H603-A/19

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) supports ~~a new risk-based oversight framework for clinical software, developed through~~ a multi-stakeholder consensus-based process **FOR DEVELOPING AND EVALUATING TECHNICAL STANDARDS FOR HEALTH INFORMATION TECHNOLOGY (HEALTH IT) AND WILL WORK WITH THE OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY ON ADOPTION OF APPROPRIATE STANDARDS INTO ITS HEALTH IT CERTIFICATION PROGRAM.** ~~The framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility.~~ Patient safety**,** ~~and appropriate~~ improvements in quality, effectiveness, and efficiency of care delivery should be paramount **WHEN DEVELOPING CERTIFICATION CRITERIA AND POLICIES SURROUNDING HEALTH IT ADOPTION AND USE.** ~~This framework should not conflict with or duplicate the medical device regulation framework. The AOA does not support data treated as a medical device regardless of the category of health information technology associated with the data.~~ The AOA ~~supports~~ **ADVOCATES FOR A FRAMEWORK FOR THE NATIONWIDE EXCHANGE OF DATA, IN A MANNER THAT ENSURES PRIVACY AND SECURITY PROTECTIONS FOR PATIENTS' HEALTH INFORMATION, FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, PUBLIC HEALTH, INDIVIDUAL ACCESS, AND PATIENT SAFETY PURPOSES**. ~~a national network for reporting patient safety events, where data can be accessed, analyzed, and communicated in a timely manner. Existing programs should be leveraged and utilized.~~ The AOA **ALSO** supports a common data structure that will enable interoperability; setting a clear course of action, supporting an exchange infrastructure, and adopting standards that will make it easier to share information so that physicians and patients can make informed decisions.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2014; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: _____July 20, 2024_____

SUBJECT: EMERGING ~~STATES~~ **AFFILIATES** – ASSISTANCE BY OTHER ~~STATES~~ **AFFILIATES** AND THE AOA – SOURCE: H604-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

EMERGING ~~STATES~~ **AFFILIATES** – ASSISTANCE BY OTHER ~~STATES~~ **AFFILIATES** AND THE AOA

The American Osteopathic Association (AOA) encourages liaison between ~~state~~ affiliate organizations whether formal or informal and supports assistance to ~~state~~ affiliate organizations in need.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1979; 1984 Reaffirmed; 1989 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _July 20, 2024_____

SUBJECT: MAIL ORDER PHARMACY – SOURCE: H613-A/19

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) opposes pharmaceutical programs
8 that require all medications be delivered to the patient's residence as failing to act in
9 the best interests of the patient. Maintenance medication prescriptions should be
10 obtainable by the means preferred by the patient.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
Pharmacy Benefit Managers – Increased Regulation of H339-A/19

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: MAINTENANCE OF LICENSURE -SOURCE: H627-A/19

SUBMITTED BY: Council on State Health Affairs and the Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs and the Bureau of Osteopathic Education have reviewed the policy; and

WHEREAS, the Council on State Health Affairs and the Bureau of Osteopathic Education believe that the policy remains relevant; now, therefore be it

RESOLVED, that the Council on State Health Affairs and the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED.

Maintenance of Licensure

Policy Statement

The American Osteopathic Association (AOA):

(1) supports the development of state level maintenance of licensure (MOL) programs to demonstrate that all physicians are competent to provide quality care that incorporates relevant technological and scientific advancements over the course of their career. Flexible pathways for achieving MOL should be maintained. The requirements for MOL should balance transparency with privacy protection and not be overly burdensome or costly to physicians or state licensing boards.

(2) Continues to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels as well as ongoing physician assessment through Osteopathic Continuous Certification (OCC)

(3) Continues to work with State Osteopathic Affiliates, the American Association of Osteopathic Examiners and other stakeholders to establish and implement MOL policies that promote patient safety and the delivery of high quality of care.

(4) Through its bureaus, councils and committees, will continue to ensure that OCC is recognized by the federal government, state governments and other regulatory agencies and credentialing bodies as equivalent to other national certifying bodies' "maintenance" or "continuous" certification programs.

34 (5) While supporting the use of board certification as a recognition of quality and
35 excellence, signifying the highest physician achievement in a particular specialty;
36 opposes any efforts to require OCC as a condition of medical licensure;
37
38 (6) Collaborates with entities properly qualified for and tasked with decision-making
39 regarding insurance payment, hospital privileges, network participation, malpractice
40 insurance coverage, physician employment, to determine the role of physician
41 board certification and OCC or other "maintenance of certification" programs in such
42 decisions.
43
44 (7) Continues to innovate and improve the OCC process.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2010; 2015 Reaffirmed; 2017 Reaffirmed; 2019 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
Osteopathic Continuous Certification – Affordability of – Source: H208-A/23
Osteopathic Licensing - Source: H213-A/22
Physician Competency Retesting - Source: H607-A/20
Uniform Pathway of Licensing of Osteopathic Physicians- Source: H361-A/19

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: OSTEOPATHIC TERMINOLOGY- GLOSSARY OF
- SOURCE: H605-A/19

SUBMITTED BY: Bureau of Membership

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset: and

WHEREAS, the Bureau of Membership has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of Membership recommends the following policy be REAFFIRMED AS AMENDED**.**

OSTEOPATHIC TERMINOLOGY- GLOSSARY OF

The American Osteopathic Association (AOA) designates the entries in the Glossary of Osteopathic Terminology as the AOA's official terms and definitions; whenever terms or definitions in the Glossary of Osteopathic Terminology conflict substantively with AOA policy, AOA branding guidelines or AOA publications' style guidelines, the AOA will seek to resolve the conflict through the Glossary of Osteopathic Terminology's standard process for revision and external input; and the ~~JAOA~~- **JOM** -The Journal of ~~the American Osteopathic Association's~~ **OSTEOPATHIC MEDICINE'S** "Instructions for Authors" will advise authors to use the terms and definitions in the Glossary of Osteopathic Terminology.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2019 Reaffirmed)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _July 20, 2024_____

SUBJECT: **CONDUCTED ELECTRICAL WEAPONS (CEW),** ~~TASER~~ SAFETY **OF –** SOURCE: H615-A/18 (REFERRED SUNSET RESOLUTION H609-A/23)

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) submitted sunset resolution H609-A/2023-SR-Taser Safety for current policy H615-A/18 to the 2023 House of Delegates and recommended that it be reaffirmed; and

WHEREAS, the 2023 House of Delegates referred this policy back to BORPH to evaluate whether further research remains needed in light of publications since the original adoption of this resolution; and

WHEREAS, a systematic review by Baliatsas, et al[1] of 33 studies on use of Conducted Electrical Weapons (CEW) was published in JAMA Network Open in 2021 and;

WHEREAS, even though the findings of the reviewed studies showed the risk for adverse health outcomes due to CEW exposure can be currently estimated as low, most of the reviewed studies had methodologic limitations and recruited participants (law enforcement officers) who were not representative of the population that usually encounters a CEW deployment; and

WHEREAS, the systematic review cannot draw conclusions regarding exposure outcomes in potentially vulnerable populations or high-risk groups, such as those under the influence of substances; and

WHEREAS, BORPH reviewed the systematic review and concluded that further research is needed on CEW safety; and

WHEREAS, AOA General Counsel advised that because “TASER” is the name of a specific product it should not be used in the policy statement, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED**.**

The American Osteopathic Association (AOA) encourages further research on cardiac arrest, death, and other adverse health effects associated with shocks from **CONDUCTED ELECTRICAL WEAPONS (CEW)** ~~taser electronic control devices~~

1

Reference:

1. Christos Baliatsas, PhD; Jenny Gerbecks, MSc; Michel L. A. Dückers, PD, PhD; C. Joris Yzermans, PhD. Human Health Risks of Conducted Electrical Weapon Exposure: A Systematic Review. JAMA Network Open. 2021;4(2):e2037209. doi:10.1001/jamanetworkopen.2020.37209. https://pubmed.ncbi.nlm.nih.gov/33576818/ accessed 1-22-2024

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Referred to BORPH)

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: PHYSICIAN PAYMENT ADJUSTMENTS FOR BUDGET NEUTRALITY

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

~~The American Osteopathic Association House of Delegates declares the following~~:

WHEREAS, in 1989 the United States Congress passed legislation, which was subsequently enacted, mandating that any estimated increases of $20 million or more to the Medicare physician payment schedule—created by upward payment adjustments or the addition of new procedures or services—must be offset by cuts elsewhere[1]; and

WHEREAS, since the mandate of budget neutrality has been used to impact physician payments by suppressing the conversion factor used to monetize relative value units associated with procedures, such that the conversion factor has changed from $38.2581 in the year 2001 to a factor of $33.8872 in 2023[2]; and

WHEREAS, because of inflation and changing costs, $38.25 in January 2001has the spending power of $67.79 in January 2023[3], representing substantial physician ~~reimbursement~~ **PAYMENT** reductions in the face of a nearly 50% loss in the valuation of those payments; and

WHEREAS, during the same time Medicare spending increased from $224.3 billion dollars in 2001[4], to $829 billion in 2021[5] representing an over 369% increase; now let it be

RESOLVED, that the American Osteopathic Association (AOA) will work with relevant stakeholders to reform budget neutrality such that all recipients of Medicare ~~reimbursement~~ **PAYMENT** be treated equally with respect to cost containment strategies; and

RESOLVED, that the AOA will work with relevant stakeholders to remediate the conversion factor to enhance physician ~~reimbursement~~ **PAYMENT** to a level that is more reflective of the changes to overall Medicare spending since the 1989 budget neutrality provision became active; and be it further

RESOLVED, that the AOA will work with relevant stakeholders to ensure that the conversion factor be modified on an annual basis at a level no less than any increase to the ~~consumer price index~~. **MEDICARE ECONOMIC INDEX**.

References

[1] Text - S.1809 - 101st Congress (1989-1990): Medicare Physician Payment Reform Act of 1989. (1989, October 31). https://www.congress.gov/bill/101st-congress/senate-bill/1809/text

[2] History of medicare conversion factors - american medical association. (n.d.). https://www.ama-assn.org/system/files/2021-01/cf-history.pdf

[3] U.S. Bureau of Labor Statistics. (n.d.). CPI inflation calculator. U.S. Bureau of Labor Statistics. https://data.bls.gov/cgi-bin/cpicalc.pl

[4] Press release report details National Health Care spending increases in 2001. CMS. (n.d.). https://www.cms.gov/newsroom/press-releases/report-details-national-health-care-spending-increases-2001#:~:text=Legislation%20added%20%247.5%20billion%20to,fastest%20growth%20rate%20since%201993.

[5] Juliette Cubanski and Tricia Neuman Published: Jan 19, 2023. (2023, January 19). What to know about Medicare spending and financing. KFF. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/

Background Information: Provided by AOA Staff

Current AOA Policy:

H311-A/23-Medicare

The American Osteopathic Association (AOA) declares its continued support of the Medicare program, the continued availability of high quality medical care at a reasonable cost and comprehensive Medicare reform to ensure that Medicare beneficiaries receive medically necessary services.

H600-A/23-Centers for Medicare and Medicaid Services Policies

The American Osteopathic Association (AOA) will continue to inform state associations and their members on policies and rules being considered by the Centers for Medicare and Medicaid Services and/or other federal agencies on major patient/physician issues and encourages the state associations to provide their members with the information and take an active role in responding to CMS on policies and rules pertinent to their members, their practices and patients.

Prior HOD action on similar or same topic: as noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 20, 2024_____

SUBJECT: HOUSE OF DELEGATES COMMITTEES

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

The American Osteopathic Association House of Delegates declares the following:

WHEREAS, the American Osteopathic Association (AOA) houses a policy compendium comprised of resolutions adopted by the House of Delegates; and

WHEREAS, while policies are reviewed every five years, in a typical year more new resolutions are adopted than sunset resolutions are allowed to expire; and

WHEREAS, the accumulation of more policies creates a larger burden on individual reference committees during the house of delegates, at times requiring service for many hours to service dozens of resolutions; and

WHEREAS, there are a growing number of AOA policies which all need to be periodically addressed as well as new resolutions. To ensure that there is ample time to review and word the amendments for more effective review in the house, one or more committees could be used to “spread the wealth”.

WHEREAS, it is in the best interests of the reference committees to have sufficient time to fully review, edit and present all the resolutions to the house; now, therefore be it

RESOLVED, that Speaker of the House shall limit the number of resolutions under consideration by any single reference committee, and will enumerate such limits annually in the Rules of the House; and, be it further

RESOLVED, that to enable this to occur, the Speaker of the House may establish additional reference committees, including but not limited to a Committee on Membership Affairs, a Committee on Ethical Affairs, and / or a Committee on Long Range Planning and Development, on an annual basis, as needed.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

The Speaker of the House annually reviews the resolutions assigned to the various reference committees by the administration to identify how many members to assign to each reference committee.

FISCAL IMPACT: In-direct expense of staff resources.

ACTION TAKEN: __Not Adopted_____

DATE: ____July 20, 2024_____

SUBJECT: PREVENTING THE CRIMINALIZATION OF MEDICAL DECISION MAKING

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, it is essential to the role of physicians to establish guidelines, review them critically, and decide when they apply and when they do not; and

WHEREAS, in recent years we are observing an increase in the arrest of physicians for the routine practice of medicine when it may deviate from guidelines and/or be “off label”, resulting in indictment and incarceration of leaders of medical academies and known experts[1]; and

WHEREAS, bodies such as state legislatures, congress, the department of justice, third-party payors, and pharmacy chains have increasingly been asserting the standard of care on medical issues regarding which they have inadequate understanding; and

WHEREAS, historically the government’s intervention on medical standards of care has not improved outcomes and at times has been deleterious to delivery of quality patient care and created perverse incentives in the management of common medical issues such as coronary artery disease; and

WHEREAS, rigid implementation of clinical or payment guidelines incentivizes the abandonment of our most complicated and vulnerable patients because of fear of prosecution; and

WHEREAS, only physicians are appropriate to determine when there has been a deviation from acceptable medical practice, and there are established mechanisms for self-regulation of physicians including boards of licensure and certification; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will act in a timely way that publicly ~~protects and assists~~ **ADVOCATES FOR** its members when non-medical bodies inappropriately interfere with medical decision-making by osteopathic physicians**.**

References:

1. [1]https://www.kevinmd.com/2023/07/the-persecution-of-pain-management-doctors.html
2. Arnold DR. Countervailing incentives in value-based payment. Healthc (Amst). 2017 Sep;5(3):125-128. doi: 10.1016/j.hjdsi.2016.04.009. Epub 2016 May 17. PMID: 28822499.
3. https://health.ucdavis.edu/news/headlines/is-reducing-opioids-for-pain-patients-linked-to-higher-rates-of-overdose-and-mental-health-crisis/2021/08
4. https://injepijournal.biomedcentral.com/articles/10.1186/s40621-020-00277-
5. https://thewestendnews.com/pain-patients-abandoned/
6. https://policysearch.ama-assn.org/policyfinder/detail/criminalization?uri=%2FAMADoc%2FHOD.xml-0-760.xml
7. https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.118.034612
8. https://www.ama-assn.org/press-center/press-releases/ama-backs-update-cdc-opioid-prescribing-guidelines
9. https://www.ccghealthcare.com/resource-library/ccg-leads-charge-in-physician-manslaughter-acquittal
10. https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html#printhttps://www.justice.gov/opa/pr/justice-department-s-criminal-division-creates-new-england-prescription-opioid-strike-force
11. https://www.chapmanlawgroup.com/case_results/two-physicians-acquitted/
12. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784633
13. https://www.justice.gov/opa/pr/justice-department-s-criminal-division-creates-new-england-prescription-opioid-strike-force
14. https://www.justice.gov/usao-nh/pr/new-hampshire-doctor-indicted-unlawfully-distributing-opioids-and-benzodiazepines
15. https://www.monroenews.com/story/news/crime/2023/01/10/dr-lesly-pompy-acquitted-all-charges-federal-drug-case/69790454007/
16. https://www.naag.org/attorney-general-journal/opinion-ruan-v-united-states-20-1410/
17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8915556/
18. https://www.pressherald.com/2022/10/26/kennebunk-doctor-charged-with-illegally-distributing-opioids/
19. https://www.reuters.com/legal/doctors-opioid-prescription-conviction-tossed-after-us-supreme-court-ruling-2023-02-03/
20. https://www.scientificamerican.com/article/doctors-prescribing-opioids-in-good-faith-should-not-be-prosecuted
21. https://wgme.com/news/local/she-changed-my-life-patients-surprised-after-maine-doctor-arrested-by-drug-strike-force
22. https://www.wmtw.com/article/harm-reduction-advocates-defend-maine-doctor-facing-opioid-distribution-charges/43128661#
23. https://www.wmur.com/article/new-hampshire-doctor-opioid-fentanyl-indictment/45159225

Background Information: Provided by AOA Staff

Current AOA Policy:

The resolved statement is covered by content in the following policies:

- H325-A/22 Interference – Lawful Off-Label Treatment of Patients: AOA supports the protection of a physician's ability to prescribe treatments and to speak freely about lawful, evidence-based, health care options, including off-label treatments or health care-related research, without fear of being sanctioned by regulatory boards, insurance companies or employers.

- H328-A/23 Healthcare Practice – Patient-Physician Relationship and: States that The AOA believes that it is the responsibility of the osteopathic physician to advocate for the rights of their patients, regardless of any contractual relationship and that the patient-physician relationship shall not be altered by any system of healthcare practice which may place economic considerations above the interest of patients.

- H617-A/23 Criminal Liability for Clinical Decisions
  "The American Osteopathic Association (AOA) opposes criminal liability for a physician whose clinical decisions were made without malice and in good faith."

- H308-A/21 Intractable and/or Chronic Pain (Not Associated with End of Life Care)
  "No physician shall be subject to criminal prosecution (by state or federal agencies) for appropriately prescribing or administering medically necessary controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

Some AOA efforts opposing interference and inappropriate sanctions at the federal level include opposing automatic formulary substitutions for certain pharmaceutical products, including generics, biosimilars, and other therapeutic alternatives. The AOA also commented in 2020 on changes to Medicaid drug utilization review program rules, expressing concern around the impact that changes related to opioid safety edits and retrospective claims review may have on unfairly targeting certain specialties.

Prior HOD action on similar or same topic: as noted above

FISCAL IMPACT: Unknown. In addition to the ongoing advocacy work of the AOA, this resolution asks that the AOA "publicly protects and assists its members when non-medical bodies inappropriately interfere with medical decision-making by osteopathic physicians." To become involved in individual matters, the AOA would need to thoroughly investigate and vet such matters, which would have significant financial cost associated with it.

ACTION TAKEN: _Referred to the Maine Osteopathic Association (MOA)_

DATE: ____July 20, 2024_____

SUBJECT: APPROVED RESOLUTIONS STATUS

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Ad Hoc Committee

WHEREAS, each year the delegates of the American Osteopathic Association (AOA) House of Delegates (HOD) adopt resolutions; and

WHEREAS, the AOA assigns adopted resolutions to the appropriate AOA staff and leadership; and

WHEREAS, the AOA provides a tracking system for adopted resolutions; and

WHEREAS, the AOA provides on the AOA Past Resolutions webpage the "Disposition of Resolution"; and

WHEREAS, state and specialty associations and AOA members continue to look to the AOA Past Resolutions webpage to ensure resolutions being submitted for consideration are not already adopted; and

WHEREAS, the only related resolution found is H366-A/18 - Resolution Retention which endorses that the AOA will maintain on file a copy of the complete resolution as approved by the AOA House of Delegates; and

WHEREAS, this current resolution is in addition to and furtherance of the prior adopted resolution H366-A/18 - Resolution Retention and provides a pathway to achieve the intended spirit of the prior resolution adding on the status (what has been done), to determine whether resolutions require sunsetting, amendment, or addition; and

~~WHEREAS, a suggested Implementation would be on the existing AOA Past Resolutions webpage, add two more columns titled "Interval Update" and "Annual Update" with bullet list of undertaken actions with option for narrative explanation when appropriate; and~~

WHEREAS, to make it simpler for future resolution writers to identify the progress of adopted resolutions; therefore, be it further

RESOLVED, that the AOA provides twice yearly status updates to the AOA Past Resolutions webpage on the implementation and actions pertaining thereto on adopted resolutions within ~~14~~ **30** days following the conclusion of the AOA Board of Trustees Midyear Meeting and within ~~14~~ **30** days following the conclusion of OMED.

31 **RESOLVED, A SUGGESTED IMPLEMENTATION WOULD BE ON THE**
32 **EXISTING AOA PAST RESOLUTIONS WEBPAGE, ADD TWO MORE**
33 **COLUMNS TITLED "INTERVAL UPDATE" AND "ANNUAL UPDATE"**
34 **WITH BULLET LIST OF UNDERTAKEN ACTIONS WITH OPTION FOR**
35 **NARRATIVE EXPLANATION WHEN APPROPRIATE**.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic:
Action item: H366-A/18 - Resolution Retention

Providing updates to the AOA Past Resolutions webpage within 14 days of the Board of Trustees Midyear meeting and OMED is a limited amount of time for staff to process the updates. Allowing for 30 days after each meeting provides staff adequate time to update the 'Disposition of Resolution' column for the resolutions.

FISCAL IMPACT: $0
Provided by OPSC: Unlikely fiscal impact as updates are within the scope of work for the AOA staff and leadership who are identified in the "Disposition of Resolution" column. This resolution clarifies a standardized pathway for updates.

Provided by Staff: While no hard dollar fiscal impact, the fiscal value of staff time would be increased by having staff provide updates an additional two times annually.

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 20, 2024_____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE - AMENDMENT TO POLICY H635-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA seeks to reiterate its firm position that payers should pay for both OMT and E/M services billed on the same date when medically necessary, and that payers should not broadly deny payment for services due to claims being appended with a modifier 25; and

WHEREAS, guidance in current AOA policy H635-A/20 American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance drafted in 2020 is now outdated in light of E/M guideline changes which took effect in 2021; and

WHEREAS, AOA is seeing more frequent action by payers to broadly deny claims appended with a modifier 25, and the AOA wants to express its strong opposition to these blanket denials, and have an up-to-date resource to use with payers on appropriate billing of OMT; and

WHEREAS, AOA wants to provide clear guidance to members on documentation best practices and establish a bright line for payers where it is inappropriate to deny claims for OMT and E/M services billed on the same date; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the below policy be **adopted to completely replace** the guidance currently in place under H635-A/20**.**

The American Osteopathic Association (AOA) supports the ability for physicians to bill for Osteopathic Manipulative Treatment (OMT) when performed as a separately identifiable procedure on the same date as an evaluation and management (E/M) service when the services are medically necessary and are supported with appropriate documentation according to the E/M Documentation Guidelines. The AOA will work with all payers to ensure that policies continue to support appropriate payment for OMT when billed with an E/M service. Additionally, the AOA will engage with private payers to ensure that their coverage policies are consistent with current medical practice, to address inappropriate claims denials, and to address blanket denials for services billed with a modifier 25.

The AOA approves the position paper below for OMT coverage and encourages all public and private payers to refer to AOA's policy when developing new policy or revising existing guidance for OMT coverage. The position paper is intended for use in educational efforts on proper documentation, billing, and payment for OMT; discusses best practices; and

acknowledges that documentation by physicians may vary based on individual needs and circumstances that should not serve as a basis for payment denials when services are medically necessary.

American Osteopathic Association (AOA) Position Paper on Osteopathic Manipulative Treatment

Osteopathic manipulative treatment (OMT) is an essential treatment tool used by physicians for a broad range of conditions, and particularly for treating somatic dysfunction. OMT should be appropriately paid for when it is medically necessary, and documentation of the service is accurate. This document provides guidance to physicians and payers on the following:

- The physicians qualified to provide OMT;
- When payment for OMT services is appropriate;
- Proper documentation and coding of OMT services, including when the service is billed on the same date as an evaluation and management (E/M) service; and
- Appropriate reporting of E/M services in conjunction with OMT.

Physicians are encouraged to use these guidelines to inform best practices for billing, coding, and documentation. Payers should also consider these guidelines in development of coverage policy and should not inappropriately limit payment for medically necessary OMT services.

Introduction to OMT

OMT is a distinct medical procedure used by physicians (DOs/MDs) to treat somatic dysfunction and other conditions. The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as the therapeutic application of manually guided forces by a physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. The AACOM glossary further elaborates on the definition, stating:

> Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: (1) the position of a body part as determined by palpation and referenced to its adjacent defined structure, (2) the directions in which motion is freer, and (3) the directions in which motion is restricted.[1]

Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions.

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[1] **The American Association of Colleges of Osteopathic Medicine (AACOM) EDUCATIONAL COUNCIL ON OSTEOPATHIC PRINCIPLES (ECOP) Glossary of Osteopathic Terminology, 3RD EDITION, 2017** ~~November 2011~~.

Osteopathic manipulative treatment can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial, and myofascial tissues (e.g. tight right shoulder muscles in a patient with gallbladder disease). Normalizing musculoskeletal activity (relaxing tense muscles, etc.) can normalize outflows through sympathetic or parasympathetic autonomic nervous systems to visceral systems, resulting in more normal visceral and organ system function. Somatic dysfunction is identified on the physical exam by one or more of the following elements: **T**issue texture changes, positional **A**symmetry, **R**ange of motion alterations, or changes in palpatory sensitivity, e.g., **T**enderness (TART).

Provider Types Qualified to Perform OMT

To perform OMT, a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine, or a medical doctor must have trained in a postgraduate osteopathic training program that encompasses osteopathic principles and practices, including hands-on demonstration and competency testing in OMT.

OMT Payment:

The decision to utilize OMT as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical to perform a history and physical examination on initial and subsequent encounters. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall care of the patient.

OMT is a paid service when somatic dysfunction is documented in the history and/or the physical examination. OMT is not paid when somatic dysfunction is absent from the patient's history or physical examination documentation. The method of OMT employed by the physician is determined by the patient's condition, age, and the effectiveness of previous methods of treatment. Because OMT is a procedure that is separate from the evaluation and management (E/M) service, both services should be payable when rendered on the same day assuming that somatic dysfunction is identified, documentation is appropriate, and that the E/M service is above and beyond the services covered in the OMT and is documented accordingly. Payers should not deny claims on the sole basis that the E/M service is billed with modifier 25 when a procedure was performed on the same date.

OMT Documentation

The medical record documentation must support the level of E/M service billed and include the somatic dysfunction that the physician observed in the body regions treated with OMT. If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the elements that constitute the E/M service and the OMT service. Following current E/M coding guidelines, the level of E/M service selected may be based on the total time spent on the E/M portion of the encounter or medical decision making (MDM). Documentation should be consistent with Current Procedural Terminology (CPT©)

guidelines to support level selection. The documentation should clearly identify the body regions affected and treated with OMT to support the procedure code(s) reported.

~~The selection of body region(s) to which OMT is applied should reflect the region(s) of documented somatic dysfunction. There may be instances when multiple regions are treated due to the occurrence of compensatory changes. When this occurs, the documentation should describe the compensatory changes and the rationale for treating these areas, especially if the patient has no complaints related to these areas. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at areas unrelated to the diagnosis~~. **THE BODY REGION(S) TO WHICH OMT IS APPLIED MUST BE REFLECTED WITHIN DOCUMENTATION OF SOMATIC DYSFUNCTION. THERE MAY BE INSTANCES WHEN MULTIPLE REGIONS ARE TREATED WHEN THE PATIENT HAS NO COMPLAINTS RELATED TO THESE AREAS. IF THERE IS INTERRELATIONSHIP SUCH AS A DISTANT MECHANICAL INFLUENCE OR THE OCCURRENCE OF COMPENSATORY CHANGES, IT IS BEST TO DESCRIBE THOSE WHEN POSSIBLE. TREATMENT SHOULD GENERALLY NOT BE DIRECTED TO AREAS OF DYSFUNCTION UNRELATED TO THE DIAGNOSIS, THAT HAVE NO INFLUENCING NATURE.** The type, frequency, and duration of OMT should be consistent with current standards of medical practice.

Factors that may affect frequency and duration of treatment are severity of illness, duration or chronicity of the patient's condition, and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician's treatment approach.

Overall, the American Osteopathic Association recommends that the E/M and OMT portions of the visit be distinctly documented and detail the regions treated, the techniques utilized, ~~and when appropriate, a description of how the patient tolerated the treatment~~. **A DESCRIPTION OF HOW THE PATIENT TOLERATED THE TREATMENT, AND OTHER DETAILS CONSISTENT WITH TYPICAL PROCEDURE DOCUMENTATION**

OMT Coding

In April 2010, the American Medical Association (AMA) Relative Value Update Committee (RUC) requested that the AOA survey the existing OMT codes to develop accurate and unbiased information for the relative value of the physician work involved in performing OMT as part of the Centers for Medicaid and Medicare Services (CMS) five-year review of the resource based relative value scale (RBRVS).

The survey process required the creation of vignettes to describe the typical patient for OMT CPT® Codes 98925-98929. Additionally, the description of the preservice, intraservice, and postservice work for OMT was included. As of January 2012, the vignettes for the typical patient and the preservice, intraservice and postservice descriptors are contained within the RUC database.

There are five OMT Service CPT© Codes (98925-98929), each corresponding to the number of body regions treated with OMT. Descriptors for each code are the following:

- 98925 *Osteopathic manipulative treatment (OMT); 1-2 body regions involved*

- 98926 *Osteopathic manipulative treatment (OMT); 3-4 body regions involved*
- 98927 *Osteopathic manipulative treatment (OMT); 5-6 body regions involved*
- 98928 *Osteopathic manipulative treatment (OMT); 7-8 body regions involved*
- 98929 *Osteopathic manipulative treatment (OMT); 9-10 body regions involved*

Vignettes and work descriptors for each OMT code can be found in Appendix C of this document. Note: The OMT service codes do not include any elements of the history, examination, and medical decision making.

Reporting E/M Services:

It is appropriate for an E/M service to be performed on initial visits where OMT may be performed, and on subsequent patient encounters if a new problem occurs or if original symptoms have changed. An appropriate significant, separately identifiable E/M service, documented according to the E/M guidelines, may be provided and reported so long as it is considered medically necessary and goes above and beyond the work associated with the OMT procedure itself. As patients may not present for the explicit purpose of undergoing an OMT procedure, the E/M service helps a physician determine if OMT needs to be provided and, if so, what body region(s) to treat and what technique(s) to employ.

A physician should select the appropriate E/M based on MDM or total time of the E/M portion of the encounter, and they should make sure to document a medically appropriate history and/or examination. According to CPT guidelines, four types of MDM are recognized, which include straightforward, low, moderate, and high. MDM “includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option” and is defined by three key elements:

- Number and complexity of the problem(s) addressed during the encounter;
- The amount and/or complexity of data to be reviewed or analyzed; and
- The risk of complications and/or morbidity or mortality of patient management.

Total time may be used alone to select the appropriate code level for E/M services. Time consists of the cumulative amount of face-to-face and non-face-to-face time **personally** spent by the physician in care of the patient on the date of the encounter. Total time can include the following activities when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
- care coordination (not separately reported)

Physicians should follow the most recent CPT guidance on E/M services whenever billing these services. Documentation for both the E/M and OMT service must be complete when the services are billed on the same day.[2]
If utilizing an electronic health record (EHR), ensure that it is capable of capturing all of the history, physical examination and medical decision making and any other service(s) provided on each patient visit.
Per CPT © guidance, Evaluation and Management services may be reported separately using Modifier- 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the OMT procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for reporting of the OMT and E/M service on the same date. Documentation of any changes to symptoms from original visit are vital to the medical necessity of the E/M service.

Documenting the Patient Visit: SOAP Note Example[3]:

Below is an example of a patient encounter and a subjective, objective, assessment, and plan (SOAP) note for each to illustrate how to document the patient's visit in the medical record. Other styles and preferences exist for medical record documentation. **Note: The E/M service should be a separately identifiable service above and beyond what is normally included in the osteopathic procedure note. If somatic dysfunction is identified in exam and OMT is recommended documentation should include a procedure note. The procedure note should be a separate note following the SOAP note**.

E/M visit level can be determined based on either medical decision making (MDM) or total time.

SOAP Note – Patient Example

S. A 20-year-old African American male complains of low back pain that began three days ago after he lifted a heavy object. Cannot straighten up when walking, pain with change of position. The patient denies radiation of pain and areas of numbness, the pain stays along the back and waist. He is comfortable when lying down, aspirin helps some, has used heat with some help. Has prior history of back pain as a child. Reviewed records provided. Symptoms resolved after undergoing physical therapy. Denies allergies, surgical history is unremarkable.

O. ~~Tenderness noted over lumbar and sacral regions. Inability to extend lumbar spine when standing. Flexion posture when standing. Muscle spasms noted in paraspinals of the lumbar region. Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing. Neurologic exam normal~~. **FLEXION POSTURE WHEN STANDING. INABILITY TO EXTEND LUMBAR SPINE ON ACTIVE AND PASSIVE RANGE OF MOTION. TENDERNESS NOTED OVER LUMBAR**

[2] American Medical Association. CPT Evaluation and Management (E/M) Code and Guideline Changes. Effective January 1, 2023. Available here.
[3] American Osteopathic Association. "Guide to Coding and Documentation: Osteopathic Manipulative Treatment, First Edition." 2017

AND SACRAL REGIONS. MUSCLE SPASMS NOTED OF BILATERAL PARASPINAL MUSCULATURE OF THE LUMBAR SPINE. L2 FRRSR. L/R BACKWARD SACRAL TORSION. NEUROLOGIC EXAM WITHIN NORMAL LIMITS. MUSCULOSKELETAL STRENGTH OF BILATERAL LOWER EXTREMITIES EQUAL AND WITHIN NORMAL LIMITS.

A. The patient is diagnosed with lumbosacral sprain/strain, likely due to lifting a heavy object. Patient has moderate pain intensity with associated activity limitations.

Lumbosacral sprain/strain S33.8XXA

Note: Based on feedback from insurers and physicians who have completed appeals processes, the AOA encourages inclusion of a narrative of considerations and judgements synthesizing their clinical findings into a clear understanding of the presenting condition and treatment strategies.

P. 1. OMT recommended for the somatic dysfunction of lumbar and sacral regions as noted
2. Continue aspirin
3. No lifting, bending, or twisting
4. Contact office if symptoms worsen

OMT Procedure Note- Patient Example

Patient decided to proceed with OMT recommended. Verbal consent obtained. Discussed risks, benefits, and potential treatment reaction with patient and patient acknowledged comprehension. Patient put in position and technique used to treat the sacral and lumbar spine regions — hypertonic paraspinal muscles and sacral spine- piriformis muscles S2-S4.

Patient tolerated procedure well. Improved Range of Motion noted along with a decreased severity of pain.

Patient instructed to drink fluids today following procedure. Discouraged bedrest and encouraged movement. Contact office if pain increases.

CODING FOR THIS CASE

Evaluation and Management: new patient/established patient 99203/99213 (with modifier 25) **ATTACHING S33.8XXA**
OMT two body regions: lumbar/sacral 98925 **ATTACHING ICD-10 CODE M99.03 AND M99.04**

Conclusion:

OMT is a procedure that is separate from the evaluation and management service, both services should be payable when rendered on the same day considering that somatic dysfunction is observed and both services are appropriately documented. Physicians should follow the above guidance to ensure that their documentation is appropriate. However, physicians have varying approaches to documentation, and payment should not be denied as long as the E/M service is a significant, separately identifiable service above

and beyond the usual preservice and postservice work associated with the OMT procedure. Payers should also consider the above guidelines in developing coverage policies to ensure they are not inappropriately denying medically necessary services.

Appendices

Appendix A: OMT Coding Information

CPT/HCPCS Codes

98925 Osteopathic Manipulative Treatment (OMT); 1-2 Body Regions Involved
98926 Osteopathic Manipulative Treatment (OMT); 3-4 Body Regions Involved
98927 Osteopathic Manipulative Treatment (OMT); 5-6 Body Regions Involved
98928 Osteopathic Manipulative Treatment (OMT); 7-8 Body Regions Involved
98929 Osteopathic Manipulative Treatment (OMT); 9-10 Body Regions Involved

ICD-10 Diagnosis Codes

ICD-10 Codes:

M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.06	Segmental and somatic dysfunction of lower extremity
M99.07	Segmental and somatic dysfunction of upper extremity
M99.08	Segmental and somatic dysfunction of rib cage
M99.09	Segmental and somatic dysfunction of abdomen and other regions

Appendix B: OMT Techniques are listed below (~~Please refer to~~ INCLUDING, BUT NOT LIMITED TO THOSE LISTED IN the AACOM Glossary of OMT Terminology ~~for more information)~~

Active method
Articulatory method
Articulatory treatment
Articulatory (ART)
Balanced ligamentous tension (BLT)
Chapman reflex
Combined method
Combined treatment
Compression of the fourth ventricle (CV-4)
Counterstrain (CS)
Cranial Treatment (CR)
CV-4
Dalrymple treatment
Direct method
Exaggeration method
Exaggeration technique
Facilitated oscillatory release technique (FOR)
Facilitated positional release (FPR) **FASCIAL DISTORTION MODEL (FDM)**
Fascial release treatment
Fascial unwinding
Functional method
Galbreath treatment
Hepatic pump
High velocity/low amplitude technique (HVLA)
Hoover technique
Indirect method (I/IND)
Inhibitory pressure technique
Integrated neuromusculoskeletal release
Jones technique
Ligamentous articular strain technique (LAS)
Liver pump
Lymphatic pump
Mandibular drainage technique
Mesenteric release technique
Muscle energy **(ME)**
Myofascial release (MFR) direct and indirect
Myofascial technique
Myotension
Osteopathic in the Cranial Field (OCF)
Passive method
Pedal pump
Percussion vibrator technique
Positional technique
Progressive inhibition of neuromuscular structure (PINS)
Range of motion technique
Soft tissue **(ST)** technique

392 Spencer technique
393 Splenic pump technique
394 Spontaneous release by positioning
395 Springing technique
396 Still technique
397 Strain-Counterstrain ® **(S/CS)**
398 Thoracic pump
399 Thrust technique (HVLA)
400 Toggle technique
401 Traction technique
402 V-spread
403 Ventral techniques
404
405
406 **Appendix C: OMT Vignettes and Coding for 98925-98929**
407
408 **OMT service code 98925:** Osteopathic manipulative treatment (OMT); one to two
409 body regions involved.
410
411 Vignette:
412 A 25-year-old female presents with right lower neck pain of two weeks duration.
413 Somatic dysfunction of cervical and thoracic regions is identified on examination.
414
415 Description of Preservice Work:
416 The physician determines which osteopathic techniques (e.g., HVLA, muscle
417 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
418 in what order the affected body regions need to be treated, and whether those body
419 regions should be treated with specific segmental or general technique approaches.
420 The physician explains the intended procedure to the patient, answers any
421 preliminary questions, and obtains verbal consent for the OMT. The patient is
422 placed in the appropriate position on the treatment table for the initial technique and
423 region(s) to be treated.
424
425 Description of Intraservice Work:
426 The patient is initially in the supine position on the treatment table. Motion
427 restrictions of C6 and C7 are isolated through palpation and treated using muscle
428 energy technique. Dysfunctions of T1 and T2 are treated using passive thrust
429 (HVLA) technique. Patient position is changed as necessary for treatment of the
430 individual somatic dysfunctions. Patient feedback and palpatory changes guide
431 further technique application as appropriate.
432
433 Description of Postservice Work:
434 Post-care instructions related to the procedure are given, including side effects,
435 treatment reactions, self-care, and follow-up. The procedure is documented in the
436 medical record.
437 **OMT Service code 98926:** Osteopathic manipulative treatment (OMT); 3-4 body
438 regions involved.

439
440 Vignette:
441 A 39-year-old female presents with right lower back pain of two weeks duration after
442 a lifting injury. Somatic dysfunction of lumbar, pelvis, and sacral regions are
443 identified on exam.
444
445 Description of Pre-Service Work:
446 The physician determines which osteopathic techniques (e.g., HVLA, Muscle
447 energy, Counterstrain, articulatory, etc.) would be most appropriate for this patient,
448 in what order the affected body regions need to be treated, and whether those body
449 regions should be treated with specific segmental or general technique approaches.
450 The physician explains the intended procedure to the patient, answers any
451 preliminary questions, and obtains verbal consent for the OMT. The patient is
452 placed in the appropriate position on the treatment table for the initial technique and
453 region(s) to be treated.
454
455 Description of Intra-Service Work:
456 The patient is initially in the prone position on the treatment table. Motion
457 restrictions of sacrum and pelvis are isolated through palpation and treated using
458 muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated
459 using passive thrust (HVLA) technique. Patient position is changed as necessary
460 for treatment of the individual somatic dysfunctions. Patient feedback and palpatory
461 changes guide further technique application as appropriate.
462
463 Description of Post-Service Work:
464 Post-care instructions related to the procedure are given, including side effects,
465 treatment reactions, self-care, and follow-up. The procedure is documented in the
466 medical record.
467
468 **OMT service code 98927:** Osteopathic manipulative treatment (OMT); five to six
469 body regions involved.
470
471 Vignette:
472 A 17-year-old male presents with pain in the neck, upper and lower back, right
473 shoulder, and right chest following an injury in a high school football game two days
474 prior. Somatic dysfunctions of the right glenohumeral and acromioclavicular joints,
475 as well as the lower cervical, upper thoracic, right upper costal, and lumbar areas
476 are identified on exam.
477
478 Description of Preservice Work:
479 The physician determines which osteopathic techniques (e.g., HVLA, muscle
480 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
481 in what order the affected body regions need to be treated, and whether those body
482 regions should be treated with specific segmental or general technique approaches.
483 The physician explains the intended procedure to the patient, answers any
484 preliminary questions, and obtains verbal consent for the OMT. The patient is

485 placed in the appropriate position on the treatment table for the initial technique and
486 region(s) to be treated.
487
488 Description of Intraservice Work:
489 The patient is initially in a side-lying position on the treatment table. Motion
490 restrictions of identified joints are isolated through palpation and treated using a
491 variety of techniques as follows: acromioclavicular joint is treated with articulatory
492 technique; glenohumeral and costal dysfunctions are treated with muscle energy
493 technique; cervical spine is treated with counterstrain technique; and thoracic and
494 lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient
495 position is changed as necessary for treatment of the individual somatic
496 dysfunctions. Patient feedback and palpatory changes guide further technique
497 application as appropriate.
498
499 Description of Postservice Work:
500 Post-care instructions related to the procedure are given, including side effects,
501 treatment reactions, self-care, and follow-up. The procedure is documented in the
502 medical record.
503
504 **OMT service code 98928:** Osteopathic manipulative treatment (OMT); seven to
505 eight body regions involved.
506
507 Vignette:
508 A 64-year-old female, in rehabilitation following a left total knee replacement,
509 presents with swelling in the left lower leg, pain in her low back, hips and pelvis with
510 muscle spasms and numbness and bilateral wrist pain with use of a walker. She
511 has a history of widespread degenerative joint disease with stiffness and pain
512 making it difficult for her to actively participate in her rehabilitation program. Somatic
513 dysfunctions of the lumbar, thoracic, and cervical spine, sacrum, pelvis, right leg,
514 and bilateral wrist joints are identified on exam.
515
516 Description of Preservice Work:
517 The physician determines which osteopathic techniques (e.g., HVLA, muscle
518 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
519 in what order the affected body regions need to be treated, and whether those body
520 regions should be treated with specific segmental or general technique approaches.
521 The physician explains the intended procedure to the patient, answers any
522 preliminary questions, and obtains verbal consent for the OMT. The patient is
523 placed in the appropriate position on the treatment table for the initial technique and
524 region(s) to be treated.
525
526 Description of Intraservice Work:
527 The patient is initially in the supine position on the treatment table. Motion
528 restrictions of identified joints are isolated through palpation and treated using a
529 variety of techniques as follows: radiocarpal joints are treated using articulatory and
530 myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated
531 using balanced ligamentous tension technique; dysfunction of C5 through T3, the

pelvis and lower extremity are treated with muscle energy technique. Lower extremity edema is treated with lymphatic drainage techniques. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT service code 98929: Osteopathic manipulative treatment (OMT); nine to ten body regions involved.

Vignette:
A 40-year-old male presents with sub-occipital headache, and pain in the neck, upper and lower back, left shoulder and chest, and right ankle. He was involved in a rear-end motor vehicle accident two weeks prior. X-rays in the emergency department (ED) were negative. He has been taking prescribed analgesic and muscle relaxant medications with minimal improvement. On examination, somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the cervical, thoracic, costal, lumbar, sacral, and pelvic regions.

Description of Preservice Work:
The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory, etc.) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intraservice Work:
The patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: occipitoatlantal joint and sacrum are treated using muscle energy and counterstrain techniques; right glenohumeral joint and pelvis are treated with articulatory technique; lumbar, thoracic, cervical, and right ankle are treated with passive thrust (HVLA) technique; costal dysfunctions are treated using muscle energy technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide selection of further technique application as appropriate.

Description of Postservice Work:

579 Post-care instructions related to the procedure are given, including side effects,
580 treatment reactions, self-care, and follow-up. The procedure is documented in the
581 medical record.
582
583 **Sources of Information**
584 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
585 Manipulation Treatment Second Edition (2024)
586 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
587 Manipulative Treatment 1st Edition (2017)
588 American Osteopathic Association (2014).
589 Position paper on Evaluation and Management services (E/M) with Osteopathic
590 Manipulative Treatment (OMT).
591 American Osteopathic Association (1998). Protocols for Osteopathic Manipulative
592 Treatment (OMT).
593 American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic
594 Glossary of OMT Terminology.
595 American Medical Association (AMA) Current Procedural Terminology (CPT©) 2015
596 Manual
597 American Medical Association (AMA) Relative Value Update Committee (RUC) Database

Source: H635-A/20

Background Information: Provided by AOA Staff
Current AOA Policy: H635-A/20 American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: Referred to the Bureau on Federal Health Programs (BFHP)

DATE: July 20, 2024

SUBJECT: PRIOR AUTHORIZATION REQUIREMENT FOR **PAYMENT** ~~REIMBURSEMENT~~ FOR OSTEOPATHIC MANIPULATIVE TREATMENT

SUBMITTED BY: American Academy of Osteopathy

REFERRED TO: AD HOC Committee

WHEREAS, osteopathic manipulative treatment (OMT) has been shown to result in significant symptom reduction when included in the management of many clinical conditions[1-41]; and

WHEREAS, the presence of somatic dysfunction found on physical examination is the clinical indication for OMT[42-44]; and

WHEREAS, the risk of significant adverse events after performing OMT is very low,[45-48] especially in comparison to commonly used analgesics[49-50]; and

WHEREAS, the American Osteopathic Association (AOA) has specifically published policy statements that include practice guidelines that support the use of OMT in clinical practice[51-53]; and

WHEREAS, nationally physicians are reporting an increase in insurance providers requiring prior authorization for office procedures.[55-56] The requirement for prior authorization **MAY** delay~~s~~ indicated procedures ~~and has been shown to influence clinical decision making, such that providers may choose alternative, potentially less effective or higher risk management options that do not require prior authorization.[55] Physicians using osteopathic manipulative treatment as part of patient management are reporting some insurers are requiring prior authorization for OMT. If OMT is delayed or not used due to the burden of prior authorization, then patients are likely to use common analgesics such as nonsteroidal anti-inflammatory drugs (NSAIDs). The incident of myocardial infarction associated with use of nonsteroidal anti-inflammatory drugs (NSAIDs) is estimated to be 1 in 2400, and the incidence of gastrointestinal bleed is 1 in 87.[49] Between 1997 and 2008, the estimated mortality from a gastrointestinal bleed associated with NSAID use was 20.9%.[50] The AOA has previously reviewed the literature and determined that the risk of significant adverse events associated with OMT to be very small.[53] Therefore, patients are at lower risk of significant adverse events by receiving OMT at the time of evaluation and management service, that if the OMT service is delayed and the patients manage their symptoms using common analgesics, such as NSAIDs.~~

WHEREAS, the requirement for prior authorization of OMT necessitates that patients return on a separate day to receive an OMT procedure and will result in an unnecessary delay in symptom reduction; and

WHEREAS, the AOA has specifically published a policy statement that supports performing OMT on the same day as the clinical evaluation and management service when the physical examination identifies somatic dysfunction that may be contributing to the patient's complaints[54]; and

WHEREAS, the AOA supports payment for both OMT and the evaluation and management services separately when both services are performed on the same day and supported by documentation[54]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) opposes a Prior Authorization requirement for Osteopathic Manipulative Treatment.

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Background Information: Provided by AOA Staff

Current AOA Policy:

H642-A/20 Prior Authorization
H619-A/23 Board Certification of Insurance Company Peer Reviewers
H620-A/23 Licensure of Insurance Company Employed Physicians

Resolution H633-A/24 OMT Coverage Determination Guidance - Amendment to Policy H635-A/20 will be discussed this year.

Prior HOD action on similar or same topic:

As noted above

FISCAL IMPACT: $

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 20, 2024_____

AMERICAN OSTEOPATHIC ASSOCIATION

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (700 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:
Joint Board/House Budget Review Committee (700 series)
This committee reviews the AOA Strategic Plan and Budget.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-700	Approval to Concur with the AOA FY 2025 Expenditures	Finance Committee	Joint Board House Budget Review Committee	Adopted

SUBJECT: Approval to Concur with the AOA FY 2025 Annual Budget

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board of Trustees "have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, with the annual budget for the fiscal year"; and

WHEREAS, the Joint Board/House Budget Review Committee will convene on July 19, 2024 to review and take action on the AOA FY 2025 Operating Budget, the AOA FY 2025 Capital Expenditures Budget and the AOA FY 2025 142 E. Ontario Building Budget reports as submitted; now therefore be it

RESOLVED, the American Osteopathic Association House of Delegates concur with the AOA FY 2025 Annual Budget as provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

ACTION TAKEN: _Adopted__ _____

DATE: ____July 21, 2024_____

American Osteopathic Association
FY 2025 142 E. Ontario Building Budget

	FY 2025 Budget
Income	
Base Rent	$ 2,624,316
Base Rent Abatement	(93,515)
Accrued Rental Income (GAAP)	(47,012)
Operating Exp Esc. - Est	203,575
RET Esc. - Estimate	80,557
Interest Income	6,150
Tenant Service Income	8,443
Total Income	**2,782,514**
Expenses	
Cleaning Expenses	278,249
Engineering Expenses	264,985
General Building	96,516
Contracted Services	321,937
Utilities	244,741
Administrative Expenses	720,444
Taxes	884,651
Non-Recoverable Expenses	363,865
Depreciation	964,067
Total Expenses	**4,139,455**
Net Operating Income Before Depreciation	**(392,874)**
Net Operating Income After Depreciation	**(1,356,941)**
Capital Expenditures	
Building Improvements	$955,448
Tenant Improvements	437,474
Leasing Commissions	170,100
Total Capital Expenditures	**$1,563,022**

American Osteopathic Association
FY 2025 Capital Expenditures Budget

		FY 2025 Budget
Information Technology		
SOMA Fonteva Implementation (See note)		-
New accounting systems		25,000
Project Management		-
New LMS		40,000
IT - Contingency		100,000
Subtotal - Information Technology	$	165,000
CBS Technology projects		
CMS - Cobalt development		150,000
Website refresh (See note)		50,000
OCC Enhanced Dashboard (See note)		26,000
Subtotal - CBS Projects	$	226,000
AOA Office - Floors, Furniture, Equipment		300,000
Subtotal - AOA Operations	$	691,000
142 E. Ontario		
Building Improvements	$	955,448
Tenant Improvements		437,475
Leasing Commissions		170,100
Subtotal - 142 East Ontario	$	1,563,023
Total Capital Request	$	2,254,023

Notes: Laptops, printers, IT licenses etc. are expensed per policy
Excess SOMA expenditures were funded by a grant from AOIA.
The website refresh and the OCC enhanced database were approved expenditures from reserves.

American Osteopathic Organization
FY2025 Operating Budget

		FY 2025 Budget
Operating Revenues		
Communications	$	72,000
Publications		250,917
Membership		14,038,750
Postdoctoral Education		6,000
CME		670,690
International Affairs		500
COCA		5,612,665
Research		1,024,400
Contributions		225,343
OMED		4,626,500
DO Day		170,000
CBS		8,435,349
Managed Services\Other		733,000
Strategic Partnerships and Health Initiatives		300,000
Total Operating Revenues	$	36,166,114
Operating Expenses		
Personnel Related Costs		
Salaries and Wages	$	16,588,930
Employee Benefits		3,712,459
Other Staff related costs		670,755
Total Personnel related costs		20,972,144
Travel and Meetings Expenses		
Speaker Travel		31,390
Travel and Meetings - Facilty costs		1,091,475
Committee Travel		3,229,687
Staff Travel		670,326
Convention Expenses		3,013,050
Subtotal Travel and Meeting Expenses		8,035,928
Technology Costs		
Computer hardware\software		188,000
Information Technology Expenses		813,456
Telephone Expenses		102,800
Database		17,933
Subtotal Technology Costs		1,122,189

Professional Services		
CBS Related Exam expenses		1,684,320
Consulting Expenses		698,725
Legal		178,000
Legal - COCA		300,000
Other		219,500
Subtotal Professional Fees		3,080,545
Other Expenses		
Credit Card Fees		725,519
Grants Expense		575,004
Occupancy Expenses		508,629
Corporate Insurance		503,000
Publication expenses		296,500
Printing		206,154
Office Supplies Total		32,000
Shipping\postage		31,775
Contract Services		16,600
Miscellaneous		55,000
Subtotal Other Expenses		2,950,181
Total Expenses	$	36,160,987
Net excess\(shortfall)	$	5,127

AMERICAN OSTEOPATHIC ASSOCIATION

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (ALL SERIES W/ACTION)
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

- Committee on Educational Affairs (200 series)
  This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.
- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.
- Committee on Public Affairs (400 series)
  This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.
- Committee on Constitution and Bylaws (500 series)
  This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.
- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.
- Joint Board/House Budget Review Committee (700 series)
  This committee reviews the AOA Strategic Plan and Budget.
- Committee on Resolutions
  This committee drafts the resolutions expressive of the sense of the HOD meeting.
- Credentials Committee
  This Committee receives and validates the credentials of the delegates and alternates, maintains a continuous roll call, determines the presence of a quorum, supervises voting and election procedures and makes recommendations on the eligibility of delegates and alternates to a seat in the House when a seat is contested.

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (200 SERIES) w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Develop and Implement Curriculum on the Care of People with Developmental Disabilities (SR-Source:H211-A/18)	BOE	Educational Affairs	Adopted
H-201	DO Degree Designation (SR–Source:H204-A/18)	BOE	Educational Affairs	Adopted as Amended
H-202	Osteopathic Manipulative Treatment (OMT) by Osteopathic Medical Students During Medical School Rotations, Promoting use of (SR-Source:H200-A/18)	BOE	Educational Affairs	Adopted as Amended
H-203	Osteopathic Postdoctoral Training in all Specialty Areas (SR–Source:H202-A/18)	BOE	Educational Affairs	Adopted as Amended
H-204	Peer-To-Peer Suicide Prevention Training Amongst Osteopathic Medical Schools (SR-Source:H212-A/18)	BOE	Educational Affairs	Adopted as Amended
H-205	Sex and Gender Based Medicine (SR-Source:H214-A/18)	BOE	Educational Affairs	Adopted as Amended
H-206	Sale of Health-Related Products and Devices (SR-Source:H209-A/18)	BOM	Educational Affairs	Adopted as Amended
H-207	Acupuncture (SR-Source:H207-A/18)	BORPH	Educational Affairs	Adopted
H-208	Osteopathic Continuous Certification-Affordability of (SR–Source:H210-A/18)	BOS	Educational Affairs	Adopted as Amended
H-209	Osteopathic Continuous Certification (SR-Source:H208-A/18)	CSHA	Educational Affairs	Adopted
H-210	Truth in Advertising – Physician Degrees (SR-Source:H206-A/18)	CSHA	Educational Affairs	Adopted as Amended
H-211	Exploring the Impact of Virtual Residency Interviews on Osteopathic Residency Match Rate	BEL	Educational Affairs	Adopted as Amended
H-212	Marketing AOA Board Certification	AOCOPM	Educational Affairs	Adopted as Amended
H-213	American Osteopathic Association Board Certification	IOMA	Educational Affairs	Not Adopted
H-214	Support for Inclusion of Osteopathic Residency Applicants in Surgical Training	OPSC/ ACOS	Educational Affairs	Adopted as Amended

SUBJECT: DEVELOP AND IMPLEMENT CURRICULUM ON THE CARE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES – SOURCE: H211-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) reaffirms the ideals set in the
7 Americans with Disabilities Act (ADA); and that the AOA encourages osteopathic
8 medical schools to develop and implement curricula on the care of people with
9 developmental disabilities.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ___July 22, 2023 _____

SUBJECT: DO DEGREE DESIGNATION – SOURCE:H204-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) enthusiastically embraces the heritage and philosophy of Dr. Andrew Taylor Still by reaffirming that DO be the recognized degree designation for all graduates of AOA Commission on Osteopathic College Accreditation (COCA) accredited colleges of osteopathic medicine ~~in the United States~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: **ENHANCING PRECEPTOR KNOWLEDGE OF** OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) ~~BY OSTEOPATHIC MEDICAL STUDENTS DURING MEDICAL SCHOOL ROTATIONS~~, PROMOTING USE OF – SOURCE: H200-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED

The American Osteopathic Association (AOA) ~~supports and~~ encourages osteopathic medical schools to provide hands-on osteopathic manipulative treatment (OMT) **TRAINING** and practice sessions to ~~physicians teaching osteopathic medical students in order to~~ **PRECEPTORS IN ORDER TO** increase their ~~understanding~~ **KNOWLEDGE OF** ~~about~~ osteopathic manipulative treatment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: OSTEOPATHIC POSTDOCTORAL TRAINING IN ALL SPECIALTY AREAS – SOURCE:H202-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association ~~urges the osteopathic profession to reaffirm itself as a complete~~ **REPRESENTING A COMPREHENSIVE** profession of medicine and surgery and ~~re~~affirms its commitment to quality osteopathic postdoctoral training **AND SUPPORTS THE DEVELOPMENT AND CONTINUATION OF OSTEOPATHICALLY RECOGNIZED PROGRAMS** in all specialty areas.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: PEER-TO-PEER SUICIDE PREVENTION TRAINING AMONGST OSTEOPATHIC MEDICAL SCHOOLS – SOURCE:H212-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

The American Osteopathic Association recommends that the American Association of Colleges of Osteopathic Medicine (AACOM) encourage osteopathic medical schools to implement peer-to-peer suicide prevention training for ~~incoming and~~ all osteopathic medical students.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: SEX AND GENDER BASED MEDICINE - SOURCE: H214-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports ~~the inclusion of the evolving~~
7 ~~understanding of sex and gender based medicine~~ **INCLUDING RELEVANT**
8 **PATHOPHYSIOLOGY AND EVIDENCE-BASED MEDICINE REGARDING SEX**
9 **AND GENDER BASED HEALTHCARE** in medical education programs and
10 curricula across the continuum.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: SALE OF HEALTH-RELATED PRODUCTS AND DEVICES – SOURCE:H209-A/18

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and now, therefore
3 be it

4 RESOLVED, that the Bureau of Membership recommends that the following policy
5 be REAFFIRMED.

6 The American Osteopathic Association believes that it is appropriate for physicians
7 to derive reasonable monetary gain from the sale of health-related products
8 or devices that are both supported by rigorous scientific testing or
9 authoritative scientific data ~~and, in the opinion of the physician, are~~ THE
10 SALE OF THESE PRODUCTS AND DEVICES TO PATIENTS MUST BE
11 DEEMED TO BE medically necessary or ~~will~~ **BE ABLE TO** provide a
12 significant health benefit provided that such action is permitted by the state
13 licensing board(s) of the state(s) in which the physician practices; and
14 inappropriate and unethical for physicians to use their physician/patient
15 relationship to attempt to involve any patient in a program for the patient to
16 distribute health related products or devices in which distribution results in a
17 profit for the physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: ACUPUNCTURE - SOURCE:H-207-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association recognizes that acupuncture may be a part
7 of the armamentarium of qualified and licensed physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1978; 1983 Reaffirmed; 1988 Reaffirmed as Amended, 1993; 1998 Reaffirmed, 2003; 2008 Reaffirmed; 2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 22, 2023 _____

SUBJECT: OSTEOPATHIC CONTINUOUS CERTIFICATION – AFFORDABILITY OF – SOURCE: H210-A/18

SUBMITTED BY: BUREAU OF OSTEOPATHIC SPECIALISTS

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Specialists (BOS) has reviewed the policy; and

WHEREAS, the cost structure of Osteopathic Continuous Certification (OCC) is relevant to AOA affiliate organizations and diplomates; and

WHEREAS, costs to participate in the OCC process are incurred by AOA diplomates; and

WHEREAS, the BOS believes that the policy is still relevant and valid but requires clarification; now, therefore be it

RESOLVED, that the BOS recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association will ~~undertake~~ **BE TRANSPARENT WITH ITS AFFILIATE ORGANIZATIONS AND DIPLOMATES RESPECTIVE TO** ~~every effort to make transparent~~ the cost structure of Osteopathic Continuous Certification (OCC) and, ~~wherever possible, to~~ **LIMIT** ~~make~~ the costs of OCC ~~affordable to its **DIPLOMATES** members and its affiliate organizations~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: OSTEOPATHIC CONTINUOUS CERTIFICATION – SOURCE:H208-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association encourages input from osteopathic
7 physicians on maintenance of licensure, maintenance of certification and
8 osteopathic continuous certification rules.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H627-A/19 Maintenance of Licensure
H210-A/16 Osteopathic Continuous Certification (OCC)
H618-A/18 Osteopathic Continuing Medical Education – AOA Accreditation of Sponsors Providing
H210-A/18 Osteopathic Continuous Certification – Affordability Of
H224-A/17 AOA Membership – Osteopathic CME Requirement Enforcement
H225-A/17 Changes to Osteopathic Continuous Certification – Impact on the Profession
H607-A/20 Physician Competency Retesting

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 22, 2023_____

SUBJECT: TRUTH IN ADVERTISING – PHYSICIAN DEGREES - SOURCE:H206-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 ~~It is the policy of the American Osteopathic Association (AOA) that osteopathic~~
7 ~~physicians should only use their DO degree earned from a college or institution that~~
8 ~~is accredited by the Commission on Osteopathic College Accreditation (COCA)~~
9 ~~when representing themselves as a physician.~~ The AOA will remain vigilant for any
10 false or erroneous information that may undermine the integrity of the profession or
11 osteopathic medicine in the US and will work with the Federation of State Medical
12 Boards (FSMB) and its constituent boards to inform them of attempts to
13 misrepresent the practice of osteopathic medicine in the US or to misrepresent the
14 education leading to the degree Doctor of Osteopathy or Doctor of Osteopathic
15 Medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1969; reaffirmed 1978; revised 1983, 1988; reaffirmed 1993; revised 1998; revised 2003; revised 2008; reaffirmed 2013)

Prior HOD action on similar or same topic:
H203-A/21 PHYSICIAN DESIGNATION, TRUTH IN ADVERTISING AND RESIDENCY/FELLOWSHIP TRAINING NON-PHYSICIAN POSTGRADUATE MEDICAL TRAINING
H220-A/22 PHYSICIAN DESIGNATION, TRUTH IN ADVERTISING AND RESIDENCY/FELLOWSHIP TRAINING NON-PHYSICIAN POST GRADUATE MEDICAL TRAINING 2022

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 22, 2023

SUBJECT: EXPLORING THE IMPACT OF VIRTUAL RESIDENCY INTERVIEWS ON OSTEOPATHIC RESIDENCY MATCH RATE

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

WHEREAS, the COVID-19 pandemic has made an indelible mark on the transition from osteopathic medical student to osteopathic resident including a transition to an overwhelming majority of virtual interviews[6]; and

WHEREAS, in the 2022 National Resident Matching Program (NRMP) Program Directors Survey, 63% of 1,176 responding programs anticipate continuing either part or all of the interview process in a virtual environment in the future[8]; and

WHEREAS, coming out of the pandemic upcoming osteopathic medical graduates receive conflicting information regarding best practices for their upcoming application cycle[2,4] ;and

WHEREAS, the NRMP as well as several specialty societies such as the Association of American Medical Colleges (AAMC), the Alliance for Academic Internal Medicine (AAIM), and Association of Program Directors in Surgery (APDS) recommend that programs conduct virtual interviews for all applicants in the 2022-2023 cycle[1,3,4,5]; however, the American Association of Colleges of Osteopathic Medicine (AACOM) strongly recommends programs give students the option to interview in person or virtually during the 2022-23 cycle[2]; and

WHEREAS, according to the 2022 NRMP program director survey, over 50% of responding programs (all specialties) reported disadvantages with the virtual interview in assessing applicant interest in and understanding of the program as well as a disadvantage in assessing the applicant's interpersonal skills and alignment with interview team[6]; and

WHEREAS, according to the 2022 NRMP program director survey, over 60% of responding programs (all specialties) reported advantages with the virtual interview in regard to reducing applicant related hosting cost, improved efficiency of interview process.[6]; and

WHEREAS, AACOM reports that to date, no formal studies have been done to ensure the bias of virtual interviewing is fully understood ~~and no evidence has provided any guidance for how to mitigate that harm[2]~~; now, therefore be it

32 RESOLVED, that The American Osteopathic Association ~~work with the National~~
33 ~~Resident Matching Program and American Association of Colleges of~~
34 ~~Osteopathic Medicine~~ **ENCOURAGES COLLABORATION AMONG**
35 **RELEVANT STAKEHOLDERS** to analyze the impact of the virtual residency
36 interview process on the osteopathic **RESIDENCY PLACEMENT** ~~match~~ rate.

References

1. APDS Task Force . (2022, June). *APDS Task Force General Surgery Application and interview consensus ...* 2022-2023 APDS Task Force Application Cycle Recommendations. Retrieved March 7, 2023, from https://students-residents.aamc.org/media/13466/download
2 .Cameron, C. (2022, May 13). *AACOM strongly recommends hybrid residency interviews for 2022-23 cycle*. Default. Retrieved March 7, 2023, from https://www.aacom.org/news-reports/press-releases/2022/05/13/aacom-strongly-recommends-hybrid-residency-interviews-for-2022-23-cycle
3. Luther, V. P., Wininger, D. A., Lai, C. J., Dao, A., Garcia, M. M., Harper, W., Chow, T. M., Correa, R., Gay, L. J., Fettig, L., Dalal, B., Vassallo, P., Barczi, S., & Sweet, M. (2022, July 8). *Emerging from the pandemic: AAIM recommendations for Internal Medicine Residency and fellowship interview standards*. The American Journal of Medicine. Retrieved March 7, 2023, from https://www.amjmed.com/article/S0002-9343(22)00502-2/fulltext
4. Murphy, B. (2022, August 10). *What to know about this year's physician residency-application cycle*. American Medical Association. Retrieved March 7, 2023, from https://www.ama-assn.org/medical-students/preparing-residency/what-know-about-year-s-physician-residency-application-cycle#:~:text=The%20Association%20of%20American%20Medical,primary%20driver%20of%20the%20format.
5. National Residency Match Program. (2022, May 16). *NRMP supports AAMC interview guidance for 2022-23 residency selection cycle*. NRMP. Retrieved March 7, 2023, from https://www.nrmp.org/about/news/2022/05/nrmp-supports-aamc-interview-guidance-for-2022-23-residency-selection-cycle/
6. National Resident Matching Program, Data Release and Research Committee: (2022, September). *Www.nrmp.org*. Results of the 2022 NRMP Program Director Survey. Retrieved March 7, 2023, from https://www.nrmp.org/wp-content/uploads/2022/09/PD-Survey-Report-2022_FINALrev.pdf

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: H-336 A/2016 is a resolution that was an action item.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: ~~MARKETING~~ **PROMOTION OF** AOA BOARD CERTIFICATION

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Osteopathic Association has deeming authority from the US Department of Education to certify physicians, and

WHEREAS, AOA board certified physicians have historically been supportive and involved members of the AOA and its divisional societies, and

WHEREAS, the AOA, and its state associations' and specialty colleges', collectively known as divisional societies, health and viability will be strengthened by having many early career physicians sit for AOA examinations, and

WHEREAS, graduates of ACGME programs must be informed of and provided reasons for pursuing AOA board certification, and

WHEREAS, the eighteen (18) AOA certifying boards depend upon item-writers who are overwhelmingly practicing physicians, and

WHEREAS, the AOA internally uses the tag line "*Practicing Physicians Certifying Practicing Physicians*", and

WHEREAS, Potential candidates must be provided with reasons for pursuing AOA Board Certification: distinctiveness, value, relevance of exam to practice, affordability, convenience and ease of maintenance. With ease of electronic communication and website branding, this resolution can be implemented with low costs and may help to expand our customer base and thus drive revenues to the certifying boards, specialty colleges, and the AOA, now therefore be it

RESOLVED, that the AOA ~~implement a branding campaign for its certifying boards to include incorporating the tag line "*Practicing Physicians Certifying Practicing Physicians*" on all AOA~~ **PROMOTE ITS** certifying boards' ~~webpages and letterhead~~ and, be it further

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) CERTIFYING BOARD SERVICES WORKGROUP PREPARE A REPORT FOR THE 2024 AOA HOUSE OF DELEGATES.

~~RESOLVED, that the American Osteopathic Association (AOA) develop and broadly distribute a one-page info sheet targeting GME sponsoring institutions,~~

~~program directors, postdoctoral trainees, and board-eligible physicians. This info sheet shall incorporate the tag line "*Practicing Physicians Certifying Practicing Physicians*" and discuss AOA certification in terms of relevance of exam to practice, affordability, value, convenience and ease of maintenance.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: H641 October 13, 2020 Marketing AOA Board Certification page 271 was brought before the HOD in 2022 and was not adopted.

FISCAL IMPACT: Up to $90,000 in additional expense
The additional expenses would consist of disposing of the current one-page information sheets and reprinting existing one-page information sheets for 27 primary specialties and 48 subspecialties, which would cost an estimated $10,000. Rebranding and updating each board's website could be from 150 to 400 hours at $200 per hour for content and design work by AOA staff. The range of additional expenses would be between $40,000 and $90,000.

ACTION TAKEN Adopted as Amended

DATE July 22, 2023

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION BOARD CERTIFICATION

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, beginning in 2000 the American Osteopathic Association (AOA) began
2 granting osteopathic board certification on a time limited basis; and

3 WHEREAS, physicians with time limited board certification are required to
4 periodically re-certify in order to maintain their AOA board certification; and

5 WHEREAS, since the implementation of the re-certification requirement there have
6 been multiple changes to the process; and

7 WHEREAS, the process of maintaining AOA board certification has become
8 increasingly complicated, time consuming, and costly; and

9 WHEREAS, there is little to no scientific evidence that board re-certification
10 improves the quality of patient care as compared to simple continuing
11 medical education licensure requirements; now, therefore be it

12 RESOLVED, the American Osteopathic Association (AOA) shall create a report
13 which demonstrates the effect, if any, of board re-certification on patient care.

Background Information: Provided by AOA Staff

Current AOA Policy:

H-211 A/2022 Equivalency Policy for Osteopathic Continuous Certification

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Estimated $500,000 - $700,000

For the AOA to conduct its own research and develop a report on the effect of osteopathic continuous certification on patient care, it would cost $500,000 over two years. The expenses would include an additional psychometrician, medical editor, purchasing data, and physician author stipends. If the work was outsourced and conducted by a consulting group, it would be an estimated $700,000. The ABMS Continuing Certification Reference Center (CCRC) contains references across multiple specialties relating to physician Board Certification. Publications regarding **Continuing Certification exams relations to quality and/or patient outcomes** are included on the ABMS CRCC.

ACTION TAKEN: ___Not Adopted____

DATE: ____July 22, 2023_____

SUBJECT: SUPPORT FOR INCLUSION OF OSTEOPATHIC ~~RESIDENCY~~ APPLICANTS ~~in~~ **INTO COMPETITIVE POSTGRADUATE** ~~SURGICAL~~ TRAINING

SUBMITTED BY: Osteopathic Physicians and Surgeons of California/American College of Osteopathic Surgeons

REFERRED TO: Committee on Educational Affairs

WHEREAS, osteopathic physicians (DOs) play a crucial role in providing comprehensive and distinctive healthcare to patients across the United States; and

WHEREAS, **ALL MEDICAL AND** surgical specialties form an integral part of healthcare delivery, encompassing various disciplines such as general surgery, orthopedic surgery, neurosurgery, and others; and

WHEREAS, there has been a concerning trend of a decreasing number of DOs matching to ~~surgical~~ **COMPETITIVE** specialties in recent years (1); and

WHEREAS, the shortage of DOs in ~~surgica~~l **COMPETITIVE** specialties has the potential to impact patient access to high-quality surgical care, particularly in underserved and rural communities; and

WHEREAS, it is essential to promote and support the inclusion of DOs in all medical specialties, including surgical disciplines; and

WHEREAS, addressing the factors contributing to the declining number of DOs matching to ~~surgical~~ **COMPETITIVE** specialties requires a collaborative effort from medical education institutions, professional organizations, and policymakers; and

WHEREAS, the American Osteopathic Association (AOA) already has the infrastructure for mentorship, advocacy, inclusion, and equality in place; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage its specialty colleges to enhance career counseling and mentorship programs for DO students interested in pursuing ~~surgical~~ **COMPETITIVE** specialties, **PARTICULARLY SURGICAL SPECIALTIES** providing students with the necessary guidance and support throughout their educational journey; and, be it further

RESOLVED, that the AOA and its ~~surgical~~ specialty colleges call upon all professional ~~surgical~~ organizations to actively engage with DOs, providing

opportunities for collaboration, research, professional development, and leadership; and, be it further

RESOLVED, that the AOA work closely with the Accreditation Council for Graduate Medical Education (ACGME) and other ~~appropriate~~ **RELEVANT** organizations to educate program directors of accredited ~~surgical specialty~~ programs to accept qualified osteopathic residency applicants.

References:
Brazdzionis J, Savla P, Oppenheim R, et al. (June 17, 2023) Comparison of Osteopathic (DO) and Allopathic (MD) Candidates Matching Into Selected Surgical Subspecialties. Cureus 15(6): e40566doi:10.7759/cureus.40566

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

AMERICAN OSTEOPATHIC ASSOCIATION

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

Committee on Professional Affairs (300 series)
This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Adolescents' Bill of Rights (SR-Source:H301-A/18)	BFHP	Professional Affairs	Adopted
H-301	Airline Medical Kits (SR–Source:H302-A/18)	BFHP	Professional Affairs	Referred to AOCOPM
H-302	Direct to Consumer Advertising in Drugs (SR–Source:H353-A/18)	BFHP	Professional Affairs	Adopted
H-303	Discrimination Against Osteopathic Physicians (SR–Source:H304-A/18)	BFHP	Professional Affairs	Adopted
H-304	Durable Medical Equipment Claims Processing (SR–Source:H303-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-305	Equality in the Military – Transgender (SR–Source:H354-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-306	Federal Student Loan Program (SR–Source:H355-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-307	Government Funding for COCA and LCME Accredited Medical Schools and Students Attending such Institutions (SR–Source:H310-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-308	Health Care that Works for all Americans (SR–Source:H313-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-309	Medicare Limiting Charge / RBRVS System (SR–Source:H325-A/18)	BFHP	Professional Affairs	Adopted
H-310	Medicare User Fees (SR–Source:H324-A/18)	BFHP	Professional Affairs	Adopted
H-311	Medicare (SR–Source:H322-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-312	Physicians In Health Professional Shortage Areas – Model Funding to Increase (SR–Source:H311-A/18)	BFHP	Professional Affairs	Adopted
H-313	Primary Care Physicians Programs in Health Professional Shortage Areas (HPSAS) – Funding to Increase (SR–Source:H307-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-314	Rural Healthcare Payment Equity (SR–Source:H334-A/18)	BFHP	Professional Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-315	Uninsured – Access Health Care (SR–Source:H338-A/18)	BFHP	Professional Affairs	Adopted
H-316	Terminology – Volunteer Osteopathic Medical Health Care Delivery (SR-Source:H349-A/18)	BFHP	Professional Affairs	Adopted
H-317	Osteopathic Medicine Definition (SR-Source:H300-A/18)	BOE	Professional Affairs	Adopted
H-318	Health Care Providers Right of Conscience (SR-Source:H314-A/18)	BOM	Professional Affairs	Adopted as Amended
H-319	Physician Health Assistance (SR-Source:H331-A/18)	BOM	Professional Affairs	Adopted
H-320	Social Media Guidelines – ~~IMPLEMENTATION~~ (SR-Source:H348-A/18)	BOM	Professional Affairs	Adopted as Amended
H-321	Alcohol and Tobacco – Advertising Ban on (SR-Source:H308-A/18)	BORPH	Professional Affairs	Adopted as Amended
H-322	Obesity – Health Plans Should Include Benefits for Treatment of (SR-Source:H327-A/18)	BORPH	Professional Affairs	Adopted as Amended
H-323	Osteopathic Manipulative Treatment (OMT) for Low Back Pain (Response to Res. No. H-334-A/2017) (SR-Source:H358-A/18)	BORPH	Professional Affairs	Adopted
H-324	Physician Fees and Charges (SR-Source:H330-A/18)	CERA	Professional Affairs	Adopted as Amended
H-325	Physician Payment for Electronic Advice, Counseling, and Treatment Plans (SR-Source:H343-A/18)	CERA	Professional Affairs	Adopted as Amended
H-326	Electronic Health Records – ~~Increasing~~ Drug **INTERACTION WARNINGS** (SR-Source:H350-A/18)	CERA	Professional Affairs	Adopted as Amended
H-327	Evaluation And Management Documentation Guidelines (SR-Source:H312-A/18)	CERA	Professional Affairs	Adopted
H-328	Healthcare Practice- Patient-Physician Relationship and (SR-Source:H319-A/18)	CERA	Professional Affairs	Adopted as Amended
H-329	Mandatory Assignment (SR-Source:H320-A/18)	CERA	Professional Affairs	Adopted
H-330	Medical Records- Policy/Guidelines for the Maintenance, Retention, and Release of (SR–Source:H321-A/18)	CERA	Professional Affairs	Adopted as Amended

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2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-331	Osteopathic Manipulative Treatment and Evaluation and Management on the Same Day of Service- Payment for (SR-Source:H328-A/18)	CERA	Professional Affairs	Adopted as Amended
H-332	Patient Confidentiality (SR-Source:H329-A/18)	CERA	Professional Affairs	Adopted
H-333	Pre-Filled Medical Necessity Form (SR-Source:H344-A/18)	CERA	Professional Affairs	Adopted
H-334	Referrals and Consults- Non-Physician Disclosures (SR-Source:H345-A/18)	CERA	Professional Affairs	Adopted
H-335	Tobacco Use (SR-Source:H335-A/18)	CERA	Professional Affairs	Adopted
H-336	Uniform Billing (SR-Source:H336-A/18)	CERA	Professional Affairs	Adopted
H-337	Expert Witness & Peer Review (SR-Source:H341-A/18)	BSGA	Professional Affairs	Adopted as Amended
H-338	Payors – Osteopathic Discrimination by (SR-Source:H318-A/18)	CSHA	Professional Affairs	Adopted
H-339	Special Licensing Pathways for Physicians – Opposition to (SR-Source:H363-A/18)	CSHA	Professional Affairs	Adopted as Amended
H-340	Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) (SR–Source:H347-A/18)	BSGA	Professional Affairs	Adopted as Amended
H-341	Timely Posting of Meeting Agendas/Materials and Approval of Meeting Minutes (SR-Source:H351-A/18)	CAGOS	Professional Affairs	Adopted
H-342	Sunset Resolutions (SR–Source:H364-A/18)	CAGOS	Professional Affairs	Adopted as Amended
H-343	Workplace Violence Against Healthcare Providers	MAOP	Professional Affairs	Adopted as Amended
H-344	Withdrawn		Professional Affairs	Withdrawn
H-345	AOA Support for the Fair Access in Residency (Fair) Act, H.R. 751	VOMA	Professional Affairs	Adopted as Amended
H-346	Reinstatement of Annual Board Certification Fee	BOT	Professional Affairs	Adopted as Amended

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2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-347	Advocate Congress to close the Title IV Loophole that has been used to enable funds to cover the cost of attendance at for profit Medical Schools that would otherwise be Ineligible	NYSOMS	Professional Affairs	Adopted as Amended

SUBJECT: ADOLESCENTS' BILL OF RIGHTS - SOURCE: H301-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association advocates that all medical facilities that
7 provide care for adolescents post an "Adolescents' Bill of Rights" which
8 clearly articulates state and local applicable laws of consent and
9 confidentiality regarding health care for adolescents who have not reached
10 the age of majority.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_ __

DATE: ___July 22, 2023_____

SUBJECT: AIRLINE MEDICAL KITS – SOURCE: H302-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the current Federal Aviation
7 Administration (FAA) Final Rules on Airline Emergency Equipment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Referred to AOCOPM_

DATE: ____July 22, 2023_____

SUBJECT: DIRECT TO CONSUMER ADVERTISING IN DRUGS – SOURCE: H353-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association opposes direct to consumer advertising of
7 prescription medicines and will work with legislative bodies and advocacy
8 organizations to make direct to consumer advertising of pharmaceuticals
9 illegal in the United States consistent with World Health Organization
10 recommendations.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2001; 2003 Reaffirmed as Amended, 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: DISCRIMINATION AGAINST OSTEOPATHIC PHYSICIANS – SOURCE: H304-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will continue to ensure that
7 legislation and regulatory policy specifies that any reference at the national
8 level in an executive order, an administrative regulation, or in the federal
9 revised statutes to “medical doctor”, “MD”, “physician”, “allopathic physician”,
10 an allopathic medical specialty board, or reference to any medical student, or
11 postgraduate, shall include and pertain to a “doctor of osteopathic medicine”,
12 “DO”, AOA specialty board, and osteopathic medical students and
13 postgraduates.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: DURABLE MEDICAL EQUIPMENT CLAIMS PROCESSING – SOURCE: H303-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association remains committed to ~~providing~~ cost
7 effective healthcare and supports a reexamination of federal policy regarding
8 the timely processing of claims for durable medical equipment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended, 2003; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: EQUALITY IN THE MILITARY – ~~TRANSGENDER~~ – SOURCE: H354-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA), as the main representative of the
7 osteopathic profession, support that all uniformed service personnel, which
8 includes military physicians, DO or MD, who are physically and operationally
9 qualified are to be recognized as members of the military in the United States
10 without regard to race, color, creed, national origin, medical degree, gender,
11 gender identity or sexual preference; and that the AOA oppose any attempt,
12 either by legislation, directive or hierarchal order, that seeks to infringe upon
13 this status.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: FEDERAL STUDENT LOAN PROGRAM – SOURCE: H355-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recommends that the Federal
7 Student Loan Program reduce interest rates **TO THE LOWEST POSSIBLE**; the
8 AOA recommend**S** that the Federal Student Loan Program defer any interest to the
9 loan until training is completed and that all student **LOAN** interest be tax deductible
10 regardless of income. **AOA SUPPORTS AFFILIATE EFFORTS TO ENSURE**
11 **THAT FORGIVEN STUDENT LOAN AMOUNTS ARE NOT COUNTED AS**
12 **TAXABLE INCOME**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: GOVERNMENT FUNDING FOR COCA AND LCME ACCREDITED MEDICAL SCHOOLS AND STUDENTS ATTENDING SUCH INSTITUTIONS – SOURCE: H310-A/18

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association will advocate for policies that promote and prioritize access for ~~u~~**U**nited ~~s~~**S**tates citizens and permanent residents who attend Commission on Osteopathic College Accreditation (COCA) and Liaison Committee on Medical Education (LCME) certified medical schools to post-graduate training programs at U.S.-based institutions, by advocating for policies that restrict access to student loans for students attending non-COCA and non-LCME certified medical schools; oppose agreements between U.S. hospitals and other health care entities that receive local, state and federal funds that discriminate against or restrict training opportunities for students of COCA and LCME accredited colleges of medicine; limit agreements between non-COCA and non-LCME certified medical schools and U.S. institutions that receive local, state or federal funding in which there is training of non-COCA or non-LCME certified medical schools for longer than 12 weeks in order to promote equal access for U.S. citizens and permanent residents; promote a structure that ensures that federal or state funding provided to U.S. institutions for the training of medical students be proportional to the percentage of ~~AOA~~ **COCA** and LCME medical school students That it trains; prohibit the use of local, state and federal funds for non-U.S. citizens that attend non-COCA or non-LCME certified medical schools; and distribute local, state, and federal funding for U.S. citizens and permanent residents that attend non-COCA or non-LCME certified medical schools proportionally to U.S. citizens and permanent residents who attend COCA or LCME certified medical schools.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: HEALTH CARE THAT WORKS FOR ALL AMERICANS – SOURCE: H313-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association ~~has a priority goal to~~ encourage**S** the U.S. Congress ~~for~~ **TO PASS** ~~passage of~~ **LEGISLATION** ~~to further the national health care debate;~~ **THAT** ~~this public debate~~ address**ES** the major issues that threaten the ability of osteopathic physicians to provide **HIGH** quality, cost-efficient health care to their communities, including the availability of affordable health insurance for all citizens~~,~~**; AND SUPPORTS THE** ~~inclusion of~~ **PAYMENT TO** osteopathic physicians, **AND** training institutions, ~~and~~ **INCLUDING** osteopathic manipulative services on payor reimbursement**.**~~, and the fundamental question of Professional Liability Tort Reform; and that follow up activity assures that Congress enacts the appropriate legislation that assures the accomplishments of the above-listed goals.~~

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: MEDICARE LIMITING CHARGE / RBRVS SYSTEM – SOURCE: H325-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association opposes Medicare's limiting charge ceiling.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1989; 1993 Reaffirmed as Amended, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: MEDICARE USER FEES – SOURCE: H324-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association opposes any legislation that would establish
7 Medicare user fees.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: MEDICARE – SOURCE: H322-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association declares its continued support of the
7 Medicare program, the continued availability of **HIGH** quality medical care at
8 a reasonable cost and comprehensive Medicare reform to ensure that
9 Medicare beneficiaries receive **MEDICALLY** necessary services.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1966; 1978 Reaffirmed; 1983 Reaffirmed as Amended, 1988, 1993, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: PHYSICIANS IN HEALTH PROFESSIONAL SHORTAGE AREAS – MODEL FUNDING TO INCREASE – SOURCE: H311-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages state and federal U.S. medical
7 student funding agencies to provide loans to U.S. citizens and permanent
8 residents who commit to practice in federally designated Health Professional
9 Shortage Areas (HPSAs) and encourages state and federal U.S. medical
10 student funding agencies to provide medical school loan forgiveness for U.S.
11 citizens and permanent residents for each year they practice in a federally
12 designated HPSA.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: PRIMARY CARE PHYSICIANS PROGRAMS IN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAS) – FUNDING TO INCREASE – SOURCE: H307-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages state and federal
7 agencies to provide funds to U.S. osteopathic and allopathic medical schools
8 to develop and maintain informational curricula programs, and mentor U.S.
9 citizens and permanent residents from federally designated Health
10 Professional Shortage Areas (HPSAs), from high school through the first
11 year in primary care practice which encourages long-term primary care
12 medical practice in HPSAs; further, the AOA encourages state and federal
13 agencies to provide loan forgiveness for graduates of osteopathic and
14 allopathic medical schools for the loans related to their medical school
15 education for each year they deliver the informational curriculum and
16 mentoring services to ~~us~~ **U.S**. citizens and permanent residents from
17 Federally designed HPSAs from high school through the first year in primary
18 care practice, which encourages long-term primary care practice in federal
19 designated HPSAs.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: RURAL HEALTHCARE PAYMENT EQUITY – SOURCE: H334-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association endorses equity in reimbursement for rural
7 physicians as part of the strategy to increase the availability of quality
8 healthcare in rural areas.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1988; 1993 Reaffirmed as Amended; 1998 Reaffirmed, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: UNINSURED – ACCESS HEALTH CARE – SOURCE: H338-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports federal and state efforts to
7 increase access to affordable health care coverage through initiatives that
8 expand coverage to the uninsured through the efficient use of both private
9 and public resources and supports efforts to reform programs such as
10 Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) to
11 provide coverage to populations that would otherwise lack health care
12 coverage and ultimately, access to needed health care services.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: Terminology – Volunteer Osteopathic Medical Health Care Delivery - SOURCE: H349-A/18

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of International Osteopathic Medicine has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau of International Osteopathic Medicine recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) recommends that the osteopathic medical profession use the following terms to more clearly describe their specific activities when delivering volunteer and/or elective medical care domestically or globally (2013):

- "Osteopathic Medical Outreach," "Osteopathic Global Health" or "Global Health Outreach" – secular-based volunteer work programs outside the everyday practice of an osteopathic physician or physician-in-training, generally carried out in underserved areas, either domestic or global.

- "Osteopathic Medical Mission" or "Medical Mission" – health care activities with specifically religious connotations, affiliations or work.

- "Humanitarian Relief" or "Osteopathic Medical Response" – efforts or programs providing health care assistance and humanitarian aid in emergency situations or disaster relief.

- "Osteopathic Medical Exchanges" or "Osteopathic Medical Rotations/Clerkships" – formal institutional partnerships with international entities (e.g., ministries of health, medical institutions, organizations, etc.) that may include sending or receiving osteopathic physicians, physicians-in-training or other health care trainees for education or outreach programs, to include elective or non-elective osteopathic medical school or residency rotations/clerkships.

Background Information: Provided by AOA Staff
Current AOA Policy: As note above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: OSTEOPATHIC MEDICINE DEFINITION – SOURCE:H300-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association holds as policy the definition of osteopathic
7 medicine as a complete system of medical care with a philosophy that combines the
8 needs of the patient with the current practice of medicine, surgery and obstetrics;
9 that emphasizes the concept of body unity, the interrelationship between structure
10 and function; and that has an appreciation of the body's ability to heal itself.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1991; 1992 Reaffirmed as Amended, 1997, 1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: HEALTH CARE PROVIDERS RIGHT OF CONSCIENCE - SOURCE: H314-A/18

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Membership has reviewed the policy; and

WHEREAS, the Bureau of Membership recommends replacing “him or her” with “them” to be gender inclusive; now, therefore be it

RESOLVED, that the Bureau of Membership recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association policy 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~~ **THEM** from providing a medically-approved service, they should recuse themselves from that aspect of care and/**or** refer the patient to another ~~provider~~ **PHYSICIAN OR LOCATION**.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
Resolution H346-A/17 PHYSICIAN ASSISTED DEATH was approved as an action.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: PHYSICIAN HEALTH ASSISTANCE - SOURCE:H331-A/18

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and

3 WHEREAS, the Bureau of Membership recommends this policy be sunset because
4 the issue brough forth was previously introduced by the Committee on
5 Professional Affairs and the Bureau of Membership has no such programing
6 or finances to assist with the rehabilitation of osteopathic physicians; now,
7 therefore be it

8 RESOLVED, that the Bureau of Membership recommends that the following policy
9 be SUNSET.

10 The American Osteopathic Association supports continued assistance in the
11 rehabilitation of the impaired osteopathic physicians through its Bureau of
12 Membership

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1973; 1978 Reaffirmed; 1983 Revised; 1988; 1993; 1998; 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: SOCIAL MEDIA GUIDELINES ~~– IMPLEMENTATION~~
- SOURCE: H348-A/18

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Membership has reviewed the policy; and

3 WHEREAS, the Bureau of Membership recommends removing "Implementation of"
4 from the title

5 RESOLVED, that the Bureau of Membership recommends that the following policy
6 be REAFFIRMED AS AMENDED.

7 The American Osteopathic Association supports the use of appropriate social media
8 by osteopathic physicians as a method to promote our profession and
9 practices.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: ALCOHOL AND TOBACCO **PRODUCTS**– ADVERTISING BAN ON - SOURCE: H-308-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association ~~endorses~~ **SUPPORTS** a ban on all
9 advertising of tobacco **PRODUCTS** and alcohol.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1988; 1993 Reaffirmed as Amended; 1998 Reaffirmed; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H613-A/18 Tobacco Use in Entertainment Media

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: OBESITY – HEALTH PLANS SHOULD INCLUDE BENEFITS FOR TREATMENT OF - SOURCE: H-327-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the inclusion of medical, surgical
7 ~~and~~ **BEHAVORIAL HEALTH** nutritional counseling and physical conditioning as a
8 paid benefit for members of all health plans for the prevention and treatment of
9 obesity.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H408-A/22 Prevention and Treatment of Obesity
H417-A/21 Obesity in Children
H429-A/21 Obesity Epidemic – Addressing the American
H433 - A/20 Childhood Obesity - Worsening Epidemic in the American Society
H-419- A/18 Pediatric Obesity

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) FOR LOW BACK PAIN (RESPONSE TO RES. NO. H-334 - A/2017) - SOURCE: H-358-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be SUNSET.

Explanatory Statement:
H-358-A/18 is a summary of the current AOA Low Back Pain Clinical Practice Guidelines, H325 - A/20 Low Back Pain Clinical Practice Guidelines, Revision of. The AOA published the original clinical practice guidelines approved by the HOD in the JAOA in 2010 under the title American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain. The revision of the guidelines was approved by the HOD in 2015 and published in the JAOA in 2016. The HOD reaffirmed the guidelines in 2020.

H325 - A/20, the current approved version of the guidelines, will be included in the sunset review process 2025. The guidelines will be reviewed and updated for submission to the HOD in 2025. Because the guidelines are reviewed and updated every 5 years, there is no need for a summary of the guidelines to continue as a separate policy of the AOA. The complete guidelines can be accessed on the AOA policy search website (https://osteopathic.org/about/leadership/aoa-policy-statements/) or at this link: Policy_H325-A-20_Low_Back_Pain_Clinical_Practice_Guidelines,_Revisions_of-2.pdf (osteopathic.org)

H358-A/18 Osteopathic Manipulative Treatment (OMT) for Low Back Pain (Response to RES. NO. H-334 - A/2017)
Policy Statement

The American Osteopathic Association supports the attached white paper entitled "Osteopathic Manipulative Treatment (OMT) for Low Back Pain."

Osteopathic Manipulative Treatment (OMT) for Low Back Pain

Background

The American Osteopathic Association first published clinical practice guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain in 2010.[1] The revision of the guidelines was approved by the AOA House of Delegates in 2015 and published in the JAOA in 2016.

The summary of the guidelines states:

The American Osteopathic Association recommends that osteopathic physicians use Osteopathic Manipulative Treatment (OMT) in the care of patients with low back pain. These guidelines update the AOA guidelines for osteopathic physicians to utilize OMT for patients with nonspecific acute or chronic LBP. Evidence from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a) supports this recommendation.[2]

Both versions of the guidelines were accepted for inclusion in the National Guideline Clearinghouse (NGC). NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. (https://www.guideline.gov/). The NGC mission is to provide physicians and other health care professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use. (NOTE FROM STAFF 3/2023: THE NGC NO LONGER EXISTS.)

The current guidelines are based on a systematic review of the literature on OMT for patients with low back pain and a meta-analysis of all randomized controlled trials of OMT for patients with low back pain in ambulatory settings by Franke et al.[3] Additionally, they build upon the 2010 AOA Clinical Practice Guidelines for Low Back Pain1 and the 2005 systematic review by Licciardone et al.[4] on which the previous guidelines were based. Franke et al.'s conclusions further strengthen the findings that OMT reduces LBP. Franke et al. specifically state that clinically relevant effects of OMT were found for reducing pain and improving functional status in patients with acute and chronic nonspecific LBP and for LBP in pregnant and postpartum women at 3 months post treatment. [3]

Evidence review for the 2015 Guidelines

In August 2014, a member of the AOA Low Back Pain Task Force conducted a literature search using keywords including back pain, low back pain, Osteopathic Manipulative Treatment (OMT), osteopathic, manual therapy and randomized controlled trials (RCT) in PubMed, CINAHL, Science Direct, and Springer Link databases from 2003-2014. During this search, the systematic review by Franke et al. published in August 2014 was discovered and a determination was made to base the revised guidelines on this publication. At the same time, personal communications yielded two additional articles by Hensel[5] and Licciardone[6] published after the literature review by Franke et al. No other studies were identified.

Two members of the AOA Low Back Pain Task Force reviewed the research design of these studies according to the methods used in the Franke et al. systematic review and determined that both articles met the rigorous criteria applied by the Franke et al researchers. As stated in the Franke et al. publication: "Only randomized clinical trials were included; specific back pain or single treatment techniques studies were excluded. Outcomes were pain and functional status. GRADE was used to assess quality of evidence." Franke et al. also concluded that "larger, high-quality randomized controlled trials with robust comparison groups are recommended."

Both Hensel's and Licciardone's studies were larger than any previous studies and were high quality RCTs with robust comparison groups. The Task Force concluded that these studies were of high quality and low bias in the sense that they incorporated randomization, blinding, baseline comparability between groups, and addressed patient compliance and attrition. The Task Force agreed that these two articles would have met the inclusion criteria of the Franke et al. team and would have been included in the Franke et al. systematic review had they been published earlier. The Task Force believes that the conclusions of the studies support the guidelines and are not contradictory to them. Therefore, they were included in the AOA guidelines.

Results

As stated in the 2016 AOA Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain[2], OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP.

OMT versus other interventions for acute and chronic nonspecific low back pain:
Franke et al.[3] found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95% CI: -0.58 to - 0.14).

OMT versus other interventions for chronic nonspecific low back pain:
More specifically, in chronic nonspecific LBP, the evidence from Franke et al[3] suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95% CI:-25.18 to -4.68) and functional status (SMD:-0.32, CI:-0.58 to -0.07).

OMT versus untreated for nonspecific low back pain in postpartum women:
For nonspecific LBP postpartum, Franke et al.[3] found that moderate-quality evidence suggested a significant difference in favor of OMT for pain (MD: -41.85; 95% CI: -49.43 to -34.27) and functional status (SMD: -1.78; 95% CI: -2.21 to -1.35).

OMT versus usual obstetric care, sham ultrasound, and untreated for nonspecific low back pain in pregnant women:
When examining nonspecific LBP in pregnancy, Franke et al.[3] found low-quality evidence that suggested a significant difference in favor of OMT for pain (MD: -23.01; 95% CI: -44.13 to -1.88) and functional status (SMD:-0.80; 95% CI: - 1.36 to -0.23).

127 Two other important studies published subsequent to the Franke et al. systematic review
128 address LBP in pregnant women and enhance the findings of Frank et al. Hensel et al.[5]
129 found that OMT was effective for mitigating pain and functional deterioration compared
130 with usual care only; however, OMT did not differ significantly from placebo ultrasound
131 treatment. In yet another study conducted by Licciardone et al.[6], the investigators found
132 that during the third trimester of pregnancy OMT has medium to large treatment effects in
133 preventing progressive back-specific dysfunction.
134
135 **Next Steps**
136 Since the systematic review for the current guidelines was completed, additional studies
137 supporting the use of OMT for low back pain have been published.[7-11] Licciardone et al.
138 found that an OMT regimen for chronic low back pain showed significant and relevant
139 measures for recovery[7], and that subgroup analysis by baseline levels of chronic low back
140 pain is a simple strategy to identify patients who have substantial improvement with OMT.[8]
141 Hensel et al. evaluated the safety of an OMT protocol[9] during the third trimester of
142 pregnancy and determined that the protocol is safe with regard to labor and delivery
143 outcomes.[10] In a systematic review and meta-analysis, Franke et al. looked at the
144 effectiveness of OMT for low back pain in pregnant or postpartum women and found that
145 OMT produces clinically relevant benefits for this population.[11]
146
147 The current guidelines were approved by the AOA House of Delegates in 2015 and thus
148 will sunset in 2020. Therefore, the AOA will need to revise the guidelines for submission to
149 the 2020 HOD. The National Guideline Clearinghouse also requires a revision every five
150 years for posting to their website. (Please note that as of this writing, funding to support the
151 NGC has not yet been secured beyond July 16, 2018; NGC has established a cut-off date
152 of March 5, 2018 for guideline submissions. The future of the NGC is still unclear.)
153 Revision of the guidelines will require a new systematic review and meta-analysis of the
154 literature. Staff anticipates beginning the revision process for the guidelines in the spring
155 of 2019. (NOTE FROM STAFF 3/2023: THE NGC NO LONGER EXISTS.)
156

References

1. Clinical Guideline Subcommittee on Low Back Pain. (2010). American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain. The Journal of the American Osteopathic Association, 110(11), 653-666.
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Background Information: Provided by AOA Staff
Current AOA Policy: As note above (2018)

Prior HOD action on similar or same topic:
H325 - A/20 Low Back Pain Clinical Practice Guidelines, Revision of

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: PHYSICIAN FEES AND CHARGES - SOURCE: H330-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; now. therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association upholds the following policy on Physician Fees and Charges.

PHYSICIAN FEES AND CHARGES

1. Physician's Fees

A physician's fees should be based on the medical services provided to the patient, with due respect for:

a. The difficulty and/or uniqueness of the services;
b. The time, skill, and experience required;
c. Customary fees charged for the same service in the same community;
d. Overhead and professional liability costs.

2. Excessive Fees

A physician should not collect excessive fees.

3. Reduced Fees

Physicians have the right to offer ~~his/her~~**THEIR** services at a reduced fee, or without fee, when hardships exist or professional courtesy dictates, if ~~he/she~~ **THEY** desire~~s~~ to do so.

4. Specialty Designation

A fee should not be dependent upon a physician's specialty designation but upon the services provided. Any physician who provides a service for which ~~he/she~~ **THEY** ~~is~~ **ARE** properly trained has the right to charge the prevailing rate for such service, whether the service is performed by a family physician, a surgeon, an internist, or any other specialist.

5. Contingency Fees

A physician's fees should be based directly on professional services rendered and not contingent on uncertain outcome. It is, therefore, deemed unethical for a physician to charge contingency fees.

6. Division of Fees

Group practices and partnerships may ethically divide income based on service, contribution to the group, and/or contractual obligations.

7. Fee Splitting

No physician may ethically split a fee to, or accept a fee from, another physician solely for the referral of a patient nor shall a physician accept payments from a hospital, clinic, laboratory, or other healthcare facility based upon patient referrals to that establishment. Surgeons may ethically engage other physicians to assist in the performance of a surgical procedure; however, the financial arrangements should be made known to the patient. This principle applies whether or not the assisting physician is the referring physician.

8. Referrals to Suppliers

Physicians shall not accept payment of any kind from any source such as a hospital, clinic, laboratory, pharmaceutical company, device manufacturer, pharmacist or other healthcare provider or supplier, for referring patients to said facility or prescribing such entity's products. All referrals and prescriptions must be based on the patient's needs and sound medical decision-making, all in the patient's best interest.

9. Form Completion Charges

A physician may charge for completion of forms.

10. Copying Charges

A physician may charge the prevailing rate for the copying of patient records and postage incurred in mailing.

11. Missed Appointments

A physician may ethically charge for missed appointments, or appointments cancelled less than 24 hours in advance, provided:

a. The patient has been previously notified in writing of the policy;
b. Utmost consideration is given to the patient, including the circumstances involved;
c. The practice is resorted to infrequently;
d. The physician's patient load is considered.

12. Delinquent Accounts

Harsh or grossly commercialized collection practices are discouraged. If a physician has experienced problems dealing with patients who have delinquent accounts, ~~he/she~~ **THEY** may properly request payment for service at the time of treatment, or may add interest or other late-payment charges in accordance with state and federal laws. The patient must be notified of such a policy in advance by one or more of the following:

a. Posting a notice in the waiting room;
b. Distribution of patient handbooks containing the policy;
c. Notification by special letter;
d. Notation of the policy on the billing statement before the charge is incurred.

The American Osteopathic Association encourages physicians to make exceptions to implementing these collection charges in cases of financial hardship, after consultation with the involved patient.

The exception to waiving collection charges is the patient who receives payment for medical services from ~~his/her~~ **THEIR** insurance company, and then fails to make payment to the physician. In this case, all legal pressure may be brought to bear on the patient and the insurance company in order to discourage this practice, both by the insurance company and by the patient.

13. **SUBSCRIPTION BASED PAYMENT**

A PHYSICIAN MAY CHOOSE TO CHARGE A REPEATING FEE (MONTHLY, YEARLY, OR OTHERS), FOR PROVISION OF CARE. IF A PHYSICIAN CHOOSES THIS MODEL OF PAYMENT, THERE SHOULD BE CLEAR EXPECTATIONS ABOUT WHAT CARE AND SERVICES WOULD BE COVERED FOR THIS FEE STRUCTURE.

~~**13**~~**. 14** Legal Restrictions
The foregoing statements are subject to any restrictions imposed by any state and federal laws or contractual obligations.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: PHYSICIAN PAYMENT FOR ELECTRONIC ADVICE, COUNSELING, AND TREATMENT PLANS - SOURCE: H343-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 **RESOLVED, THE AOA RECOGNIZES THAT THE ABILITY FOR PHYSICIANS**
7 **TO PROVIDE TELEMEDICINE SERVICES AND BE COMPENSATED, IS**
8 **NECESSARY TO IMPROVE ACCESS TO CARE FOR ALL PATIENTS; AND BE**
9 **IT FURTHER**

10 **RESOLVED,** The American Osteopathic Association strongly encourages payers to
11 include as a benefit for physicians to receive payment parity for professional advice,
12 consultation and development of patient treatment plans provided to patients, family
13 members or designee via telemedicine; **AND BE IT FURTHER,**

14 **RESOLVED, THE AOA RECOGNIZES THAT CREATING INFRASTRUCTURE**
15 **AND POLICIES FOR TELEMEDICINE IS NECESSARY TO IMPROVE**
16 **OUTCOMES.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: ELECTRONIC HEALTH RECORDS – ~~INCREASING~~ DRUG **INTERACTION WARNINGS** - SOURCE: H350-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy title be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association supports ongoing evaluation and
7 improvement of ~~increasing~~ drug interaction severity warnings in electronic health
8 records (EHR) and will collaborate with EHR companies to correct inappropriate
9 severity warnings.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES - SOURCE: H312-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association:

7 1. Advocates the use of an independent profession/specialty matched
8 medical peer review process for physicians identified as outliers.

9 2. Opposes the continuation of random pre-payment audits of claims.

10 3. Advocates that any auditing of outpatient medical records be conducted on
11 a retrospective post-payment basis and is statistically sound using
12 determinations in effect at the time of claim.

13 4. Opposes the practice that requires physicians to repay alleged over-
14 payments before all appeal remedies have been exhausted.

15 5. Advocates immunity from Medicare sanctions for physicians voluntarily
16 participating in Medicare sponsored alternative payment models.

17 6. Advocates that the Centers for Medicare and Medicaid Services (CMS)
18 develop educational programs that help physicians identify mistakes or
19 misunderstandings with their coding so as to avoid civil penalties.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008 Reaffirmed as Amended; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted___

DATE: ____July 22, 2023_____

SUBJECT: HEALTHCARE PRACTICE- PATIENT-PHYSICIAN RELATIONSHIP AND - SOURCE: H319-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; now. therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association believes that it is the responsibility of the osteopathic physician**S** to advocate for the rights of ~~his/her~~ **THEIR** patients, regardless of any contractual relationship and that the patient-physician relationship shall not be altered by any system of healthcare practice which may place economic considerations above the interest of patients.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (Status: 1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: MANDATORY ASSIGNMENT - SOURCE: H320-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the right of physicians to accept
7 assignments of payments on a case-by-case basis.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1988; 1993 Reaffirmed as Amended; 1998 Reaffirmed, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: MEDICAL RECORDS- POLICY/GUIDELINES FOR THE MAINTENANCE, RETENTION, AND RELEASE OF - SOURCE: H321-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; and

WHEREAS, language has been amended to ensure it is not construed, in any way, to oppose information blocking provisions codified in regulation in 2020, and to reaffirm AOA's support for privacy protections established under HIPAA, to share only the minimum necessary patient information; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) supports the use of appropriate single ICD codes should suffice to justify the ordering of laboratory tests, if those tests are ordered as part of the evaluation of a disease process or in the context of an already known disease; and the AOA will communicate this policy to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, health insurance companies and to the U.S. Congress.

MEDICAL RECORDS-POLICY / GUIDELINES FOR THE MAINTENANCE, RETENTION AND RELEASE OF

The American Osteopathic Association urges osteopathic physicians to become familiar with the applicable laws, rules or regulations on retention of records and patient access to medical records in their states; and approves the following Policy/ Guidelines for the Maintenance, Retention and Release of Medical Records (1998; revised 2003; 2008; reaffirmed as amended 2013).

POLICY/GUIDELINES FOR THE MAINTENANCE, RETENTION AND RELEASE OF MEDICAL RECORDS

A. Release of records*:* The record is a confidential document involving the osteopathic patient-physician relationship and shall not be communicated to any other person or entity without the patient's prior written consent, unless required by law. **TRANSMISSION OF PATIENT DATA TO A THIRD PARTY SHALL ONLY ENTAIL THE MINIMUM NECESSARY TO ACHIEVE THE INTENDED PURPOSE.** ~~Notes made in treating a patient are primarily for the osteopathic physician's own use and constitute his or her personal property.~~ Under The Health Insurance

Portability and Accountability Act of 1996 (HIPAA), patients have the right to request access to review and copy certain information in their medical records. In addition, HIPAA provides patients with the right to request an amendment to health information in their medical records. HIPAA also provides patients with the right to request an "accounting of disclosures" of their protected health information. Upon written request of the patient, an osteopathic physician shall provide a copy of, or a summary of, the record to the patient or to another physician **OR OTHER PROVIDER**, an attorney, or other person or entity authorized by the patient as provided by law. Medical information shall not be withheld because of an unpaid bill for medical services.

B. Records upon retirement or departure from a group*:* A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation or other reasons. When an osteopathic physician retires or dies, patients shall be notified in a timely manner and urged to find a new physician and shall be informed that, upon authorization, records will be sent to the new physician. Records which may be of value to a patient, and which are not forwarded to a new physician shall be retained consistent with the privacy requirements under federal and/or state laws and regulations, either by the treating osteopathic physician, or such other person lawfully permitted to act as a custodian of the records. The patients of an osteopathic physician who leaves a group practice must be notified that the osteopathic physician is leaving the group. It is unethical to withhold the address of the departing osteopathic physician if requested by the patient or his or her authorized designee. If the responsibility for notifying patients falls to the departing osteopathic physician rather than to the group, the group shall not interfere with the discharge of these duties by withholding patient lists or other necessary information.

C. Sale of medical practice: In the event that an estate of, or the practice of an osteopathic physician's medical practice is sold, the assets of such practice or estate, both hard and liquid, should be transferred in a mutually agreeable manner consistent between seller and buyer. If medical records of the estate or of the practicing physician are included in such sale they should be transferred between seller and buyer in accordance with state and federal guidelines to remain compliant with the confidentiality rules and regulations which govern the security of such records, allowing the buyer to have the opportunity to continue caring for those patients.

All active patients should be notified that the osteopathic physician (or the estate) is transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other physician of their choice. Rather than destroy the records of a deceased osteopathic physician, it is better that they be transferred to a practicing physician who will retain them consistent with privacy requirements under federal and/or state laws and regulations and subject to requests from patients that they be sent to another physician. A reasonable charge may be assessed for the cost of duplicating records. Any sale of a medical practice should conform to IRS and federal guidelines.

D. Retention of records: Osteopathic physicians have an obligation to retain patient records. The following guidelines are offered to assist osteopathic physicians in meeting their ethical and legal obligations:

1. Medical considerations are the principal basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether an osteopathic physician would want the information if he or she were seeing the patient for the first time.

2. If a particular record no longer needs to be kept for medical reasons, the osteopathic physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information. If a patient is a minor, the statute of limitations for medical malpractice claims may not begin to run until the patient reaches the age of majority.

4. Whatever the statute of limitations, an osteopathic physician should measure time from the last personal professional contact with the patient.

5. The records of any patient covered by Medicare or Medicaid must be kept in accordance with the respective regulations.

6. In order to preserve confidentiality when discarding old records, all documents should be destroyed. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023 _____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT AND EVALUATION & MANAGEMENT ON THE SAME DAY OF SERVICE – PAYMENT FOR - SOURCE: H328-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association supports payment for osteopathic
7 manipulative treatment (OMT) and evaluation and management services separately
8 when performed on the same day of service **AND SUPPORTED BY**
9 **DOCUMENTATION**.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: PATIENT CONFIDENTIALITY - SOURCE: H329-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association policy supports that in such cases where the
7 physician is bound by law to protect patient confidentiality, the physician shall only
8 be required to provide information that can be disclosed under law and where
9 possible, the physician shall be allowed to submit narrative reports or only copies of
10 the part of a medical record that is pertinent in lieu of a complete record.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: PRE-FILLED MEDICAL NECESSITY FORM - SOURCE: H344-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages physicians to verify
7 directly with patients that the patient is in need of supplies; further, the AOA
8 supports disclosure regarding medical necessity and making it inappropriate for
9 supply companies to provide physicians with medical necessity certification forms
10 on which the quantity or indication of a need for a product is pre-filled.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: REFERRALS AND CONSULTS- NON-PHYSICIAN DISCLOSURES - SOURCE: H345-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association recommends that a patient referred to a
7 physician specialist should be seen and evaluated by a physician specialist. Any
8 care by a non-physician in a specialist's office / clinic should be disclosed to the
9 patient and referring physician before the care is provided.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: TOBACCO USE - SOURCE: H335-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports third-party coverage of evidence-
7 based approaches for the treatment of tobacco use and nicotine withdrawal.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: ___July 22, 2023_____

SUBJECT: UNIFORM BILLING - SOURCE: H336-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association opposes charging a fee or other penalty to
7 physicians for the payment claims that they submit for care provided to Medicare
8 and Medicaid patients.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: EXPERT WITNESS & PEER REVIEW – SOURCE:H341-A/18

SUBMITTED BY: Council of State Government Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommend that the following policy be REAFFIRMED AS AMENDED:

WHITE PAPER - EXPERT WITNESS & PEER REVIEW

Introduction:

The days when physicians would not testify against fellow colleagues because they did not want to break the code of silence previously associated with the profession are long over. [1] Today, it is common practice for physicians to serve as medical experts in medical malpractice actions. The 1993 U.S. Supreme Court case *Daubert v. Merrell Dow Pharmaceutical* gave the Court an opportunity to establish guidelines for expert witness testimony. The Court concluded that expert witness testimony should be scientifically valid. Additionally, the Court said that testimony is valid if there has been peer review and general acceptance of the testimony.

There is a great deal of skepticism about the role of the physician-expert, and whether an expert's testimony is valid.[2] Some physicians travel the country routinely testifying in malpractice actions, and in many instances they are considered "hired guns" who will alter their opinions for the highest bidder.[3] Concern over speculative expert testimony has led critics to call for stricter scrutiny of expert testimony and to appeal to professional organizations to take a more active role in monitoring physicians who give inaccurate testimony.[4]

Peer Review of Osteopathic Manipulative Treatment

The integrity of both judicial and administrative proceedings regarding physicians and alleged medical malpractice depends in part on the honest, unbiased testimony of expert witnesses. Such testimony serves to clarify and explain technical concepts and to articulate professional standards of care. To that end, the AOA has adopted the policy that "osteopathic physicians acting as medical directors, expert witnesses, or peer reviewers, and affecting patient treatment, outcome of care, and access to care, are practicing osteopathic medicine." This statement suggests that expert witness testimony should be subject to peer review.

The introduction of a peer review requirement, however, presents an interesting question for osteopathic physicians: namely, should MDs be allowed to review the work of osteopathic physicians without the input of another DO? One of the important elements of osteopathic training is osteopathic manipulative treatment (OMT), a practice unique to the osteopathic profession. Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine (NMM/OMM) is a unique specialty within the osteopathic profession that should be reviewed by a like peer. Because both DOs and MDs are licensed for the unlimited practice of medicine in all 50 states, members of either branch of the medical profession can generally testify concerning the actions of the members of the other branch of the profession. However, considering the uniqueness of OMT, MDs will not likely have the education or training to determine if the actions of osteopathic physicians using OMT were within the appropriate standard of care.

In addition, peer review takes place in both hospital and outpatient settings, and by third party payers. Various entities—including the Centers for Medicare and Medicaid Services, managed care organizations, third party payers, and workers' compensation programs—often use peer review for determinations in reimbursement decisions. In addition, many insurance carriers have claims for the service of OMT "peer reviewed" by health care providers that are either not trained or who are inadequately trained in Osteopathic Principles and Practices. Osteopathic physicians are highly trained in the integration of expert, cost effective, and judicious application of OMT when indicated and appropriate.

Healthcare Setting Peer Review

The AOA has always fostered and encouraged peer review, both through voluntary mechanisms and, since 1972, through Federal Peer Review Programs. The AOA wishes to reaffirm its commitment to peer review regardless of federal policy or program changes. Osteopathic medicine must promote and facilitate peer review among and through its members in health care settings.

Medical Societies & Expert Witness Policies

A number of medical organizations have created programs to address the problem of inaccurate expert witness testimony.

In 1989, the American Academy of Pediatrics (AAP) created policy on appropriate expert witness testimony that includes concerns specific to pediatric cases, as well as suggestions for improving the quality of expert testimony by implementing certain requirements for expert witnesses.[5] the American Academy of Family Physicians (AAFP) supports similar requirements.[6] The American Association of Neurological Surgeons (AANS) has guidelines for expert witnesses and operates a professional conduct program under which members can be disciplined for unprofessional conduct if they violate these guidelines.[7] In 2004, the American Academy of Orthopedic Surgeons (AAOS) created an expert witness program that involves

education and advocacy components.[8] The American Society of Anesthesiologists (ASA) also maintains an expert witness testimony review program under which ASA members may submit complaints against other members for violating ASA guidelines on expert testimony.[9]

In addition to the previously described medical societies, other medical organizations that track and monitor their member testimonies include the North American Spine Society and the American College of Osteopathic Obstetricians & Gynecologists (ACOOG), American College of Obstetricians and Gynecologists (ACOG). The ACOG has developed a "qualifications" document~~s~~ that spells out to members the responsibilities and obligations of expert witnesses.[10] Finally, both the American College of Emergency Physicians **(ACEP)** and the American College of Surgeons mandate that their members submit transcripts of depositions and testimony.

Expert Testimony in the Court Room

Judges determine the admissibility of evidence, including expert testimony, based upon judicially created standards and the rules of evidence applicable to their jurisdiction. As a result, the requirements a physician must meet to qualify as an expert witness can be unclear and vary from state to state. An increasing number of states also require physicians to meet statutorily-defined requirements relating to licensure, specialization and practice activity in order to qualify as an expert witness in a medical liability case.[11]

Licensed in the State

Twenty-Four states have statutes that address the licensure required to testify as an expert witness in a medical liability case. Nearly all of these statutes simply require the physician to be licensed to practice in one or more of the fifty states. However, Tennessee requires physician experts to be licensed in the state or a state bordering Tennessee. In addition, Florida and South Carolina require out of state experts to become certified or licensed, respectively, to qualify as an expert witness. **TWENTY-FOUR STATES REFER TO OR INCORPORATE RULE 702 - EXPERT WITNESS IN THEIR STATUTES. THIS RULE DEFINES AN EXPERT WITNESS BASED ON THEIR KNOWLEDGE, SKILL, EXPERIENCE, TRAINING, OR EDUCATION WITHOUT EXPLICITLY STATING THAT LICENSURE IS A PREREQUISITE.**

Active Practice or Teaching

Twenty-three states have statutes that require medical experts to have devoted a certain percentage of their professional time to active practice or teaching, or to have been engaged in active practice or teaching within a certain number of years. Arizona, Kansas, Michigan, New Jersey, North Carolina, Ohio and West Virginia require medical experts to have devoted at least half of their professional time to active clinical practice or teaching.

Board Certification and Specialization

Thirty-two states have statutes that address the specialization or board certification a physician must possess to testify as a medical expert. **TWENTY-TWO STATES REQUIRE AN EXPERT TO BE TRAINED AND EXPERIENCED IN THE SAME SPECIALTY, SUBSPECIALTY, DISCIPLINE OR SCHOOL OR PRACTICE AS THE PERSON THE EXPERT IS TESTIFYING ABOUT.** ~~Alabama, Alaska, California, Connecticut, Florida, Louisiana, Michigan, Mississippi, Montana, Nevada, North Carolina, Ohio, Texas, Virginia and West Virginia require an expert to be trained and experienced in the same specialty, subspecialty, discipline or school or practice as the person the expert is testifying about.~~ If the testimony concerns the practice of a board-certified physician in the field in which he or she is certified, ~~Arizona, Delaware, Maryland, New Jersey, Ohio~~, **TWELVE STATES** require the expert to be board certified in the same or similar field as well.

Pennsylvania and South Carolina permit a medical expert to either be board certified or have professional knowledge and experience in the practice area or specialty in which the opinion is offered.

Pretrial Certificates/Affidavits of Merit

Another technique employed by states to weed out frivolous claims and unnecessary expert testimonies are “certificates of merit,” also known as “affidavits of merit.” A certificate of merit is an affidavit, signed by the plaintiff’s expert witness and attached to the original complaint, certifying that the expert witness is knowledgeable of the relevant facts of the case, is qualified to express an opinion on the merits of the case, and certifying that there is a reasonable and meritorious cause for the filing of the action. In addition, the certificate of merit officially states that the expert is qualified to make a determination of whether the defendant physician departed from the standard of care in treating the injured plaintiff. Twenty-six states currently require a physician to verify that a malpractice lawsuit has merit before it can be filed.

Other Provisions

Aside from the more traditional criteria stated above, some states adopt a broader set of expert witness qualifications. Idaho requires that expert witnesses to have knowledge of the community standards to which his or her testimony is addressed. Nevada requires expert medical testimony to be given by a provider who practices or has practiced in an area that is substantially similar to the type of practice engaged in by the defendant physician at the time of the alleged negligence. Rhode Island only requires “knowledge, skill, experience, training or education” to qualify as an expert witness. Oklahoma, **AND** Pennsylvania ~~and Illinois~~ permit retired physicians to serve as expert witnesses. ~~Illinois allows retired physicians to testify if they can provide proof of attendance and completion of continuing education courses for three years previous to giving testimony.~~

Some states have also clarified that a physician who provides expert testimony is engaged in the practice of medicine or is otherwise subject to discipline by the state’s licensing board for providing false, deceptive, or misleading testimony. California, Florida, Mississippi, Ohio and South Carolina have statutes that subject

expert witnesses to discipline by the state's licensing board. In 2002, the state medical board in North Carolina ordered a physician's license to be suspended for one year due to expert testimony he provided under the theory that the physician had engaged in unprofessional conduct.

Expert Testimony in Administrative and Disciplinary Hearings

Whereas traditional courts and juries have, for the most part, adopted requirements that expert testimony be used in medical malpractice cases, professional licensing boards have responded differently. Medical licensing boards work to police the actions of physicians by establishing and enforcing the standards of medical care within their communities, frequently without the aid of expert testimony.[12] This is because in most administrative settings the judge is trier of both fact and law. Expert testimony is taken to assist the judge as the trier of fact, but it is not required.[13] In some settings, experts will testify only by deposition; whereas in others, live testimony is always needed. Additionally, it is possible that the review panel can provide opinion evidence.

Policy Behind Adopting a Requirement for Expert Testimony in Administrative Hearings

The expert testimony requirement serves three main purposes. First, expert testimony protects the defendant's right to review rather than allow a professional board to base its decision only on its own expertise.[14] Second, having expert testimony in the record makes it easier for the defendant to challenge the evidence used to support the professional board's claim.[15] Finally, many courts recognize that members of a professional board are not necessarily qualified to make a medical opinion, and do not want to put a defendant's license at risk under those circumstances. However, most jurisdictions, even those who require expert testimony, often can decide when to apply the requirement. Consequently, states have a tendency to modify or soften their rules concerning the admission of expert testimony in administrative hearings.[16]

Compensation and Disclosure Requirements

In addition to peer review and strengthened expert witness qualifications, the unregulated compensation an expert witness may charge for medical testimony has contributed to the "hired gun" perception. Exorbitant compensation for expert witness testimony dilutes the integrity of the medical profession by creating the perception that these witnesses have an incentive to tailor their testimonies to the needs of the attorneys who pay them.-[17] This perception is exacerbated by the practice of making the payment of an expert witness's fee contingent upon the outcome of the case. In most jurisdictions, the common law rule forbade paying expert witnesses a contingent fee.[18] Arizona, ~~Arkansas~~, Florida, Michigan, ~~Mississippi,~~ New Hampshire, New Jersey, North Carolina, ~~Utah,~~ and Wisconsin now have statutes that prohibit paying expert witnesses on a contingency basis or make expert testimony provided according to a contingent fee arrangement inadmissible.

AOA Policy statements

Appropriate standards are necessary to govern the use of expert testimony and peer review. The following statements represent the AOA's position on appropriate use of expert witness testimony and peer review:

The AOA believes that based on the *Daubert* decision, a trial court must determine if the opinion of the expert is reliable. In making that determination, the trial court may consider: (1) whether the theory or technique has been or can be tested; (2) whether the theory or technique has been proven by the peer review process or published within the scientific community; (3) the known rate of error, or the potential rate of error; (4) whether standards exist in the particular field or science from which the expertise comes; and (5) whether the theory or technique that is the subject of the opinion or testimony has been generally accepted by the particular scientific community;

The AOA finds that as a result of the *Daubert* decision, the medical community has developed guidelines for evidence-based medicine. Evidence-based medicine may be authenticated by three sources: (1) large, controlled, randomized clinical trials; (2) observational scientific studies; and (3) consensus recommendations from a panel of recognized experts in the clinical or research field;[19]

The AOA affirms its commitment to promote and facilitate peer review among and through its members;

The AOA supports a policy that peer review of osteopathic physicians should be conducted by other osteopathic physicians, whenever possible, to account for osteopathic physicians' unique training in Osteopathic Principles and Practices and OMT;

The AOA believes that when the standard of care involves a procedure unique to the osteopathic practice of medicine, such as OMT, then only osteopathic physicians should conduct peer review of DOs;

The AOA pledges to pursue any and all legal and legislative recourses to assure that insurance claims reviewed by peers regarding the provision of OMT procedures may only be conducted by qualified osteopathic physicians;

The AOA believes that the voluntary hospital peer review process remains the most natural and appropriate vehicle through which to effect institutional peer review;

The AOA believes that all peer review should remain confidential and undiscoverable except to the physician who is the subject of the peer review;

The AOA believes that all review under the peer review organization program of osteopathic diagnosis and therapeutics be performed by osteopathic physicians.

The AOA believes that an osteopathic physician's failure to provide truthful testimony or peer review constitutes unprofessional conduct subject to peer review consistent with the AOA's policy that expert testimony and peer review by osteopathic physicians constitute the practice of medicine;

The AOA encourages state divisional societies to develop and implement appropriate procedures and measures to monitor and discipline member expert witnesses who provide fraudulent and misleading testimony;

The AOA pledges to support any osteopathic society that wishes to develop its own program to discipline physicians for unprofessional conduct related to expert witness testimony;

The AOA pledges to act as a clearinghouse for advice on the issue of expert witness testimony;

The AOA supports updating state licensing laws to include "providing false or misleading information in the role of expert witness" in the definition of unprofessional conduct;

The AOA's believes that an expert witness should not provide medical testimony that is false, misleading, or without medical foundation;

The AOA's believes that an expert witness should have a current, unrestricted license to practice in the same state as the defendant physician. Preferably, the expert witness should be board certified in the same medical specialty as the defendant and the certifying board should be one that is recognized by the state;

The AOA's believes that an expert witness should be three (3) years removed from residency training and should be engaged in active medical practice or have teaching experience, or any combination thereof in the same specialty or subspecialty, for a period of no less than three (3) years prior to the date of the testimony. In cases where the physician serving as an expert witness has completed a forensic science, pediatric child abuse, or other approved forensic fellowship and where the expert testimony specifically relates to that training, the requirement of being three (3) years removed from residency training is waived;

298 The AOA encourages state licensing boards to grant temporary licensure to out-of-
299 state expert witnesses upon a showing of the inability to find an in-state expert
300 witness to make them subject to disciplinary sanctions of the state licensing boards;
301
302 The AOA opposes allowing expert witnesses to accept compensation that is
303 contingent on the outcome of the case;
304
305 The AOA believes that an expert witness' compensation must be proportionate to
306 the time, level of expertise, and effort given for preparing and attending court
307 appearances; and
308
309 The AOA supports a policy that imposes mandatory disclosure to the court and
310 opposing parties of the qualifications of the expert witness, access to copies of all
311 publications authored by the witness in the preceding ten (10) years, and access to
312 transcripts from all cases in which the witness has testified as an expert witness in
313 the preceding four (4) years.

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[11] See, AOA Division Of State Government Affairs, *Expert Witness Chart* (2018).
[12] In Re Lustgarten, 177 N.C.App. 633 (2006)
[13] Timothy P. McCormack, *Expert Testimony and Professional Licensing Boards: What is Good, What is Necessary, and the Myth of the Majority-Minority Split*, 53 Me. L. Rev. 139, 144 (2001).
[14] Daniel Solomon, *Medical Expert Testimony in Administrative Hearings*, 17 J. NAALJ 285 (1997)
[15] McCormack, *supra* note 23 at 147
[16] *Id.*

[17] *Id* at 187.
[18] Tanya Albert, *On the hot seat: Physician expert witnesses. With scrutiny high and the other side out to get the "hired gun," court appearances can be a trial for physicians who serve as expert witnesses,* American Medical News, April 8, 2002.
[19] 27 NCAC2.3, rule 3.4, comment 3.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; reaffirmed as amended 2013; reaffirmed as amended 2018)

Prior HOD action on similar or same topic:
H308-A/20 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: PAYORS – OSTEOPATHIC DISCRIMINATION BY
- SOURCE: H318-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) is opposed to discrimination against
7 osteopathic physicians by payors; and urges that federal and state legislation
8 must clearly state that any and all payors must accept as sufficient
9 professional credentials all licenses properly granted by state boards of
10 medicine or osteopathic medicine, and all specialty certifications granted by
11 boards approved by the AOA or American Board of Medical Specialties.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H304-A/18 Discrimination Against Osteopathic Physicians
H605-A/22 Discrimination – The Practice of Osteopathic Medicine
Resolution H629-A/20 Discrimination by Insurers was approved as an action

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: Special Licensing Pathways for Physicians – Opposition to - SOURCE: H363-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) oppose**S** the creation of special
7 licensing pathways which allow physicians who are not currently enrolled in an ~~AOA~~
8 ~~or~~ Accreditation Council for Graduate Medical Education (ACGME) accredited
9 training program ("residency"), or who have not completed at least one year of post-
10 graduate U.S. medical education accredited by the ~~AOA or~~ ACGME, to practice
11 medicine under limited supervision by a fully trained and licensed physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic:
H640-A/20 Non-Physician Clinicans

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (UEHVPA) – SOURCE H347-A/18

SUBMITTED BY: Council of State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the current version of the Uniform Emergency Volunteer Health Practitioners Act ('UEHVPA") contains sections 11 – 15, which are not included in our existing policy; and

WHEREAS, the Council on State Health Affairs has reviewed the policy and additional sections, and determined all to be relevant; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommend that the following policy be REAFFIRMED AS AMENDED:

Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)

Policy Statement

The American Osteopathic Association supports enactment of the ~~following~~ Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) **WITH AMENDENTS TO INCLUDE D.O.S WHEREVER M.D.S ARE LISTED.** ~~as written by the National Conference of Commissioners on Uniform State Laws and amended by the AOA~~.

~~**UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (UEVHPA)**~~

~~SECTION 1. SHORT TITLE. This [act] may be cited as the Uniform Emergency Volunteer Health Practitioners Act.~~

~~SECTION 2. DEFINITIONS. In this [act]:~~

~~(1) "Disaster relief organization" means an entity that provides emergency or disaster relief services that include health or veterinary services provided by volunteer health practitioners and that:~~

~~(A) is designated or recognized as a provider of those services pursuant to a disaster response and recovery plan adopted by an agency of the federal government or [name of appropriate governmental agency or agencies]; or~~

~~(B) regularly plans and conducts its activities in coordination with an agency of the federal government or [name of appropriate governmental agency or agencies].~~

~~(2) "Emergency" means an event or condition that is an [emergency, disaster, or public health emergency] under [designate the appropriate laws of this state, a political subdivision of this state, or a municipality or other local government within this state].~~

~~(3) "Emergency declaration" means a declaration of emergency issued by a person authorized to do so under the laws of this state [, a political subdivision of this state, or a municipality or other local government within this state].~~

~~(4) "Emergency Management Assistance Compact" means the interstate compact approved by Congress by Public Law No. 104-321,110 Stat. 3877 [cite state statute, if any].~~

~~(5) "Entity" means a person other than an individual.~~

~~(6) "Health facility" means an entity licensed under the laws of this or another state to provide health or veterinary services.~~

~~(7) "Health practitioner" means an individual who is an MD or a DO, and licensed under the laws of this or another state to provide health services.~~

~~(8) "Health services" means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of individuals or human populations, to the extent necessary to respond to an emergency, including:~~

~~(A) the following, concerning the physical or mental condition or functional status of an individual or affecting the structure or function of the body:~~

~~(i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; and~~

~~(ii) counseling, assessment, procedures, or other services;~~

~~(B) sale or dispensing of a drug, a device, equipment, or another item to an individual in accordance with a prescription; and~~

~~(C) funeral, cremation, cemetery, or other mortuary services.~~

~~(9) "Host entity" means an entity operating in this state which uses volunteer health practitioners to respond to an emergency.~~

~~(10) "License" means authorization by a state to engage in health or veterinary services that are unlawful without the authorization. The term includes authorization under the laws of this state to an individual to provide health or veterinary services based upon a national certification issued by a public or private entity.~~

~~(11) "Person" means an individual, corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.~~

~~(12) "Scope of practice" means the extent of the authorization to provide health granted to a health practitioner by a license issued to the practitioner in the state in which the principal part of the practitioner's services are rendered, including any conditions imposed by the licensing authority.~~

~~(13) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.~~

~~(14) "Volunteer health practitioner" means a health practitioner who provides, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.~~

~~Legislative Note: Definition of "emergency": The terms "emergency," "disaster," and "public health emergency" are the most commonly used terms to describe the circumstances that may lead to the issuance of an emergency declaration referred to in this [act]. States that use other terminology should insert the appropriate terminology into the first set of brackets. The second set of brackets should contain references to the specific statutes pursuant to which emergencies are declared by the state or political subdivisions, municipalities, or local governments within the state.~~

~~Definition of "emergency declaration": The references to declarations issued by political subdivisions, municipalities or local governments should be used in states in which these entities are authorized to issue emergency declarations.~~

~~Definition of "state": A state may expand the reach of this [act] by defining this term to include a foreign country, political subdivision of a foreign country, or Indian tribe or nation.~~

~~SECTION 3. APPLICABILITY TO VOLUNTEER HEALTH PRACTITIONERS. This [act] applies to volunteer health practitioners registered with a registration system that complies with Section 5 and who provide health in this state for a host entity while an emergency declaration is in effect.~~

~~SECTION 4. REGULATION OF SERVICES DURING EMERGENCY.~~

~~(a) While an emergency declaration is in effect, [name of appropriate governmental agency or agencies] may limit, restrict, or otherwise regulate:~~

~~(1) the duration of practice by volunteer health practitioners;~~

~~(2) the geographical areas in which volunteer health practitioners may practice;~~

~~(3) the types of volunteer health practitioners who may practice; and~~

~~(4) any other matters necessary to coordinate effectively the provision of health or veterinary services during the emergency.~~

~~(b) An order issued pursuant to subsection (a) may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].~~

~~(c) A host entity that uses volunteer health practitioners to provide health services in this state shall:~~

~~(1) consult and coordinate its activities with [name of the appropriate governmental agency or agencies] to the extent practicable to provide for the efficient and effective use of volunteer health practitioners; and~~

~~(2) comply with any laws other than this [act] relating to the management of emergency health, including [cite appropriate laws of this state].~~

~~SECTION 5. VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEMS.~~

~~(a) To qualify as a volunteer health practitioner registration system, a system must:~~

~~(1) accept applications for the registration of volunteer health practitioners before or during an emergency;~~

~~(2) include information about the licensure and good standing of health practitioners which is accessible by authorized persons; and~~

~~(3) meet one of the following conditions:~~

~~(A) be an emergency system for advance registration of volunteer health-care practitioners established by a state and funded through the Health Resources Services Administration under Section 319I of the Public Health Services Act, 42 USC Section 247d-7b [as amended];~~

~~(B) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed pursuant to Section 2801 of the Public Health Services Act, 42 U.S.C. Section 300hh [as amended];~~

~~(C) be operated by a:~~

~~(i) disaster relief organization;~~

~~(ii) licensing board;~~

~~(iii) national or regional association of licensing boards or health practitioners;~~

~~(iv) health facility that provides comprehensive inpatient and outpatient health-care services, including a tertiary care and teaching hospital; or~~

~~(v) governmental entity; or~~

~~(D) be designated by [name of appropriate agency or agencies] as a registration system for purposes of this [act].~~

~~(b) While an emergency declaration is in effect, [name of appropriate agency or agencies], a person authorized to act on behalf of [name of governmental agency or agencies], or a host entity, may confirm whether volunteer health practitioners utilized in this state are registered with a registration system that complies with subsection (a). Confirmation is limited to obtaining identities of the practitioners from the system and determining whether the system indicates that the practitioners are licensed and in good standing.~~

~~(c) Upon request of a person in this state authorized under subsection (c), or a similarly authorized person in another state, a registration system located in this state shall notify the person of the identities of volunteer health practitioners and whether the practitioners are licensed and in good standing.~~

~~(d) A host entity is not required to use the services of a volunteer health practitioner even if the practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.~~

~~Legislative Note: If this state uses a term other than "hospital" to describe a facility with similar functions, such as an "acute care facility", the final phrase of subsection (b)(4) should include a reference to this type of facility – for example, "including a tertiary care, teaching hospital, or acute care facility."~~

~~SECTION 6. RECOGNITION OF VOLUNTEER HEALTH PRACTITIONERS LICENSED IN OTHER STATES.~~

~~(a) While an emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with Section 5 and licensed and in good standing in the state upon which the practitioner's registration is based, may practice in this state to the extent authorized by this [act] as if the practitioner were licensed in this state.~~

~~(b) A volunteer health practitioner qualified under subsection (a) is not entitled to the protections of this [act] if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.~~

~~SECTION 7. NO EFFECT ON CREDENTIALING AND PRIVILEGING.~~

~~(a) In this section:~~

~~(1) "Credentialing" means obtaining, verifying, and assessing the qualifications of a health practitioner to provide treatment, care, or services in or for a health facility based upon a unified national standard.~~

~~(2) "Privileging" means the authorizing by an appropriate authority, such as a governing body, of a health practitioner to provide specific treatment, care, or services at a health facility subject to limits based on factors that include license, education, training, experience, competence, health status, and specialized skill.~~

~~(b) This [act] does not affect credentialing or privileging standards of a health facility and does not preclude a health facility from waiving or modifying those standards while an emergency declaration is in effect.~~

~~SECTION 8. PROVISION OF VOLUNTEER HEALTH OR VETERINARY SERVICES; ADMINISTRATIVE SANCTIONS.~~

~~(a) Subject to subsections (b) and (c), a volunteer health practitioner shall adhere to the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other laws of this state.~~

~~(b) Except as otherwise provided in subsection (c), this [act] does not authorize a volunteer health practitioner to provide services that are outside the practitioner's scope of practice, even if a similarly licensed practitioner in this state would be permitted to provide the services.~~

~~(c) [Name of appropriate governmental agency or agencies] may modify or restrict the health or veterinary services that volunteer health practitioners~~

~~may provide pursuant to this [act]. An order under this subsection may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].~~

~~(d) A host entity may restrict the health or veterinary services that a volunteer health practitioner may provide pursuant to this [act].~~

~~(e) A volunteer health practitioner does not engage in unauthorized practice unless the practitioner has reason to know of any limitation, modification, or restriction under this section or that a similarly licensed practitioner in this state would not be permitted to provide the services. A volunteer health practitioner has reason to know of a limitation, modification, or restriction or that a similarly licensed practitioner in this state would not be permitted to provide a service if:~~

~~(1) the practitioner knows the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service; or~~

~~(2) from all the facts and circumstances known to the practitioner at the relevant time, a reasonable person would conclude that the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service.~~

~~(f) In addition to the authority granted by law of this state other than this [act] to regulate the conduct of health practitioners, a licensing board or other disciplinary authority in this state:~~

~~(1) may impose administrative sanctions upon a health practitioner licensed in this state for conduct outside of this state in response to an out-of-state emergency;~~

~~(2) may impose administrative sanctions upon a practitioner not licensed in this state for conduct in this state in response to an in-state emergency; and~~

~~(3) shall report any administrative sanctions imposed upon a practitioner licensed in another state to the appropriate licensing board or other disciplinary authority in any other state in which the practitioner is known to be licensed.~~

~~(g) In determining whether to impose administrative sanctions under subsection (f), a licensing board or other disciplinary authority shall consider the circumstances in which the conduct took place, including any exigent circumstances, and the practitioner's scope of practice, education, training, experience, and specialized skill.~~

~~Legislative Note: The governmental agency or agencies referenced in subsection (c) may, as appropriate, be a state licensing board or boards rather than an agency or agencies that deal[s] with emergency response efforts.~~

~~SECTION 9. RELATION TO OTHER LAWS.~~

~~(a) This [act] does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this [act]. Except as otherwise provided in subsection (b), this [act] does not affect requirements~~

~~for the use of health practitioners pursuant to the Emergency Management Assistance Compact.~~

~~(b) [Name of appropriate governmental agency or agencies], pursuant to the Emergency Management Assistance Compact, may incorporate into the emergency forces of this state volunteer health practitioners who are not officers or employees of this state, a political subdivision of this state, or a municipality or other local government within this state.~~

~~Legislative Note: References to other emergency assistance compacts to which the state is a party should be added.~~

~~SECTION 10. REGULATORY AUTHORITY.~~

~~[Name of appropriate governmental agency or agencies] may promulgate rules to implement this [act]. In doing so, [name of appropriate governmental agency or agencies] shall consult with and consider the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact and shall also consult with and consider rules promulgated by similarly empowered agencies in other states to promote uniformity of application of this [act] and make the emergency response systems in the various states reasonably compatible.~~

~~Legislative Note: References to other emergency assistance compacts to which the state is a party should be added.~~

~~SECTION 11. CIVIL LIABILITY FOR VOLUNTEER HEALTH PRACTITIONERS; VICARIOUS LIABILITY.~~

~~Civil liability should be limited to those instances where both malicious intent is demonstrated, and the plaintiff has met a clear and convincing standard for the burden of proof.~~

~~SECTION 11. LIMITATIONS ON CIVIL LIABILITY FOR VOLUNTEER HEALTH PRACTITIONERS[; VICARIOUS LIABILITY].~~

~~ALTERNATIVE A~~

~~(A) SUBJECT TO SUBSECTION (C), A VOLUNTEER HEALTH PRACTITIONER WHO PROVIDES HEALTH OR VETERINARY SERVICES PURSUANT TO THIS [ACT] IS NOT LIABLE FOR DAMAGES FOR AN ACT OR OMISSION OF THE PRACTITIONER IN PROVIDING THOSE SERVICES.~~

~~(B) NO PERSON IS VICARIOUSLY LIABLE FOR DAMAGES FOR AN ACT OR OMISSION OF A VOLUNTEER HEALTH PRACTITIONER IF THE PRACTITIONER IS NOT LIABLE FOR THE DAMAGES UNDER SUBSECTION (A).~~

~~(C) THIS SECTION DOES NOT LIMIT THE LIABILITY OF A VOLUNTEER HEALTH PRACTITIONER FOR:~~

~~(1) WILLFUL MISCONDUCT OR WANTON, GROSSLY NEGLIGENT, RECKLESS, OR CRIMINAL CONDUCT;~~

~~(2) AN INTENTIONAL TORT;~~

~~(3) BREACH OF CONTRACT;~~

~~(4) A CLAIM ASSERTED BY A HOST ENTITY OR BY AN ENTITY LOCATED IN THIS OR ANOTHER STATE WHICH EMPLOYS OR USES THE SERVICES OF THE PRACTITIONER; OR~~

~~(5) AN ACT OR OMISSION RELATING TO THE OPERATION OF A~~

~~MOTOR VEHICLE, VESSEL, AIRCRAFT, OR OTHER VEHICLE.~~

~~(D) A PERSON THAT, PURSUANT TO THIS [ACT], OPERATES, USES, OR RELIES UPON INFORMATION PROVIDED BY A VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEM IS NOT LIABLE FOR DAMAGES FOR AN ACT OR OMISSION RELATING TO THAT OPERATION, USE, OR RELIANCE UNLESS THE ACT OR OMISSION IS AN INTENTIONAL TORT OR IS WILLFUL MISCONDUCT OR WANTON, GROSSLY NEGLIGENT, RECKLESS, OR CRIMINAL CONDUCT.~~

~~[(E) IN ADDITION TO THE PROTECTIONS PROVIDED IN SUBSECTION (A), A VOLUNTEER HEALTH PRACTITIONER WHO PROVIDES HEALTH OR VETERINARY SERVICES PURSUANT TO THIS [ACT] IS ENTITLED TO ALL THE RIGHTS, PRIVILEGES, OR IMMUNITIES PROVIDED BY [CITE STATE LAW.]]~~

~~ALTERNATIVE B~~

~~(A) SUBJECT TO SUBSECTION (B), A VOLUNTEER HEALTH PRACTITIONER WHO RECEIVES COMPENSATION OF [$500] OR LESS PER YEAR FOR PROVIDING HEALTH OR VETERINARY SERVICES PURSUANT TO THIS [ACT] IS NOT LIABLE FOR DAMAGES FOR AN ACT OR OMISSION OF THE PRACTITIONER IN PROVIDING THOSE SERVICES. REIMBURSEMENT OF, OR ALLOWANCE FOR, REASONABLE EXPENSES, OR CONTINUATION OF SALARY OR OTHER REMUNERATION WHILE ON LEAVE, IS NOT COMPENSATION UNDER THIS SUBSECTION.~~

~~(B) THIS SECTION DOES NOT LIMIT THE LIABILITY OF A VOLUNTEER HEALTH PRACTITIONER FOR:~~

~~(1) WILLFUL MISCONDUCT OR WANTON, GROSSLY NEGLIGENT, RECKLESS, OR CRIMINAL CONDUCT;~~

~~(2) AN INTENTIONAL TORT;~~

~~(3) BREACH OF CONTRACT;~~

~~(4) A CLAIM ASSERTED BY A HOST ENTITY OR BY AN ENTITY LOCATED IN THIS OR ANOTHER STATE WHICH EMPLOYS OR USES THE SERVICES OF THE PRACTITIONER; OR~~

~~(5) AN ACT OR OMISSION RELATING TO THE OPERATION OF A MOTOR VEHICLE, VESSEL, AIRCRAFT, OR OTHER VEHICLE.~~

~~(C) A PERSON THAT, PURSUANT TO THIS [ACT], OPERATES, USES, OR RELIES UPON INFORMATION PROVIDED BY A VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEM IS NOT LIABLE FOR DAMAGES FOR AN ACT OR OMISSION RELATING TO THAT OPERATION, USE, OR RELIANCE UNLESS THE ACT OR OMISSION IS AN INTENTIONAL TORT OR IS WILLFUL MISCONDUCT OR WANTON, GROSSLY NEGLIGENT, RECKLESS, OR CRIMINAL CONDUCT.~~

~~[(D) IN ADDITION TO THE PROTECTIONS PROVIDED IN SUBSECTION (A), A VOLUNTEER HEALTH PRACTITIONER WHO PROVIDES HEALTH OR VETERINARY SERVICES PURSUANT TO THIS [ACT] IS ENTITLED TO ALL THE RIGHTS, PRIVILEGES, OR IMMUNITIES PROVIDED BY [CITE STATE LAW].]~~

~~SECTION 12. WORKERS' COMPENSATION COVERAGE.~~

~~(A) IN THIS SECTION, "INJURY" MEANS A PHYSICAL OR MENTAL INJURY OR DISEASE FOR WHICH AN EMPLOYEE OF THIS STATE WHO IS INJURED OR CONTRACTS THE DISEASE IN THE COURSE OF THE EMPLOYEE'S EMPLOYMENT WOULD BE ENTITLED TO BENEFITS UNDER THE WORKERS' COMPENSATION [OR OCCUPATIONAL DISEASE] LAW OF THIS STATE.~~

~~(B) A VOLUNTEER HEALTH PRACTITIONER WHO DIES OR IS INJURED AS THE RESULT OF PROVIDING HEALTH OR VETERINARY SERVICES PURSUANT TO THIS [ACT] IS DEEMED TO BE AN EMPLOYEE OF THIS STATE FOR THE PURPOSE OF RECEIVING BENEFITS FOR THE DEATH OR INJURY UNDER THE WORKERS' COMPENSATION [OR OCCUPATIONAL DISEASE] LAW OF THIS STATE IF:~~

~~(1) THE PRACTITIONER IS NOT OTHERWISE ELIGIBLE FOR SUCH BENEFITS FOR THE INJURY OR DEATH UNDER THE LAW OF THIS OR ANOTHER STATE; AND~~

~~(2) THE PRACTITIONER, OR IN THE CASE OF DEATH THE PRACTITIONER'S PERSONAL REPRESENTATIVE, ELECTS COVERAGE UNDER THE WORKERS' COMPENSATION [OR OCCUPATIONAL DISEASE] LAW OF THIS STATE BY MAKING A CLAIM UNDER THAT LAW.~~

~~(C) THE [NAME OF APPROPRIATE GOVERNMENTAL AGENCY] SHALL ADOPT RULES, ENTER INTO AGREEMENTS WITH OTHER STATES, OR TAKE OTHER MEASURES TO FACILITATE THE RECEIPT OF BENEFITS FOR INJURY OR DEATH UNDER THE WORKERS' COMPENSATION [OR OCCUPATIONAL DISEASE] LAW OF THIS STATE BY VOLUNTEER HEALTH PRACTITIONERS WHO RESIDE IN OTHER STATES, AND MAY WAIVE OR MODIFY REQUIREMENTS FOR FILING, PROCESSING, AND PAYING CLAIMS THAT UNREASONABLY BURDEN THE PRACTITIONERS. TO PROMOTE UNIFORMITY OF APPLICATION OF THIS [ACT] WITH OTHER STATES THAT ENACT SIMILAR LEGISLATION, THE [NAME OF APPROPRIATE GOVERNMENTAL AGENCY] SHALL CONSULT WITH AND CONSIDER THE PRACTICES FOR FILING, PROCESSING, AND PAYING CLAIMS BY AGENCIES WITH SIMILAR AUTHORITY IN OTHER STATES.~~

~~LEGISLATIVE NOTES: THE BRACKETED TERM "OCCUPATIONAL DISEASE" SHOULD NOT BE USED IN STATES THAT DO NOT HAVE SPECIFIC OCCUPATIONAL DISEASE LAWS.~~

~~STATES SHOULD REVIEW THEIR WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE LAWS TO DETERMINE WHETHER THEY HAVE APPROPRIATE PROVISIONS FOR PROVIDING WAGE LOSS BENEFITS TO VOLUNTEER HEALTH PRACTITIONERS. IF NECESSARY, AN ADDITIONAL SUBSECTION CROSS REFERENCING SPECIAL PROVISIONS INCLUDED IN WORKERS' COMPENSATION LAWS FOR CALCULATING WAGE-LOSS BENEFITS FOR VOLUNTEERS, OR DESIGNATING HOW WAGE LOSS BENEFITS FOR VOLUNTEERS WILL BE DETERMINED, SHOULD BE ADDED TO THIS SECTION.~~

~~STATES SHOULD ALSO REVIEW THEIR WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE LAWS TO DETERMINE WHETHER CURRENT LAWS MAY PROVIDE MORE EXPANSIVE BENEFITS TO VOLUNTEERS THAN ARE OTHERWISE PROVIDED BY THIS ACT, SUCH AS BENEFITS FOR INJURIES OR DEATHS OCCURRING DURING DISASTER TRAINING OR DRILLS. IF CURRENT STATE LAWS PROVIDE MORE EXPANSIVE BENEFITS AND STATES WISH TO EXTEND SUCH BENEFITS TO VOLUNTEER HEALTH PRACTITIONERS UNDER THIS ACT, A PROVISION SHOULD BE ADDED TO THIS SECTION CONFORMING THE SCOPE OF BENEFITS AVAILABLE UNDER THIS ACT TO THOSE AVAILABLE UNDER THE OTHER LAWS.~~

~~**THIS SECTION DEFERS TO OTHER PROVISIONS OF STATE LAW TO DETERMINE WHETHER AND TO WHAT EXTENT THE OPTION TO ELECT WORKERS' COMPENSATION OR OCCUPATIONAL DISEASE BENEFITS CONSTITUTES THE EXCLUSIVE REMEDY AGAINST THE STATE FOR INJURIES OR DEATH THAT OCCURS WHEN ACTING AS A VOLUNTEER HEALTH PRACTITIONER IN THE STATE. IF EXISTING STATE LAWS DO NOT ADEQUATELY ADDRESS THIS TOPIC, STATES SHOULD CONSIDER WHETHER APPROPRIATE LANGUAGE CLARIFYING WHETHER AND TO WHAT EXTENT THESE BENEFITS CONSTITUTE AN EXCLUSIVE REMEDY SHOULD BE ADDED TO THIS SECTION.**~~

~~**SECTION 13. UNIFORMITY OF APPLICATION AND CONSTRUCTION. IN APPLYING AND CONSTRUING THIS UNIFORM ACT, CONSIDERATION MUST BE GIVEN TO THE NEED TO PROMOTE UNIFORMITY OF THE LAW WITH RESPECT TO ITS SUBJECT MATTER AMONG STATES THAT ENACT IT.**~~

~~**SECTION 14. REPEALS. THE FOLLOWING ACTS AND PARTS OF ACTS ARE REPEALED:**~~
~~**(1) .....**~~
~~**(2) .....**~~

~~**SECTION 15. EFFECTIVE DATE. THIS [ACT] TAKES EFFECT . . . .**~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; reaffirmed 2013; reaffirmed 2018)

Prior HOD action on similar or same topic:
H319-A/21 Good Samaritan Acts (Hold Harmless Agreement) Performed on Commercial Aircraft
H605-A/21 Disaster Relief Volunteers

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended____

DATE: ___July 22, 2023_____

SUBJECT: TIMELY POSTING OF MEETING AGENDAS/MATERIALS AND APPROVAL OF MEETING MINUTES – SOURCE: H351-A/18

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Committee on AOA Governance and Organizational Structure has reviewed the policy; now, therefore be it

RESOLVED, that the Committee on AOA Governance and Organizational Structure recommends that the following policy be REAFFIRMED.

Agendas and meeting materials for American Osteopathic Association (AOA) meetings will be sent to committee members and posted to a dedicated webpage on the AOA website at least ten (10) business days prior to the respective meeting. The minutes from AOA meetings will be submitted to the respective committee members for review and comment no later than ten (10) business days following the conclusion of the meeting. Committee members shall then review and provide feedback for AOA staff to incorporate and submit to the committee chair and/or vice chair within ten (10) business days. The committee chair and/or vice chair shall then have ten (10) business days to review and approve any revisions.

AOA staff shall then distribute revised minutes to committee members within ten (10) business days of their approval by the committee chair and/or vice chair, and then they shall be posted to a dedicated website accessible to members no later than ten (10) business days following final approval.

Meeting materials containing sensitive or confidential information may be redacted with the authorization of the appropriate bureau or committee chair and AOA legal counsel prior to being placed on the public website but shall never be redacted in the official minutes of record. No bureau or committee recommendations may be considered by any other AOA body until the minutes of the meeting have been finally approved. Note: “appropriate members” will be defined as members of the bureau, committee or board at the time the meeting was held; and that AOA staff leadership be held accountable by the AOA Board of Trustees for immediately, appropriately and consistently implementing this policy to promote organizational transparency and protect AOA volunteers in the performance of their fiduciary duties.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: SUNSET RESOLUTIONS – SOURCE: H364-A/18

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Committee on AOA Governance and Organizational Structure (CAGOS) has reviewed the policy; and

WHEREAS, CAGOS has provided modifications to ensure the policy reads correctly; now, therefore be it

RESOLVED, that the Committee on AOA Governance and Organizational Structure recommends that the following policy be REAFFIRMED AS AMENDED.

~~The American Osteopathic Association supports that when a sunsetting resolution is presented for review and is recommended for Disapproval, the submitting organization must offer a thorough explanatory statement as to the reason this recommendation is offered; and that the substitution of another resolution that is sunsetting the same year, that the current numbered resolution must be presented as opposed to the expiring year resolution; and that when a Sunsetting resolution is presented for review and recommended for disapproval based on the substitution of another resolution that has been enacted in another year and is not sunsetting, that the more current resolution and policy must be presented for easier review to make certain that the intent and policy are indeed being covered; and when there are recommendations made to alter or enhance, other than for spelling, grammar and clarification and all else of what would be considered "editorial", a resolution that is due for sunsetting and is being presented for approval, that a significant explanatory statement must be presented.~~

THE AMERICAN OSTEOPATHIC ASSOCIATION REVIEWS POLICY EVERY FIVE YEARS TO EITHER REAFFIRM, REAFFIRM WITH AMENDMENTS OR SUNSET THE POLICY. A THOROUGH EXPLANATORY STATEMENT AS TO THE REASON SUPPORTING THE DECISION SHOULD BE PROVIDED. POLICIES UNDER SUNSET REVIEW WILL RECEIVE A NEW RESOLUTION NUMBER PERTINENT TO THE YEAR OF REVIEW. IF APPROVED BY THE HOUSE OF DELEGATES, THE RESOLUTION NUMBER PROVIDED DURING THE YEAR OF REVIEW WILL BECOME THE NEW POLICY NUMBER. THE SOURCE CODE LISTED WITHIN THE TITLE WILL REFLECT THE CURRENT POLICY NUMBER UNDER REVIEW.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: WORKPLACE VIOLENCE AGAINST HEALTHCARE PROVIDERS

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Professional Affairs

WHEREAS, the definition of workplace violence as defined by the Occupational Safety and Health Administration (OSHA) is “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site;”[1] and

WHEREAS, the incidence of violence against healthcare workers has increased exponentially over the last five years, and further escalated in the era of the COVID pandemic[2],[3],[4],[5],[6],[7]; and

WHEREAS, there is correlation between decrease in physician and healthcare worker wellbeing (in the form of burn out, leaving one’s job, mental and physical decompensation) and an increase of the incidence of violence in the healthcare setting[8],[9],[10]; and

WHEREAS, the Joint Commission has published standards for hospitals for response to violence on healthcare workers[11],[12],[13]; and

WHEREAS, there remains an incomplete, disunited, and vague response to violence against physicians and other healthcare workers from healthcare systems, law enforcement, professional associations and politicians;[14] and

WHEREAS, our American Osteopathic Association (AOA) represents more than 168,000 osteopathic medical professionals across the United States by "advocating at the state and federal levels on issues that affect DOs and osteopathic medical students;"[15] and

WHEREAS, there is not unified language or policy in regards to a criminal response to workplace violence across the various States where osteopathic physicians practice; and

WHEREAS, "some States raise the offense from simple assault to aggravated assault depending on specific classes of persons (teachers or school employees, park district employees, police officers, and persons over age 60 according to some laws), and in some cases have upgraded assault charges from misdemeanor to felonies;"[16] and

WHEREAS, there is a precedent set of felonious charges against those who commit acts of violence against police officers and other public servants[17]; now therefore be it

RESOLVED, that ~~our~~ **THE** AOA ~~will formally adopt~~ **RE**~~-~~**AFFIRMS** the position that acts of violence against ~~healthcare workers~~ **PHYSICIANS,** ~~**AND THEIR**~~ **LEARNERS, STAFF AND HEALTHCARE WORKERS** should be prosecuted criminally as a felony across all states, territories, provinces, where osteopathic physicians practice; and be it further

RESOLVED, that ~~our~~ **THE** AOA ~~will~~ ~~not only~~ ~~**NOT ONLY**~~ support**S** ~~current~~ ~~**CURRENT**~~ legislation in line with the position that acts of violence against ~~healthcare workers~~ **PHYSICIANS,** ~~**AND THEIR**~~ **LEARNERS, STAFF AND HEALTHCARE WORKERS** should be prosecuted criminally as a felony across all **JURISDICTIONS** ~~states, territories, provinces~~, where osteopathic physicians practice, ~~but~~ ~~**ALSO WILL SUPPORT EFFORTS MADE**~~ ~~will actively lobby at the state and/or federal level for the adoption of uniform policy across all states where osteopathic physicians practice~~; and be it further

~~RESOLVED, that our AOA form a task force with a specific duty to create rhetoric and legislation to be lobbied at the state and/or federal level in support of the position that acts of violence against healthcare workers~~

~~should be prosecuted criminally as a felony across all states, territories, provinces, where osteopathic physicians practice, for the pursuit of increased protection of healthcare workers; and be it further~~

RESOLVED, that ~~our~~ **THE** AOA will ~~actively reduce~~ **OPPOSE** stigma**TIZING PHYSICIANS, ~~AND THEIR~~ LEARNERS, STAFF** ~~against~~ **AND ~~OTHER~~ HEALTHCARE WORKERS** ~~healthcare workers from~~ **WHO** speak~~ing~~ out against workplace violence in the healthcare environment ; and be it further

RESOLVED, that ~~our~~ **THE** AOA ~~**pledge**~~ **ACKNOWLEDGE** that the threat against physician well being, in the form of workplace violence, is a threat against the healthcare system, and therefore society as a whole.

References

[1] https://www.osha.gov/healthcare/workplace-violence

[2] "Health workers become unexpected targets during COVID-19," The Economist. May 11, 2020. https://www.economist.com/international/2020/05/11/health-workers-become-unexpected-targets-during-covid-19.2022

[3] https://www.nytimes.com/2020/04/27/world/americas/coronavirus-health-workers-attacked.html. Accessed Oct 2, 2020.

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[5] "Attacks on health care in the context of COVID-19." World Health Organization. July 30, 2020.

[6] https://jamanetwork.com/journals/jama/fullarticle/276929.

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[8] Peng, L., Xing, K., Qiao, H., Fang, H., Ma, H., Jiao, M., ... Kang, Z. (2018). Psychological violence against general practitioners and nurses in Chinese township hospitals: incidence and implications. Health and quality of life outcomes, 16(1), 117. https://doi. org/10.1186/s12955-018-0940-9.

[9] "Burnout in physicians who are exposed to workplace violence" Hacer, T and Ali, A. Journal of Forensic and Legal Medicine Vol 69, January 2020 https://doi.org/10.1016/j.jflm.2019.101874. (https://www.sciencedirect.com/science/article/pii/S1752928X19301106)

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[11]"Some public health officials are resigning amid threats during the Covid-19 pandemic." CNN. June 23, 2020. https://www.cnn.com/2020/06/22/us/health-officials-threats-coronavirus/index.html.

[12]https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/

[13] "Prevalence of workplace violence against healthcare workers: a systemic review" Liu K, Gan Y, Kian H et al. Occup Environ Med 2019; 76: 927-937
[14] https://www.findlaw.com/legalblogs/criminal-defense/is-it-a-felony-to-hit-or-assault-a-nurse/
[15] https://osteopathic.org/about/
[16] RES. NO. H-647-A/2015 Author Dr. Mehrdod Ehteshami & Georgia Osteopathic Association
[17] https://www.law.cornell.edu/uscode/text/18/111

Background Information: Provided by AOA Staff

Current AOA Policy: H324-A/20 Violence Against Healthcare Staff

AOA policy supports legislation to hold patients and their associates accountable for physical assault and verbal threats to health care staff by upgrading penalties under federal and relevant state law and legislation from misdemeanors to felonies where applicable.

For several Congresses, the AOA Public Policy team has been and continues to be active on this issue. The AOA's support and advocacy were instrumental in the passage of the Workplace Violence Prevention for Health Care and Social Service Workers Act in the House of Representatives last Congress.

After its House passage, the AOA led the effort in partnering with 44 osteopathic state and specialty affiliates on a letter encouraging Senate leadership to take similar action.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: ~~$160,000 Annual Expense~~

~~The fiscal impact includes the hiring of a full-time employee for state and federal to "actively lobby" for this issue as well as the creation of a task force.~~

ACTION TAKEN __Adopted as Amended__

DATE ____July 22, 2023_____

SUBJECT: ~~AOA SUPPORT FOR THE FAIR ACCESS IN RESIDENCY (FAIR) ACT, H.R. 751~~ **AOA SUPPORT FOR GME EQUITY**

SUBMITTED BY: Virginia Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Osteopathic medicine is the fastest growing field in the US, representing more than 11% of US physicians, and Colleges of Osteopathic Medicine currently educate more than 35,000 physicians, 25% of all US medical students[1]; and

WHEREAS, The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) is the licensing exam series required by the Commission on Osteopathic College Accreditation (COCA) to be taken by all osteopathic (DO) medical students in order to graduate from COCA-accredited medical schools[2]; and

WHEREAS, The United States Medical Licensing Examination (USMLE) is the licensing exam series taken by all allopathic (MD) medical students[3]; and

WHEREAS, The COMLEX-USA and USMLE are equivalent medical licensing exams, supported by published predictive validity and score concordance studies[4]; and

WHEREAS From 2015 to 2020, residency training was consolidated under a single accreditor, the Accreditation Council for Graduate Medical Education (ACGME) for all US residency and fellowship programs[5]; and

WHEREAS The percentage of DOs matching to their preferred surgical specialties has declined since single accreditation[6]; and

WHEREAS, According to the 2022 National Residency Matching Program survey, 32% of Residency Program Directors reported never (7%) or seldom (25%) interviewing DO seniors[7]; and

WHEREAS, For residency programs that do interview DOs, 56% require the USMLE[7]; and

WHEREAS, ACGME does not specify the licensing exams that residency applicants must take to be eligible for appointment in ACGME-accredited residency programs [8]; and

WHEREAS, In 2020 it was reported that approximately 60% of osteopathic medical students took at least one portion of the USMLE[9]; and

WHEREAS, DO students who take the USMLE spend an additional $2,235 in exam fees and 32 hours of exam time per student[10]; and

WHEREAS, Licensing examinations increase rates of stress, anxiety and depression among medical students, placing significant hardships on DO students who complete both the COMLEX-USA and USMLE[11]; and

WHEREAS, These exclusionary and burdensome requirements on DOs impact specialty choices of osteopathic medical students and exacerbate physician workforce shortages, particularly in rural and underserved communities; and

WHEREAS, Medicare accounts for 71% of Graduate Medical Education (GME) funding totaling over $10 billion annually[12]; and

WHEREAS, The Fair Access In Residency (FAIR) Act, H.R. 751, requires Medicare-funded GME programs, as a condition for participation, to report annually the number of residency applicants and acceptances from osteopathic and allopathic medical schools[13]; and

WHEREAS, The FAIR Act requires residency programs to affirm annually that they accept applications from osteopathic and allopathic medical schools, and that if an examination score is required for acceptance, the COMLEX-USA and USMLE will be ~~equally~~ **EQUITABLY** accepted[13]; and

WHEREAS, The FAIR Act [13] aims to reduce barriers and promote equality of opportunity for DO students and ensure that the nation is leveraging all available physicians to support access to healthcare; now, therefore be it

RESOLVED, THAT THE AOA SUPPORTS NON-LEGISLATIVE, PROPERLY VETTED LEGISLATIVE AND REGULATORY AND OTHER PUBLIC POLICY SOLUTIONS THAT ASSURE GME EQUITY FOR OSTEOPATHIC MEDICAL STUDENTS AND ALSO ASSURE UNIVERSAL ACCEPTANCE OF APPLICATIONS FROM QUALIFIED OSTEOPATHIC MEDICAL STUDENTS AND UNIVERSAL ACCEPTANCE OF COMLEX WHEN A TEST SCORE IS REQUIRED BY A GME PROGRAM; AND, BE IT FURTHER

RESOLVED THAT THE AOA BOARD OF TRUSTEES REPORT BACK SEMI-ANNUALLY TO THE MEMBERS BEGINNING WITH THE MIDYEAR MEETING ON THE PROGRESS THAT HAS BEEN MADE TO ASSURE EQUITY EXISTS FOR OSTEOPATHIC GRADUATES TO ENTER RESIDENCY PROGRAMS IN ALL FIELDS OF MEDICINE AND SURGERY.

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
Resolution H321-A/19 Recognition of COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs was approved for action

AOA promotes parity between osteopathic and allopathic medical students, residents, and physicians among residency program directors; and collaboration with AACOM, NBOME, AMA, ACGME, and all other appropriate parties, to educate residency program directors on the interpretation of COMLEX-USA score with the understanding that the COMLEX-USA is the most appropriate standardized exam to evaluate the competency of an osteopathic medical student.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_____

DATE: _____July 22, 2023_____

SUBJECT: ~~REINSTATEMENT OF ANNUAL BOARD CERTIFICATION~~ **NON-AOA MEMBER CME SERVICES AND ACTIVITY** FEE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, an annual AOA board certification fee has been required for all diplomates since at least 1986; and

WHEREAS, AOA terminated the annual board certification fee for the period from June 1, 2019, through May 31, 2022, as part of the class action settlement; and

WHEREAS, the settlement further stipulated that the AOA has the right to reinstate an annual board certification fee any time after May 31, 2022, if so determined by the AOA House of Delegates; and

WHEREAS, currently non-members do not have access to self-report their CME activities and must email all CME to AOA staff which is manually entered; and

WHEREAS, non-members can purchase a paid subscription to AOA CME Portal to self-report CME and access their AOA CME Activity Report; and

WHEREAS, access to free and discounted CME activities, CME self-reporting, the AOA CME Activity Report, and emailing CME activities to AOA for staff entry are AOA member benefits; and

WHEREAS, at the direction of the AOA Board of Trustees and the Finance Committee, AOA staff analyzed the direct and indirect costs of certification maintenance; and

WHEREAS, these costs include state medical license verification, staff entry of CME activities for diplomates, verification of specialty board CME requirements, certification database maintenance, and customer service; now, therefore be it

RESOLVED, that the ~~AOA~~ annual ~~board certification~~ **NON-AOA MEMBER CME SERVICES AND ACTIVITY** fee be ~~reinstated at~~ an amount determined by the AOA Board of Trustees starting in 2024; and, be it further

RESOLVED, that the annual ~~board certification~~ **NON-AOA MEMBER CME SERVICES AND ACTIVITY** fee is waived for regular AOA members; and, be it further

30 RESOLVED, that the annual ~~board certification~~ **NON-AOA MEMBER CME**
31 **SERVICES AND ACTIVITY** fee be part of the CME Portal subscription fee;
32 and, be it further

33 RESOLVED, that all AOA diplomates have access to self-report their CME
34 activities.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $900,000 Annual Revenue
Based on the number of non-members who have active AOA board certification, we anticipate an additional $900,000 in revenue annually.

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: ADVOCATE CONGRESS TO CLOSE THE TITLE IV LOOPHOLE THAT HAS BEEN USED TO ENABLE FUNDS TO COVER THE COST OF ATTENDANCE AT FOR PROFIT MEDICAL SCHOOLS THAT WOULD OTHERWISE BE INELIGIBLE

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are a number of strategies used by for-profit offshore medical schools that take advantage of loopholes that are intended to address economic needs of students attending programs of higher education; and

WHEREAS, according to Chronicle of Higher Education for-profit Caribbean medical schools have been exploiting a loophole in the U.S. federal student-aid system to obtain funding for which they would not otherwise be eligible, and.

WHEREAS, some offshore medical schools encourage students to concurrently enroll in secondary, and often unnecessary, degree programs at online American universities that are approved to participate in the Title IV system and to borrow the maximum allowed amount in federal loans and to use that money to pay for both programs, and

WHEREAS, this workaround was uncovered by the Postsecondary Equity and Economics Research or (PEER) Project[i], a public-interest research group started by academics at Columbia and George Washington Universities and lawyers at the National Student Legal Defense Network[ii]; and

WHEREAS, they publish this activity in a recent report "The Hidden Loophole: How Predatory Offshore Medical Schools are Partnering with U.S. Universities to Access Federal Student Aid Funds"[iii] ; and

WHEREAS, at least 18 Caribbean medical schools and two American online providers, Franklin and Walden Universities, have been part of the concurrent-enrollment partnership, which has been around for a decade; and

WHEREAS, in the aforementioned report, it is noted that none of the students interviewed by the PEER Project had received a degree, either from the medical schools or the online universities; and

WHEREAS, Caribbean medical schools often cater to American students who are unable to gain admission to American medical schools. The schools have offices in the United States, but many do not meet eligibility requirements to participate in the Title IV federal-aid program because of poor job-placement

results and subpar passage rates on medical-licensure exams, among other factors. They are also not subject to American regulatory oversight or accreditation by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA); and

WHEREAS, although the cost of attendance at Title IV-ineligible medical schools is typically less than at their eligible peer institutions — average tuition and fees at ineligible Caribbean medical schools is $109,100 — they can be costly for students who have to pay out of pocket or take out private loans; and

~~WHEREAS, students interviewed for the report informed the author, Angela Moats, that the online universities set up tables or hosted pizza lunches at the medical schools to market the program. Others were told about it by their medical-school financial-aid office; and~~

WHEREAS, many of the secondary degrees were in health-care management or administration, which are not necessary for practicing medicine, and in some cases, students were borrowing for additional bachelor's degrees; and

WHEREAS, the online programs benefited from additional students' enrolling in one or two courses a semester, while the medical schools were able to get federal-aid funds. "The Department of Education essentially helped keep them afloat,"; and

~~WHEREAS, "To be clear, concurrent enrollment was presented to students not as an academic option but for financial-aid purposes," said Libby DeBlasio Webster, co-director of the PEER Project and senior counsel at the network. Medical students approached the researchers after the network filed a federal civil-rights lawsuit against one of the online universities, Walden University; and~~

WHEREAS, Federal regulations don't explicitly forbid concurrent-enrollment plans, although it is illegal for colleges to tell prospective students that they can use federal student-aid dollars to pay tuition for a second-degree program at an ineligible institution. ~~Moats and Webster stated that they hoped the Department of Education would review Title IV regulations to close the loophole;~~ now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with the American Medical Association (AMA) and other interested stakeholders to advocate for congressional oversight of the misuse of Title IV funding by for-profit offshore medical schools (which would otherwise be ineligible for such funding) through any partnership, affiliation or other type of arrangement with a Title IV-eligible institution. The oversight would expressly prohibit and prevent the use of funds granted in an application to be used for any

68 purposes, including but not limited to tuition, transportation, or cost of
69 attendance at an institution not identified in the primary application.

References

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2. https://www.defendstudents.org/
3. chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.peerresearchproject.org/peer/research/body/PEER_Hidden_Loophole_D.pdf

Background Information: Provided by AOA Staff

Current AOA Policy:

H302-A/20 Protecting American Students from Profit-Driven Foreign Medical Schools

AOA policy states that federal student loans shall be restricted from medical schools not subject to the accreditation standards of the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education.

Past actions on this issue includes AOA's support for the Foreign Medical School Accountability Fairness Act, which would extend current standards on student-body enrollment and pass rates for U.S.-based medical schools to all medical schools outside of the U.S. and Canada that receive federal funding.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

AMERICAN OSTEOPATHIC ASSOCIATION

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (400 SERIES) -w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Breastfeeding Mothers – Protecting (SR-Source:H426-A/18)	BFHP	Public Affairs	Adopted
H-401	**PROTECTING PATIENTS FROM SEXUAL ABUSE IN THE HEALTHCARE SETTING** ~~American Osteopathic Association Makes Public Statement and Develops Protocols To Prevent Sexual Abuse of Patients~~ (SR-Source:H427-A/18)	BORPH	Public Affairs	Adopted as Amended
H-402	Breastfeeding Exclusivity (SR-Source:H425-A/18)	BORPH	Public Affairs	Adopted as Amended
H-403	Cervical Cancer, Screening for (SR-Source:H405-A/18)	BORPH	Public Affairs	Adopted as Amended
H-404	Choosing Wisely Campaign (SR-Source:H404-A/18)	BORPH	Public Affairs	Adopted as Amended
H-405	Concerns in Homeless Population (SR-Source:H428-A/18)	BORPH	Public Affairs	Adopted as Amended
H-406	Disaster Preparedness Planning (SR-Source:H417-A/18)	BORPH	Public Affairs	Adopted as Amended
H-407	Energy Drinks (SR-Source:H422-A/18)	BORPH	Public Affairs	Adopted
H-408	Environmental Health (SR-Source:H402-A/18)	BORPH	Public Affairs	Adopted
H-409	Fire Prevention – Teaching of (SR-Source:H408-A/18)	BORPH	Public Affairs	Adopted
H-410	Gambling Disorder (SR-Source:H401-A/18)	BORPH	Public Affairs	Adopted
H-411	Healthy Lifestyles (SR-Source:H406-A/18)	BORPH	Public Affairs	Adopted as Amended

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2023 RESOLUTION ROSTER (400 SERIES) -w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-412	Healthy People **2030** ~~2020~~ (SR-Source:H409-A/18)	BORPH	Public Affairs	Adopted as Amended
H-413	Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of (SR-Source:H424-A/18)	BORPH	Public Affairs	Referred to BORPH
H-414	Immunizations (SR-Source:H411-A/18)	BORPH	Public Affairs	Adopted
H-415	Medication Take-Back Program (SR-Source:H407-A/18)	BORPH	Public Affairs	Adopted
H-416	"Opioid Overdose" Deaths in America – Epidemic (SR-Source:H423-A/18)	BORPH	Public Affairs	Adopted as Amended
H-417	Osteopathic Manipulative Treatment of Somatic Dysfunction of the Head, Safety in (SR-Source:H420-A/18)	BORPH	Public Affairs	Adopted as Amended
H-418	Patient Education (SR-Source:H412-A/18)	BORPH	Public Affairs	Adopted as Amended
H-419	Policy Statement on End-of-Life Care - Referred Sunset Res. No. H424-A/2022 (SR-Source:H438-A/17)	BORPH	Public Affairs	Adopted as Amended
H-420	Pediatric Medical Imaging (SR-Source:H416-A/18)	BORPH	Public Affairs	Adopted
H-421	Pediatric Obesity (SR-Source:H419-A/18)	BORPH	Public Affairs	Adopted as Amended
H-422	Tuberculosis Medical Training (SR-Source:H415-A/18)	BORPH	Public Affairs	Adopted
H-423	Distracted Driving (SR-Source:H418-A/18)	CSHA	Public Affairs	Adopted
H-424	Artificial Intelligence in Health Care – Task Force	MAOPS	Public Affairs	Adopted as Amended
H-425	Recognizing the Issue of Weight Bias in Healthcare	OPSC	Public Affairs	Adopted as Amended
H-426	Osteopathic Medicine is High-Value Care	OPSC/MOMA	Public Affairs	Adopted
H-427	Voter Registration as a Social Determinant of Health	SOMA	Public Affairs	Not Adopted

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (400 SERIES) -w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-428	Amendment to H444-A/20 “Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders”	SOMA	Public Affairs	Adopted as Amended
H-429	Supporting Access to Over-the-Counter Oral Contraceptive Pills	SOMA	Public Affairs	Adopted as Amended

SUBJECT: BREASTFEEDING MOTHERS – PROTECTING
-SOURCE: H426-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports legislation protecting the rights of
7 breastfeeding mothers.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008 Amended; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: **PROTECTING PATIENTS FROM SEXUAL ABUSE AND MISCONDUCT** ~~**IN THE HEALTHCARE SETTING** American Osteopathic Association Makes Public Statement and Develops Protocols to Prevent Sexual Abuse of Patients~~ SOURCE: H-427-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association support**S IMPLEMENTATION OF**
9 ~~development of a toolkit with templates of~~ comprehensive uniform protocols for
10 adoption by **ALL** ~~osteopathic~~ **HEALTHCARE** institutions and organizations to
11 protect patients from **SEXUAL ABUSE AND MISCONDUCT** ~~abuse; and to be~~
12 ~~implemented~~ so that suspected violations are investigated and appropriately
13 referred to legal authorities for prosecution when appropriate.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

The AOA and other organizations are addressing this issue. In 2017, the American Academy of Osteopathy adopted a position paper on Recommended Guidelines for Pelvic Examination and Treatment. The guidelines address Informed Consent, Modesty and Comfort, Pelvic Examinations, Osteopathic Indications, and Documentation. https://www.academyofosteopathy.org/assets/docs/PelvicExaminationAndTreatment2.pdf

In May 2017, the Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Sexual Misconduct. AOA Board of Trustee Member Teresa A. Hubka, DO represented the AOA on this workgroup. The Report and Recommendations of the workgroup were adopted as policy by the FSMB in May 2020. https://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf

In January 2018, the AOA made a public statement on sexual abuse of patients related to the Larry Nassar case. AOA President Mark A. Baker, DO, sent a letter to AOA members and affiliates. The letter was also published in The DO. https://thedo.osteopathic.org/2018/01/aoa-president-mark-baker-responds-larry-nassar-case/

The AOA will continue to monitor this issue. Possible tactics to be executed but not limited to include making and disseminating public statements, supporting the position of profession-related organizations, as well as participating with AOA leadership representation in official workgroups or organized committees.

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: BREASTFEEDING EXCLUSIVITY- SOURCE:H-425-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports dissemination of information by practicing physicians about the health benefits associated with the duration and exclusivity of breastfeeding for six months. Additionally, ~~in harmony with the Centers for Disease Control and Prevention, American Academy of Pediatrics, and American Academy of Family Physicians,~~ the encouragement of breastfeeding should continue while adding complementary solid foods for at least one year.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H416-A/22 Promotion Protection and Support of Breastfeeding
H331-A/21 Support of Breastfeeding

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: CERVICAL CANCER, SCREENING FOR – SOURCE:H-405-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association encourages all osteopathic physicians and
7 students to continue to educate themselves and their patients on current guidelines
8 related to cervical cancer screening using the Pap and/**OR** HPV testing.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: CHOOSING WISELY CAMPAIGN - SOURCE:H-404-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) endorses the spirit of the "Choosing
9 Wisely Campaign" to help disseminate information and education to patients and
10 health care providers to make prudent decisions in the evaluation and management
11 of medical conditions. ~~t~~The AOA also supports a higher level of commitment to
12 increasing the evidence base for the effectiveness of osteopathic manipulative
13 treatment with the ultimate goal of submitting it to be included in the campaign.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: CONCERNS IN **PEOPLE WITH HOUSING INSECURITY** ~~HOMELESS POPULATION~~ – SOURCE:H-428-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) encourage**S** all physicians to partner with their communities ~~to understand barriers to health, and advocate~~ to improve access to healthcare for people experiencing **HOUSING INSECURITY** ~~homelessness~~. ~~; and the~~ **THE AOA** support**S**, through education and advocacy, **THE** dissemination of social and health related resources and programs that serve ~~**HOMELESS**~~ individuals and families **WITH HOUSING INSECURITY**. ~~experiencing a homeless situation and their care providers; and~~ **THE AOA** ~~advocate, promote, and~~ support**S** programs that ensure delivery of primary and preventive healthcare to all underserved populations, including those experiencing **HOUSING INSECURITY.**~~homelessness.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic:
H449-A/20 Homeless Support

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: DISASTER PREPAREDNESS PLANNING – SOURCE: H-417-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports the Centers for Disease Control and Prevention's (CDC) Centers for Public Health Preparedness programs established to strengthen **PREPAREDNESS FOR** terrorism and **OTHER** emergenc**IES**~~y~~ ~~preparedness~~ by linking academic expertise to state and local health agency needs, including programs that focus on vulnerable populations such as, but not limited to, pregnant women, new mothers, infants, and the elderly.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H212-A/21 Disaster Response Courses and Training Within Colleges of Osteopathic Medicine
H605-A/21 Disaster Relief Volunteers

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: __July 22, 2023_____

SUBJECT: ENERGY DRINKS – SOURCE:H-422-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports community awareness and
7 education regarding the effects and potential dangers of consuming energy drinks,
8 and encourages physicians to screen for the use of energy drinks.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: ENVIRONMENTAL HEALTH - SOURCE: H-402-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association strongly encourages the federal government
7 to increase its efforts to promote standards which will prevent human suffering and
8 death from environmental threats and hazards; and reaffirms its commitment to
9 support governmental agencies' efforts in eradicating environmentally related health
10 risks.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1970; 1978 Reaffirmed as Amended; 1983 Reaffirmed; 1988 Reaffirmed as Amended; 1993 Reaffirmed; 1998 Reaffirmed as Amended, 2003; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H417 - A/20 Environmental Responsibility - Waste Materials

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: FIRE PREVENTION – TEACHING OF - SOURCE:H-408-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports fire prevention education.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1988; 1993 Reaffirmed as Amended, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 22, 2023_____

SUBJECT: GAMBLING DISORDER - SOURCE: H-401-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports research on gambling disorder.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: HEALTHY LIFESTYLES - SOURCE: H-406-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association promotes guidelines for healthy lifestyles **AND RECOGNIZES THE IMPORTANCE OF COLLABORATION ON THIS TOPIC AMONG SPECIALTIES AND NATIONAL ORGANIZATIONS.** ~~and will continue to work with Congress and related state and federal health care agencies to develop those guidelines.~~ A healthy lifestyle includes healthy eating, regular exercise and maintaining a healthy weight. Healthy eating is **CONSUMING A DIET RICH IN WHOLE, MINIMALLY PROCESSED FOODS.** ~~based on a diet rich in fruits and vegetables, with limited intake of fat, sugar and salt.~~ A healthy lifestyle eliminates the use of tobacco and illicit drugs, **AVOIDS THE MISUSE OF PRESCRIPTION MEDICATIONS,** and limits alcohol intake. A healthy lifestyle also includes proper care for mental health, **ADEQUATE SLEEP, STRESS MANAGEMENT** and encourages connection with one's community.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed as Amended, 2002; 2007; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H424 - A/20 Healthy Family, Support of
H320 - A/19 Healthy Weight for Families

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: HEALTHY PEOPLE **2030** ~~2020~~ — SOURCE:H-409-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association supports "Healthy People ~~2020~~ **2030**"
WHICH INCLUDES THE FOLLOWING OBJECTIVES:

1. HEALTH CONDITIONS
2. HEALTHY BEHAVIORS ~~POPULATIONS~~
3. HEALTHY POPULATIONS
~~3~~ 4. SETTINGS AND SYSTEMS
~~4~~ 5. SOCIAL DETERMINANTS OF HEALTH

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008; 2013 Referred for review and comment; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended

DATE: ____July 22, 2023_____

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING – CLINICAL AND PUBLIC HEALTH APPLICATION OF - SOURCE: H-424-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the American College of Osteopathic Obstetricians and Gynecologists have reviewed this policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports widespread application of HIV testing in the clinical setting particularly for those at risk for HIV infection as determined by physician evaluation; supports continued anonymous testing and counseling programs in public health facilities to maximize individual participation; supports mandatory HIV testing only for source patients, in cases of rape or incest, or in cases of an accidental exposure in patients who are at risk for HIV/AIDS; and supports the following recommendation of the American College of Osteopathic Obstetricians and Gynecologists.

A. Healthcare Workers

1. Healthcare workers have a minimal risk of acquiring HIV infection from patients; however, this risk is much greater than the extremely remote possibility of transmission to patients.

2. Properly used universal precautions are effective in the prevention of transmission of bodily fluids between healthcare workers and patients and diminish the risk of infection. Serologic testing of patients and/or healthcare workers for the purposes of infection control does not prevent the transmission of HIV infection nor enhance the effectiveness of universal precautions. The AOA supports and encourages patients who know they are HIV positive to inform their physician that they are HIV positive prior to receiving medical care.

3. The AOA opposes mandatory testing of patients and healthcare workers as there is no scientific data supporting the efficacy of such testing in the prevention of HIV transmission in the healthcare setting. Should any state or the federal government legislate mandatory HIV testing for any group, the AOA is opposed to any such legislation which does not include the entire population because such legislation

discriminates against certain groups. The AOA affirms the right of HIV-infected individuals to practice their occupations in a manner which does not present any identifiable risk of transmission of disease and pledges itself to promote the ability of these individuals to continue productive careers so long as they can do so responsibly and safely.

4. The AOA supports programs for effective education and implementation of universal precautions in all healthcare settings.

B. Public and Patient Education

1. Although studies have demonstrated an improved awareness of HIV infection and its modes of transmission, myths and misconceptions persist.

2. The AOA supports public education programs that provide accurate, up-to-date and clearly stated information regarding HIV transmission. The AOA urges increased governmental appropriations for implementing public health measures to assist in halting the increasing incidence of HIV and AIDS.

3. Primary care physicians occupy a central role in education of patients regarding preventative healthcare in general and are in an ideal position to serve a central role in HIV prevention.

4. The AOA encourages all osteopathic physicians to be knowledgeable in HIV risk evaluations and to incorporate candid and nonjudgmental assessment of related risk behaviors in routine patient care.

C. Medical Education

1. Osteopathic medical students and physicians in training are particularly vulnerable to the socioeconomic consequences of occupationally acquired HIV infection. The osteopathic profession bears a unique responsibility to provide for their maximum protection and social wellbeing.

All osteopathic medical schools and postdoctoral training programs should make available: life, health and disability insurance including coverage for occupationally acquired HIV infection; effective education and training in AIDS, infection control and universal precautions. 1991; revised 1992; reaffirmed 1997, revised 2003; reaffirmed 2013

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1991; revised 1992; reaffirmed 1997, revised 2003; reaffirmed 2013; reaffirmed 2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to BORPH___

DATE: ___July 22, 2023_____

SUBJECT: IMMUNIZATIONS - SOURCE: H-411-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the Centers for Disease Control
7 and Prevention in its efforts to achieve a high compliance rate among infants,
8 children and adults by encouraging osteopathic physicians to immunize patients of
9 all ages when appropriate; supports the HHS National Vaccine Implementation
10 Plan; and encourages third-party payers to pay for vaccines and their
11 administration.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H411 - A/22 Meningococcal Vaccine Recommendations
H402 - A/20 Public Education Regarding the Importance and Safety of Vaccines for Infants, Children and Adults
H407 - A/20 Vaccines for Children Program
H425 - A/20 Immunization of 9 to 26 Year Old Male and Females with Human Papilloma Virus Vaccine
H417- A/19 Vaccines

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 22, 2023____

SUBJECT: MEDICATION TAKE-BACK PROGRAM - SOURCE: H-407-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the national prescription drug take-
7 back day that aims to provide a safe, convenient and responsible means of
8 disposing of prescription drugs, while also educating the general public about the
9 potential for abuse of medications; and encourages its state associations and local
10 agencies to sponsor take-back medication days on a frequent basis but at least
11 annually.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 22, 2023_____

SUBJECT: "OPIOID OVERDOSE" DEATHS IN AMERICA – EPIDEMIC
-SOURCE: H-423-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association ~~recommends systematic evaluation of~~ **SUPPORTS** ~~all available~~ interventions to prevent opioid overdose deaths including patient education **TREATMENT OF OPIOID USE DISORDER (OUD) WITH FDA APPROVED MEDICATIONS,** and the normalization of take-home Naloxone **FOR OVERDOSE REVERSAL**.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H322-A/22 Naloxone and other Opioid Antagonists
H-632 – A/18 Increasing the Education and Preventative Prescribing of Naloxone use for Opioid Overdose

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT OF SOMATIC DYSFUNCTION OF THE HEAD, SAFETY IN - SOURCE: H-420-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association ~~promotes~~ **SUPPORTS** public awareness of the complexity and vulnerability of the human central nervous system~~;~~ ~~promotes public awareness for~~ **AND** the safe intervention of physical forces to the head by the educated hands of a trained osteopathic physician~~;~~. ~~advocates~~ **THE AOA SUPPORTS** full disclosure to patients of all requirements for accredited education, qualifying training, and licensure of AOA recognized medical treatments including osteopathic manipulative treatment of the head~~; AND promotes~~ **AND ENCOURAGES** health care laws which support~~s~~ the teaching of medical interventions to fully qualified professionals~~;~~. **THE AOA** ~~holds the position~~ **BELIEVES** that medical licensure is the most appropriate foundation for the practice of osteopathic medicine and surgery, including osteopathic manipulative treatment of somatic dysfunction of the head ~~including~~ **AND** osteopathic cranial manipulative medicine~~;~~.**THE AOA** ~~and~~ believes that the practice of OMT ~~of~~ **FOR** somatic dysfunction of the head and osteopathic cranial manipulative medicine requires a professional clinical diagnosis, complete medical treatment plan, professional ethics, and appropriate follow-up care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 22, 2023

SUBJECT: PATIENT EDUCATION - SOURCE: H-412-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association ~~reaffirms its commitment to~~ **SUPPORTS** the
9 advancement of patient education to promote a better understanding of personal
10 health and wellness.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1983,1988 Reaffirmed as Amended,1993,1998, 2003, 2008, 2013 Reaffirmed, 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: REFERRED SUNSET RES. NO. H-424-A/22 POLICY STATEMENT ON END OF LIFE CARE - SOURCE: H438-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, in 2022 the AOA House of Delegates referred Sunset Res. No. H-424-A/2022 Policy Statement on End of Life Care to the Bureau on Osteopathic Research and Public Health; now, therefore be it;

RESOLVED, that the white paper titled End of Life Care Policy Statement be reaffirmed as amended.

The American Osteopathic Association approves the white paper on end of life care and

- encourages all osteopathic physicians to **BE FAMILIAR WITH** ~~maintain competency in~~ end of life care ~~through educational programs such as the web-based osteopathic Education for Professionals on End of Life Care (Osteopathic EPEC) modules;~~
- supports the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end of life issues;
- urges osteopathic medical schools, and appropriate training programs to support innovative approaches to instruction in geriatric medicine and end of life care;
- encourages all osteopathic physicians to stay current with their individual state statutes on end of life care;
- supports public policies which upholds a patient's right to a "Do Not Attempt Resuscitation" (DNAR) and/or ~~a~~Allow ~~n~~Natural ~~d~~Death (~~and~~AND) designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or Durable Medical Power of Attorney (DMPOA);
- encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions;
- will work to implement policies to ensure **ACCESS TO** hospice and palliative services for all individuals, including the developmentally challenged, children, and other special populations **REGARDLESS OF INSURANCE STATUS**;
- ~~and urges that~~ **ENCOURAGES** osteopathic physicians **TO** recognize the importance of cultural diversity in perspectives on death, suffering, bereavement and rituals at the end of life, and incorporate cultural assessment into their comprehensive evaluation of the patient and family; **AND**

- ~~the AOA~~ will work to identify sources of culturally appropriate information on advance directives, palliative care, and end of life ethical issues in populations served by osteopathic physicians.

AMERICAN OSTEOPATHIC ASSOCIATION END OF LIFE CARE WHITE PAPER

The osteopathic approach to care can be particularly beneficial at the end of life. Attending to the patient and family holistically is a key principle of osteopathic medicine. Osteopathic palliative care improves the quality of life of patients and their families facing serious illness, through prevention and relief of physical, psychosocial and spiritual suffering. Osteopathic palliative care utilizes many modalities of treatment including osteopathic manipulative medicine.

End of life decisions should be the result of the collaboration and mutual informing of the patient, the patient's **SELF-DEFINED** family and health care professionals, each sharing his or her own expertise to help the patient make the best possible decision.

Adults with decision-making capacity should be informed of their choices and that they have the legal and ethical right to make their own decisions about their end of life care, including the right to receive or refuse recommended life-sustaining or life-prolonging medical treatment. This position honors the patient's autonomy and liberty as guaranteed in the United States Constitution and the Patient Self-Determination Act. This right exists even when the physician disagrees with the patient's decisions.

Patients without decision-making capacity have the right to assurance that their previously executed instructive advance directives, such as living wills, proxy directives (Durable Medical Power of Attorney -DMPOA) and Physician Orders for Life Sustaining Treatment (POLST) will be honored to guide others in delivering their health care. It should be noted that the term "physician" may also mean "medical" in this context. Advance directives delineate treatment options selected by an individual and enable decisions to be made by reviewing these documented wishes. The principle of "substituted judgment" allows for a proxy to speak for an individual who is unable to do so, based upon close personal knowledge of the incapacitated person. The principle of "best interests" (what the reasonable and informed patient would select) is invoked if the individual's wishes are not known. The over-riding issue is not what the family or friends want for the patient at end of life, but rather what would the patient want for himself or herself. If the patient were to awaken and be able to fully understand the circumstances, what decisions would the patient make? If the answer is clear, it is unethical, except in extraordinary circumstances, not to follow the patient's wishes.

Creating **advance directives** (living wills or designating a Durable Medical Power of Attorney) is to be encouraged IN advance of a life threatening situation with the assistance of trusted professionals. Persons holding the DMPOA/legally designated proxy should make decisions in accordance with the patient's previously expressed preferences. Living wills document the desired treatments but leave much room for interpretation when the situation doesn't match the directives, so a combination may be best. If no DMPOA/legally designated proxy has been selected and there is no state approved surrogate available and the patient has not executed an advanced directive or expressed preferences for care at end of life, then decisions should be made based on the principle of "best interests".

When there is disagreement, confusion or a request for another opinion, the use of an ethics committee is to be encouraged. Quality of life should be viewed from the patient's perspective in all these decisions because quality of life can only be self-determined. Extreme caution must be exercised when trying to determine what constitutes quality of life for another person as research has shown that patients consistently assess their quality of life to be better than their caregivers **BELIEVE.** ~~think the patients do.~~ Unfortunately, no documentation or proxy designation can definitively prevent or curtail disagreements between family members.

Palliative care is always appropriate when patients and families are facing a life threatening illness. The osteopathic physician understands that physical suffering from pain; dyspnea and other end of life symptoms can be relieved with good osteopathic medical management. The patient may also need psychosocial and spiritual assistance to address suffering in those domains as well. Hospice and palliative care services provide invaluable benefits to families and patients. The earliest possible involvement of hospice in the end of life care of patients should be encouraged.

The existence of a medical technology does not mandate its use. A physician is not required to provide **futile medical care** though it may be difficult to determine that a requested treatment is actually futile. A life-prolonging treatment may allow a terminally ill patient to achieve an important life goal such as seeing a grandchild, but in other cases aggressive therapies serve only to prolong suffering and expense associated with the dying process. The physician should employ full disclosure and compassionate honesty in discussing a treatment's likely benefits and burdens. If agreement cannot be reached, a consultation with an ethics committee is appropriate. If an ethics committee is not available, it may be necessary to seek the assistance of a court-appointed guardian. When a patient and physician cannot align their goals and treatment approaches, a congenial transfer of care may be necessary. Patient abandonment is unethical.

Withholding or withdrawing life sustaining treatments are considered morally, legally, and ethically identical because the end results are the same. When the benefit of a treatment is uncertain a time-limited trial is frequently advisable to help clarify prognosis. Offering treatment and then withdrawing it if it proves to be ineffective or burdensome is preferable to not offering the treatment at all.

Artificial nutrition and hydration may actually prolong the dying process. The use of artificial nutrition and hydration involves invasive medical procedures with potential side effects and complications. A decision to not provide or to discontinue this intervention may pose significant challenges to professional caregivers as well as to families. Physicians need to assist patients and families to understand the role of artificial nutrition and hydration at the end of life. Research has shown that dying patients do not experience hunger or thirst.

"Do Not Resuscitate/DNR" status is appropriate for patients who are dying from a primary illness or injury, or for whom cardiopulmonary resuscitation (CPR) would not be effective or for whom the burden of treatment outweighs the benefit. It is important to ensure that patients with DNR status receive all comfort care and appropriate treatments. A DNR status does not preclude treatment of correctable conditions. ~~CPR efforts that involve a deliberate decision not to attempt aggressively to bring a patient back to life are~~

~~not appropriate and a clear ethical violation~~. ~~**DELIBERATELY PERFORMING INEFFECTIVE CPR ("SLOW CODE") IS UNETHICAL.**~~

"PHYSICIAN ASSISTED SUICIDE" IS GENERALLY DEFINED AS A PATIENT OBTAINING THE ASSISTANCE OF A PHYSICIAN TO SECURE THE MEANS TO CAUSE ~~HIS/HER~~ THEIR OWN DEATH. PHYSICIAN ASSISTED SUICIDE IS LEGAL ONLY AS DETERMINED BY SPECIFIC STATE LAW.

IN THE DEFINITION OF EUTHANASIA, SOMEONE OTHER THAN THE PATIENT ADMINISTERS THE LIFE-ENDING DRUG. EUTHANASIA IS ILLEGAL IN ALL STATES.

WHILE THERE ARE EUPHEMISMS FOR THE TERM PHYSICIAN ASSISTED SUICIDE (PAS), THE DEFINITION OF THIS PRACTICE MAKES IT VERY CLEAR THAT THE PATIENT IS DYING BY SUICIDE AND THE PHYSICIAN HAS ASSISTED BY PROVIDING THE MEANS/MEDICATION PRESCRIPTION.

A FURTHER COMPLICATION OF EMPLOYING PHYSICIAN-ASSISTED SUICIDE IS THAT THE REQUIRED SELF-ADMINISTRATION BY THE PATIENT IS UNAVAILABLE TO THE PARALYZED, THOSE WITH ALS, THOSE WHO CAN'T SWALLOW, AND THOSE WITH GI CANCERS WHICH PREVENT ABSORPTION OF ORAL MEDICATION.

The request for physician-assisted suicide is frequently a call for help. Individuals may request physician-assisted suicide for reasons other than pain, e.g., inability to cope, fear of being a burden, or lack of control. T**HE "OREGON DEATH WITH DIGNITY ACT – 2022 DATA SUMMARY" IS A REPORT OF THE 25 YEARS OF DATA GENERATED FROM IMPLEMENTATION OF THIS LAW IN THE FIRST STATE TO ENACT SUCH A LAW. THE REASONS IDENTIFIED BY PATIENTS WHO DID DIE BY SUICIDE UNDER THIS LAW ARE LISTED IN A TABLE ON PAGE 14 OF THIS DOCUMENT.[1] AS SHOWN IN THE TABLE, OVER THE 25 YEARS OF THE IMPLEMENTATION OF THIS LAW, 28% OF THE CONCERNS PROMPTING INGESTION OF LIFE-ENDING MEDICATION WERE DUE TO "INADEQUATE PAIN CONTROL OR CONCERN ABOUT IT." THE CONCERNS AT THE TOP OF THE LIST, AT 90% EACH, WERE "LESS ABLE TO ENGAGE IN ACTIVITIES MAKING LIFE ENJOYABLE," AND "LOSING AUTONOMY."[1] OTHER CONCERNS INCLUDED "LOSS OF DIGNITY" (71%), "BURDEN ON FAMILY, FRIENDS/CAREGIVERS" (48%), "LOSING CONTROL OF BODILY FUNCTIONS" (44%), AND "FINANCIAL IMPLICATIONS OF TREATMENT" (5%)**.[1]

The alternative to physician-assisted suicide is HAVING physicians who are committed to providing excellence in end of life care and continuing to attend their dying patients. Community resources such as hospice programs should be made available to all patients. ~~Hospice and palliative care principles do not support physician assisted suicide and euthanasia remains an illegal practice.~~

ADDITIONAL SPECIFIC ALTERNATIVES TO PHYSICIAN-ASSISTED SUICIDE IN DEALING WITH ISSUES AT END OF LIFE INCLUDE, VOLUNTARILY STOPPING EATING AND DRINKING (VSED), STOPPING LIFE-SUSTAINING THERAPIES, PROPORTIONAL PALLIATIVE SEDATION, AND PALLIATIVE SEDATION TO

UNCONSCIOUSNESS.[2]

WHETHER OR NOT PHYSICIANS SHOULD CHOOSE TO SUPPORT AND THEN PARTICIPATE IN THE PRACTICE OF PHYSICIAN-ASSISTED SUICIDE IS CONTROVERSIAL. IT IS ALSO A PERSONAL DECISION, REFLECTING THE MORAL CONSCIENCE AND BELIEFS OF EACH PHYSICIAN. ~~EVERY~~ THE LAW IN EVERY STATE RECOGNIZES THE PERSONAL NATURE OF THIS DECISION FOR EVERY PHYSICIAN AND SPECIFICALLY DOES NOT REQUIRE ANY PHYSICIAN TO ADVOCATE FOR OR PARTICIPATE IN THIS PRACTICE.

SOME ORGANIZATIONS HAVE TAKEN AN OFFICIAL POSITION ON THIS ISSUE. PHYSICIAN-ASSISTED SUICIDE IS OPPOSED BY THE AMERICAN MEDICAL ASSOCIATION[3], THE AMERICAN COLLEGE OF PHYSICIANS[4] AND THE NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION[5], THE LARGEST SUCH MEMBER ORGANIZATION DEALING EXCLUSIVELY WITH END-OF-LIFE ISSUES. THE AMERICAN ASSOCIATION OF FAMILY PHYSICIANS[6] HAS TAKEN A POSITION OF "ENGAGED NEUTRALITY." THE AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE (AAHPM) HAS TAKEN A POSITION OF "STUDIED NEUTRALITY." [7] THE AAHPM STATEMENT GOES ON TO ADD "HOWEVER AS A MATTER OF SOCIAL POLICY, THE ACADEMY HAS CONCERNS ABOUT A SHIFT TO INCLUDE PHYSICIAN-ASSISTED DYING IN ROUTINE MEDICAL PRACTICE, INCLUDING PALLIATIVE CARE. SUCH A CHANGE RISKS UNINTENDED LONG-RANGE CONSEQUENCES THAT MAY NOT YET BE DISCERNABLE, INCLUDING EFFECTS ON THE RELATIONSHIP BETWEEN MEDICINE AND SOCIETY, THE PATIENT AND PHYSICIAN, AND THE PERCEIVED OR ACTUAL INTEGRITY OF THE MEDICAL PROFESSION." (NOTA~~E~~ BENE: THE ACADEMY USES THE TERM 'PHYSICIAN-ASSISTED DYING')

Legal involvement to resolve end of life conflicts is sometimes inevitable, but is usually not the approach of choice. Legislative "remedies" including single-person and single-situation laws are also inappropriate. By far, the best approach to prevention/resolution of conflict is by documented advanced planning, good communication, and the assistance of an ethics committee. Collection of "clear and convincing evidence" of the patient wishes as cited in a US Supreme Court decision, as well as the principles of "substituted judgment" and "best interests" discussed above apply to the decision-making process.

Families of patients living with a terminal illness also have needs: the need to understand the dying process, the need to have cultural and religious differences understood and respected, the need to process grief. The osteopathic physician understands the important contribution of the family to the patient's overall wellbeing and includes the family in the palliative plan of care.

Patients living with a life threatening illness as well as those who are terminally ill have a right to **relief of pain** as well as relief of other physical symptoms. Fear of regulatory scrutiny should never be a deterrent to the prescription of adequate doses of analgesic medications. State licensing boards of medicine and pharmacy should provide assurance to physicians that this care is appropriate and protected under the law. Osteopathic colleges and graduate medical education programs are encouraged to review curricula in

order that adequate education in osteopathic pain management is provided to osteopathic trainees at all levels of their education. Physicians in practice will want to avail themselves of educational opportunities ~~such as Osteopathic-EPEC~~ to stay current in pain management and other aspects of end of life care. Osteopathic physicians should always assure their patients that they will provide safe and comfortable dying. Alternatively, patients may elect to suffer significant pain so that they remain alert and engaged until death. In every circumstance, patient autonomy for decision-making must be upheld.

At the end of life, the goal is comfort for the patient and psychosocial support of the family. Osteopathic physicians, through their holistic approach, are well suited to provide quality end of life care. DOs are in a unique position to provide important leadership in enhancing end of life care in the United States. There is no finer gift that osteopathic physicians can give than to provide excellent care through all phases of life and no one is better suited to the task.

Nota bene: In an area as sensitive as end of life, no white paper can address all scenarios and permutations. It should be understood that this white paper presents general guidelines, and osteopathic physicians will always tailor appropriate management to the needs of their individual patients and families.

References

1. "Oregon Death with Dignity Act – 2022 Data Summary" Table On Page 14, Accessed On 4.6.2023 At Https://Www.Oregon.Gov/Oha/Ph/Providerpartnerresources/Evaluationresearch/Deathwithdignityact/Documents/Year25.Pdf
2. Institute Of Medicine: "Dying In America: Improving Quality And Honoring Individual Preferences Near The End Of Life." Washington, Dc: National Academies Press, 2015.
3. H-140.952 Physician Assisted Suicide, Accessed April 2023 At Https://Code-Medical-Ethics.Ama-Assn.Org/ , And Policy Finder.
4. Sulmasy Ls, Mueller Ps For The Ethics, Professionalism And Human Rights Committee Of The American College Of Physicians, "Ethics And Legalization Of Physician-Assisted Suicide: An American College Of Physicians Position Paper" Ann Intern Med.2017;167:576-578.
5. Statement On Medical Aid In Dying, National Hospice And Palliative Care Organization, Approved June 16, 2021, Https://Www.Nhpco.Org/Wp-Content/Uploads/Medical_Aid_Dying_Position_Statement_July-2021.Pdf, Accessed April 2023.
6. AAFP, Https://Www.Aafp.Org/News/2018-Congress-Fmx/20181010cod-Hops.Html
7. Statement On Physician-Assisted Dying. American Academy Of Hospice And Palliative Medicine (AAHPM), 2016, Https://Aahpm.Org/Positions/Pad Accessed March 2023.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 referred to BORPH)

Prior HOD action on similar or same topic:

H322-A/19 End-Of-Life Care – Use of Placebos In
H600-A/19 Hospice – Federal Payment for Required Face-To-Face Visits
H409-A/17 Prenatal and Pediatric Hospice and Palliative Care – Support For
H411-A/17 Hospice Care Programs – AOA Support For

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: PEDIATRIC MEDICAL IMAGING - SOURCE: H-416-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the reduction of excess ionizing
7 radiation exposure of the pediatric population and urges its members involved in
8 medical imaging of pediatric patients to review the latest research and educational
9 materials from the National Cancer Institute and other organizations and pledge to
10 do their part to “child-size” the radiation dose used in children’s imaging.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: PEDIATRIC OBESITY - SOURCE: H-419-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

~~The American Osteopathic Association (AOA) encourages dissemination of research related to pediatric obesity and continuing medical education (CME) activities; encourages primary care physicians to teach and use body mass index (BMI) measurements; and encourages physicians providing health care to children to~~

~~1. Monitor their patients for excessive weight gain;~~

~~2. Discuss the possible long and short term consequences of excessive weight gain (E.G. cardiovascular and respiratory problems) with patients and their parents and institute a treatment plan or a referral as appropriate;~~

~~3. Advise patients to engage in moderate, physical activity daily, limit television, computer and video games, and spend family time together in physical activities; and~~

~~4. Advise parents to eat together as a family, set goals for the appropriate number of fruits and vegetables per day, serve portion sizes that are right for a child's age, limit snacking on empty calorie foods, and serve as role models for eating healthy foods. 2008.~~

THE AOA ENCOURAGES~~SUPPORTS~~:

1. **DISSEMINATION OF RESEARCH RELATED TO PEDIATRIC OBESITY;**

2. **CONTINUING MEDICAL EDUCATION (CME) ACTIVITIES ADDRESSING PEDIATRIC OBESITY; AND**

3. **~~THE USE OF BODY MASS INDEX (BMI) MEASUREMENTS FOR CHILDREN.~~ THE USE OF EVIDENCE-BASED GUIDELINES CONCURRENT WITH CURRENT RECOMMENDATIONS.**

~~**THE AOA ENCOURAGES PHYSICANS WHO PROVIDE HEALTH CARE TO CHILDREN TO:**~~

1. ~~**MONITOR THEIR PATIENTS FOR EXCESSIVE WEIGHT GAIN;**~~

2. ~~**DISCUSS POSSIBLE LONG AND SHORT-TERM CONSEQUENCES OF EXCESSIVE WEIGHT GAIN (E.G., CARDIOVASCULAR AND RESPIRATORY PROBLEMS WITH PATIENTS AND PARENTS, AND INSTITUTE A TREATMENT PLAN OR REFERRAL AS APPROPRIATE;**~~

3. ~~**ADVISE PATIENTS TO ENGAGE IN MODERATE, PHYSICAL ACTIVITY DAILY, LIMIT TELEVISION, COMPUTER AND VIDEO GAMES, AND SPEND FAMILY TIME TOGETHER IN PHYSICAL ACTIVITIES; AND**~~

4. ~~**ADVISE PARENTS TO EAT TOGETHER AS A FAMILY, SET GOALS FOR THE APPROPRIATE NUMBER OF FRUIT AND VEGETABLES PER DAY, SERVE PORTION SIZES THAT ARE RIGHT FOR A CHILD'S AGE, LIMIT SNACKING ON EMPTY CALORIE FOODS, AND SERVE AS ROLE MODELS FOR EATING HEALTHY FOODS.**~~

THE AOA ENCOURAGES PHYSICIANS WHO PROVIDE HEALTHCARE TO CHILDREN AND ADOLESCENTS TO PROVIDE CARE AND CLINICAL RECOMMENDATIONS TO THE PATIENT AND/OR PARENT OR GUARDIAN IN ALIGNMENT WITH CURRENT EVIDENCE-BASED GUIDELINES AND/OR PRACTICES.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic:
H408-A/22 Prevention and Treatment of Obesity
H417-A/21 Obesity in Children
H429-A/21 Obesity Epidemic – Addressing the American
H433 - A/20 Childhood Obesity - Worsening Epidemic in the American Society

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 22, 2023

SUBJECT: TUBERCULOSIS MEDICAL TRAINING – SOURCE:H-415-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports tuberculosis prevention programs
7 carried out by the Centers for Disease Control and Prevention (CDC), The National
8 Institutes of Health (NIH) and other organizations and encourages the use of the
9 CDC's core curriculum on tuberculosis by osteopathic physicians who treat patients
10 diagnosed with tuberculosis or who are at high risk for tuberculosis disease or
11 infection.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1993; 1998 Reaffirmed as Amended; 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: DISTRACTED DRIVING - SOURCE: H418-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports appropriate legislation to ensure
7 safe driving without distractions.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H413-A/17 Substance Impaired and Distracted Driving

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: ___July 22, 2023_____

SUBJECT: ARTIFICIAL INTELLIGENCE IN HEALTHCARE~~— TASK FORCE~~

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Public Affairs

WHEREAS, the use of artificial intelligence (AI) in healthcare is increasing at an unprecedented pace, with the potential to transform healthcare delivery, improve patient outcomes, and reduce healthcare costs; and

WHEREAS, the ethical, legal, and social implications of AI in healthcare are complex and multifaceted, with issues including but not limited to data privacy, bias, and the impact on healthcare professionals; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~forms a task force to~~ stud~~y~~IES the impact of AI in healthcare, including but not limited to:

1. The potential benefits and risks of AI in healthcare for patients, healthcare professionals, and healthcare organizations.
2. The ethical, legal, and social implications of AI in healthcare, including issues related to data privacy, bias, and transparency.
3. The impact of AI on the roles and responsibilities of healthcare professionals and the potential need for new training and education.
4. The potential impact of AI on healthcare costs and the healthcare system as a whole.
5. The potential impact of AI on the practice of osteopathic medicine; and, be it further

~~RESOLVED, that the task force include members with expertise in AI, medical ethics, and medical law~~.

RESOLVED, THAT AOA WILL PROVIDE A REPORT AND ACTION PLAN TO THE HOUSE OF DELEGATES AT ITS MEETING IN 2024.

Background Information: Provided by AOA Staff

Current AOA Policy: None

AOA does not currently have policy on AI, and this would be helpful in supporting AOA engagement in this space. AOA previously had a Health IT workgroup that engaged on this issue but has been inactive since early 2021. If this is adopted, we will need to identify a way to ensure we have the appropriate staff resources to manage this workstream.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $125,000 Annual Expense
The fiscal impact is contributed to the formation of a task force, assuming the task force would meet in-person as well as expense for the appropriate staffing to manage the workstream.

ACTION TAKEN: __Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: RECOGNIZING THE ISSUE OF WEIGHT BIAS IN HEALTHCARE

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Public Affairs

WHEREAS, approximately 1 in 3 adults (30.7%) have overweight and more than 2 in 5 adults (42.4%) have obesity[1]; and

WHEREAS, while there has been a push to recognize obesity as a disease, there is still a lack of recognition of the role that implicit weight bias plays in the care for individuals with overweight and obesity and

WHEREAS, providers with weight bias are less likely to provide thorough, patient-centered care to individuals with overweight or obesity[2]; and

WHEREAS, individuals with overweight and obesity are less likely to use preventative health care services and are more likely to avoid treatment, due to perceived weight bias and negative experiences[3,4]; and

~~WHEREAS, the emphasis put on weight by physicians distracts from pertinent health issues that the patients came to be seen for, therefore affecting patient's health utilization[5]; and~~

WHEREAS, H429-A/21 states that the "American Osteopathic Association…will initiate a profession-wide program to provide leadership in addressing the American obesity epidemic"; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes that ~~disproportionate~~ bias suffered by individuals with overweight and **OBESE CONDITIONS** ~~obesity~~ in healthcare is a public health issue; and be it further

RESOLVED, THAT THE AOA SUPPORTS EQUITABLE AND AFFORDABLE INSURANCE COVERAGE FOR PROVEN TREATMENTS, INCLUDING THE USE OF PHARMACEUTICALS IN THE MANAGEMENT OF INDIVIDUALS WITH OVERWEIGHT AND OBESE CONDITIONS, AND BE IT FURTHER

RESOLVED, the AOA promote greater awareness and research regarding how to reduce the implicit and explicit bias in healthcare ~~is~~ needed to improve the treatment and management of individuals with **THE** ~~**DISEASES**~~ **CONDITIONS OF** overweight and obesity.

References

1. Fryar CD, Carroll MD, Afful J. Prevalence of overweight, obesity, and severe obesity among adults aged 20 and over: United States, 1960-1962 through 2017-2018. NCHS Health E-Stats. 2020.
2. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes Rev. 2015 Apr;16(4):319-26. doi: 10.1111/obr.12266. Epub 2015 Mar 5. PMID: 25752756; PMCID: PMC4381543.
3. Lawrence, B. J., Kerr, D., Pollard, C. M., Theophilus, M., Alexander, E., Haywood, D., & O'Connor, M. (2021). Weight bias among health care professionals: A systematic review and meta,Äêanalysis. Obesity, 29(11), 1802-1812. https://doi.org/10.1002/oby.23266
4. Fruh SM, Graves RJ, Hauff C, Williams SG, Hall HR. Weight Bias and Stigma: Impact on Health. Nurs Clin North Am. 2021 Dec;56(4):479-493. doi: 10.1016/j.cnur.2021.07.001. PMID: 34749889; PMCID: PMC8641858.
5. Alberga, A. S., Edache, I. Y., Forhan, M., & Russell-Mayhew, S. (2019). Weight bias and Health Care Utilization: A scoping review. Primary Health Care Research & Development, 20. https://doi.org/10.1017/s1463423619000227

Background Information: Provided by AOA Staff

Current AOA Policy:

H408 – A/22 Prevention and Treatment of Obesity Policy Statement

H429-A/21 Obesity Epidemic – Addressing the American Policy Statement

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___Adopted as Amended_

DATE ____July 22, 2023_____

SUBJECT: OSTEOPATHIC MEDICINE IS HIGH-VALUE CARE

SUBMITTED BY: Osteopathic Physicians and Surgeons of California / Montana Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the Centers for Medicare & Medicaid Services (CMS) have established
2 a goal to have 100 percent of Original Medicare Beneficiaries in accountable
3 care relationships by 2030 [(1)]; and

4 WHEREAS, The Institute for Healthcare Improvement has defined the Triple Aim of
5 medicine as: improving the patient experience of care (including quality and
6 satisfaction), improving the health of populations, and reducing the per capita
7 cost of health care [(2)]; and

8 WHEREAS, studies have shown that osteopathic care, including osteopathic
9 manipulative treatment (OMT), can improve outcomes in a variety of clinical
10 presentations; and

11 WHEREAS, the addition of OMT to standard care in neonatal intensive care units
12 has been shown to decrease length of stay and costs of care [(3)]; and

13 WHEREAS, research shows that patient's experiences and expectations improve in
14 the setting of an appropriate bedside evaluation [(4)]; and

15 WHEREAS, the power of empathy and mind-body connection in osteopathic
16 medical education is being studied by the American Association of Colleges
17 of Osteopathic Medicine [(5)]; now, therefore be it

18 RESOLVED, that osteopathic medicine, including OMT, meets the values of the
19 Triple Aim, and represents high-value care.

References

1. https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care
2. https://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx
3. Cerritelli F, Pizzolorusso G, Renzetti C, Cozzolino V, D'Orazio M, Lupacchini M, Marinelli B, Accorsi A, Lucci C, Lancellotti J, Ballabio S, Castelli C, Molteni D, Besana R, Tubaldi L, Perri FP, Fusilli P, D'Incecco C, Barlafante G. A multicenter, randomized, controlled trial of osteopathic manipulative treatment on preterms. PLoS One. 2015 May 14;10(5):e0127370. doi: 10.1371/journal.pone.0127370. PMID: 25974071; PMCID: PMC4431716.
4. Abraham Verghese, Erika Brady, Cari Costanzo Kapur, et al. The Bedside Evaluation: Ritual and Reason. Ann Intern Med.2011;155:550-553. [Epub 18 October 2011]. doi:10.7326/0003-4819-155-8-201110180-00013
5. https://www.aacom.org/programs-events/programs-initiatives/project-in-osteopathic-medical-education-and-empathy

Background Information: Provided by AOA Staff
Current AOA Policy:
H436-A/21 Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) – Affirming the Scientific and Medical Foundation of Policy Statement

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___Adopted_____

DATE ____July 22, 2023_____

SUBJECT: VOTER REGISTRATION AS A SOCIAL DETERMINANT OF HEALTH

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, citizens from historically excluded backgrounds are impacted more by barriers to voting[1,2]; and

WHEREAS, individuals who experience voter suppression have disproportionately worse health outcomes, and these disparities largely affect people of color[2,3]; and

WHEREAS, the relationship between health and voter participation perpetuates inequities in health, social, and economic policy, further worsening health disparities[3]; and

WHEREAS, individuals who vote as a form of civic participation self-report a better state of health than those who do not vote or choose to abstain from voting[4]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) acknowledge voting as a social determinant of health and establish a relationship between voter participation and health outcomes.

References

1. Yagoda N. Addressing Health Disparities Through Voter Engagement. Ann Fam Med. 2019 Sep;17(5):459-461. doi: 10.1370/afm.2441. PMID: 31501209; PMCID: PMC7032920.
2. Pabayo R, Liu SY, Grinshteyn E, Cook DM, Muennig P. Barriers to Voting and Access to Health Insurance Among US Adults: A Cross-Sectional Study. The Lancet Regional Health - Americas. 2021;2:100026. doi:10.1016/j.lana.2021.100026.
3. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. Public Health Rev. 2020;41:16. doi:10.1186/s40985-020-00133-6.
4. Kim S, Kim C, You MS. Civic participation and self-rated health: a cross-national multi-level analysis using the world value survey. J Prev Med Public Health. 2015;48(1):18-27. doi:10.3961/jpmph.14.031.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Not Adopted____

DATE: ____July 22, 2023_____

SUBJECT: AMENDMENT TO H444-A/20 "ADOPTING AND PROMOTING NON-STIGMATIZING LANGUAGE FOR SUBSTANCE USE DISORDERS"

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, substance use disorder is recognized as a chronic medical condition by the American Society of Addiction Medicine[1]; and

~~WHEREAS, the word "relapse" has a negative connotation when used toward patients[2] and is not a term that is used to describe those with other chronic conditions who have a reemergence of their disease; and~~

WHEREAS, language used to describe conditions can change patient outcomes and alter physician-patient relationships[3]; now, therefore be it

RESOLVED, that policy H444-A/20 be amended to read: The American Osteopathic Association (AOA) commit to the use of clinically-accurate, non-stigmatizing, person-first language (**INCLUDING, BUT NOT LIMITED TO,** "substance use disorder," "recovery," "substance misuse," "positive or negative urine screen," "person with a substance use disorder," and "**RECURRENCE OF USE**") and discourage the use of stigmatizing terminology ~~(**SUCH AS**, "substance abuse," "substance abuser," "addict," "alcoholic," "clean/dirty," and "**RELAPSE**")~~ in future publications, resolutions, and educational materials both in print and online.

References

1. Definition of Addiction. (2011, August 15). American Society of Addiction Medicine. Retrieved from https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512_4.
2. Ashford, Robert D., Austin M. Brown, and Brenda Curtis. "Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias." Drug and alcohol dependence 189 (2018): 131-138.
3. Robert D. Ashford, Austin M. Brown, Jessica McDaniel & Brenda Curtis (2019) Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals, Substance Use & Misuse, 54:8, 1376-1384, DOI: 10.1080/10826084.2019.1581221.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above: H444-A/20 Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders Policy Statement

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED
DATE: July 22, 2023

SUBJECT: SUPPORTING ACCESS TO ~~OVER-THE-COUNTER~~ ORAL CONTRACEPTIVE PILLS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, access to safe, effective, and affordable contraceptives is necessary to maintain reproductive autonomy[1,2]; ~~and~~**NOW THEREFORE BE IT**

~~WHEREAS, currently oral contraceptive pills (OCPs) are available prescription only[1,3]; and~~

~~WHEREAS, organizations such as the American College of Obstetricians and Gynecologists (ACOG)[4], the American Academy of Family Physicians (AAFP)[5], and the American Medical Association (AMA)[6] support over-the-counter access to oral contraceptive pills; now, therefore be it~~

RESOLVED, that the American Osteopathic Association (AOA) stand in support of affordable ~~over-the-counter~~ access to oral contraceptive pills**.** ~~**CONSISTENT WITH FDA GUIDELINES** without an age restriction; and, be it further~~

~~RESOLVED, that the American Osteopathic Association (AOA) encourage the U.S. Food and Drug Administration to approve affordable over-the-counter access to oral contraceptive pills without an age restriction.~~

References

1. Committee opinion no. 615: Access to contraception. (2015*). Obstetrics and Gynecology*, 125(1), 250–255. *https://doi.org/10.1097/01.AOG.0000459866.14114.33*.
2. Grindlay, K., & Grossman, D. (2016). Prescription Birth Control Access Among U.S. Women at Risk of Unintended Pregnancy. *Journal of women's health* (2016), 25(3), 249–254. https://doi.org/10.1089/jwh.2015.5312.
3. *Grossman D, Grindlay K, Li R, Potter JE, Trussell J, Blanchard K. Interest in over-the-counter access to oral contraceptives among women in the United States. Contraception. 2013 Oct;88(4):544-52. doi: 10.1016/j.contraception.2013.04.005. PMID: 23664627; PMCID: PMC3769514.*
4. American College of Obstetricians and Gynecologists. *Over-the-Counter Access to Hormonal Contraception.* (2019). 134(4), 10. from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception.
5. American Academy of Family Physicians. *Over-the-Counter Oral Contraceptives.* (2019). Retrieved August 28, 2022, from https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html.
6. American Medical Association. *AMA urges FDA to make oral contraceptives available over-the-counter.* (2022). Retrieved May 5, 2023, from https://www.ama-assn.org/press-center/press-releases/ama-urges-fda-make-oral-contraceptive-available-over-counter.

Background Information: Provided by AOA Staff
Current AOA Policy: H409-A/22 Contraceptive Coverage Legislation

AOA policy is limited to maintaining co-payment for contraceptive services at a cost no higher than the set level of co-payment for any other prescription.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended
DATE: _____July 22, 2023_____

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (500 SERIES) -wACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Constitution and Bylaws (500 series)
This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-500	Amendments to the American Osteopathic Association Constitution- Article VI: Sec 1B (***Second Read***)	CAGOS	Constitution & Bylaws	Adopted as Amended
H-501	Amendments to the American Osteopathic Association Constitution- Article VI: Sec 1D ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-502	Amendments to the American Osteopathic Association Constitution- Article VII: Sec 2 ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-503	Amendments to the American Osteopathic Association Constitution- Article X ***(Second Read)***	CAGOS	Constitution & Bylaws	Adopted as Amended
H-504	WITHDRAWN			
H-505	Amendments to the American Osteopathic Association Constitution – Article IX – Amendments **(First Read)**	CAGOS	Constitution & Bylaws	First Read
H-506	Amendments to the American Osteopathic Association Constitution – Article VII: Section 2 ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-507	Amendments to the American Osteopathic Association Constitution - Article VIII: Section 1 C, D and E ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-508	Amendments to the American Osteopathic Association Constitution – Article X ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-509	WITHDRAWN			
H-510	Amendments to the American Osteopathic Association Bylaws – Article XI: Section 1 and Section 2	CAGOS	Constitution & Bylaws	Adopted as Amended
H-511	Amendments to the American Osteopathic Association Bylaws – Article I: Section 1 and 3	CAGOS	Constitution & Bylaws	Referred to CAGOS
H-512	Amendments to the American Osteopathic Association Bylaws – Article II: Section 2 A	CAGOS	Constitution & Bylaws	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (500 SERIES) -wACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-513	Amendments to the American Osteopathic Association Bylaws – Article II: Section 3	CAGOS	Constitution & Bylaws	Adopted as Amended
H-514	Amendments to the American Osteopathic Association Bylaws – Article II: Section 4	CAGOS	Constitution & Bylaws	Adopted as Amended
H-515	Amendments to the American Osteopathic Association Bylaws – Article III: Section 1, 2 and 3	CAGOS	Constitution & Bylaws	Adopted as Amended
H-516	Amendments to the American Osteopathic Association Bylaws – Article IV: Section 2	CAGOS	Constitution & Bylaws	Adopted as Amended
H-517	Amendments to the American Osteopathic Association Bylaws – Article V: Section 3	CAGOS	Constitution & Bylaws	Adopted as Amended
H-518	WITHDRAWN			
H-519	Amendments to the American Osteopathic Association Bylaws – Article VII: Section 5	CAGOS	Constitution & Bylaws	Adopted as Amended
H-520	Amendments to the American Osteopathic Association Bylaws – Article VIII: Section 9 and New Article XI: Section 1 and 2	CAGOS	Constitution & Bylaws	Postpone to 2024
H-521	Amendments to the American Osteopathic Association Bylaws – Article VIII: Section 6 F, 7 A and D	CAGOS	Constitution & Bylaws	Adopted as Amended
H-522	Amendments to the American Osteopathic Association Bylaws – Article VII: Section 1 H	CAGOS	Constitution & Bylaws	Adopted as Amended
H-523	Amendments to the American Osteopathic Association Bylaws – Article XII	CAGOS	Constitution & Bylaws	Postpone to 2024
H-524	Conflicts of Interest	MAOP	Constitution & Bylaws	Not Adopted
H-525	Interpretation of the American Osteopathic Association Code of Ethics for Employed Physicians	IOMA	Constitution & Bylaws	Not Adopted

SUBJECT: AMENDMENTS TO ARTICLE VI, SEC 1 B OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(*Second Read*)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VI – House of Delegates - Section 1 - Composition, Part B Student Council Representation – of the Constitution at the 2023 House of Delegates annual meeting: now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VI – House of Delegates, Section 1 - Composition, Part B (Student Council Representation)

B. Student Council Representation in Divisional Societies

Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by ~~the association~~ **THE COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION (COCA)** and located in the state represented by that divisional society, such student delegate IS to be elected according to the Bylaws of the American Osteopathic Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted_as Amended__

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO ARTICLE VI SEC 1 D OF AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(Second Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VI – House of Delegates – Section 1 – Composition – Part D - of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VI - House of Delegates, Section 1 - Composition

D. REPRESENTATION OF OSTEOPATHIC POSTDOCTORAL TRAINEES AND NEW PHYSICIANS IN PRACTICE. OSTEOPATHIC PHYSICIANS IN POSTDOCTORAL TRAINING AND NEW PHYSICIANS IN PRACTICE SHALL BE REPRESENTED BY THREE DELEGATES TO BE SELECTED BY THE BUREAU OF EMERGING LEADERS AS PROVIDED IN THE BYLAWS OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO ARTICLE VII SEC 2 OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(Second Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VII – Officers – Section 2 – Administrative Officers – of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VII - Officers, Section 2- Administrative Officers
The administrative officers shall be Chief Executive Officer, a ~~controller~~ **CHIEF FINANCIAL OFFICER**, a General Counsel, and an Editor**-IN-CHIEF** who shall all be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO ARTICLE X OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(Second Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article X – Gender Disclaimer – of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article X - Gender Disclaimer
The American Osteopathic Association is open to **ALL** persons ~~of both sexes~~ and does not discriminate against any persons because of ~~sex~~ **THEIR GENDER IDENTITY**; therefore, the wording herein importing the masculine or feminine gender ~~includes the~~ **IS INCLUSIVE OF ALL** ~~other~~ gender **IDENTITIES** and imports no such discrimination.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None
This resolution to be discussed in conjunction with resolution H508-A/23 and H523-A/23.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE IX ***(First Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article IX - Amendments - of the Constitution at the 2024 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

Article IX – Amendments
This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by U.S. mail or electronic communication to each **VOTING REPRESENTATIVE OF THE** divisional **SOCIETY** and **AFFILIATED ORGANIZATION** ~~specialty society~~ ~~entitled to and voting representatives~~ to the House of Delegates, posted on the AOA's website, and **COMMUNICATED IN AN OFFICIAL PUBLICATION OF THE ASSOCIATION** ~~published ON-LINE in the on-line edition of *THE DO* *The Journal of Osteopathic Medicine*~~ not less than two months nor more than four months prior to the meeting at which they are to be acted upon.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __*First Read*_____

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE VII: SECTION 2 ***(First Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the role of the Editor will exist however not as an Administrative Officer. The proposed updated definition of the role of the Editor has been updated in the Bylaws; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VII – Officers – Section 2 Administrative Officers - of the Constitution at the 2024 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

Article VII – Officers
Section 2 – Administrative Officers
The administrative officers shall be Chief Executive Officer, a Controller[1], **AND** a General Counsel~~, and an Editor~~ who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Background Information: Provided by AOA Staff

Current AOA Policy: None
Prior HOD action on similar or same topic: None

[1] The title of Controller to Chief Financial Officer is under review as a second read in 2023.

FISCAL IMPACT: $0

ACTION TAKEN: _____*First Read*_____

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION - ARTICLE VIII: SECTION 1 C, D AND E ***(First Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VIII – Board of Trustees and Executive Committee – Section 1 Board of Trustees, Part C, Part D and Part E - of the Constitution at the 2024 House of Delegates annual meeting; and

WHEREAS, Section 1-C are grammatical correction; Section 1-D is a grammatical correction and the AOA no longer has these programs; and Section 1-E is a grammatical correction; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

Article VIII – Board of Trustees and Executive Committee
Section 1 – Board of Trustees
The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-eight members.

C. One new physician in practice member elected by the House of Delegates to serve for **A TERM OF** one year. Candidates for the new physician in practice position **SHALL BE** osteopathic physicians who have completed their postdoctoral training within the past five years ~~shall be~~ **AND BE** nominated by **THE** Bureau of Emerging Leaders. Candidates must be members in good standing of the AOA;

D. One postdoctoral trainee, to include intern, resident, or a fellow, member elected by the House of Delegates to serve for **A TERM OF** one year. Candidates for the postdoctoral trainee position shall be enrolled in an **ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION** (ACGME) ~~or AOA-approved~~ internship, residency or fellowship. Candidates for the postdoctoral trainee position shall be nominated by the Bureau of Emerging Leaders. Candidates should be members in good standing of the AOA; and

E. One student member elected by the House of Delegates to serve for **A TERM OF** one year. Candidates for the student position shall be nominated, in ~~altering~~ **ALTERNATING** years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA).

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___*First Read*_____

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – ARTICLE X ***(First Read)***

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article X – Gender Disclaimer - of the Constitution at the 2024 House of Delegates annual meeting; and

WHEREAS, the pronouns within the Constitution and Bylaws to be updated to 'their', 'them', 'they' to be gender neutral to show inclusivity. The usage of these pronouns would eliminate the need for a gender disclaimer; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2023 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2024 House of Delegates:

AOA Constitution

~~Article X - Gender Disclaimer~~
~~The American Osteopathic Association is open to persons of both sexes and does not discriminate against any persons because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic:
H439-A20 Gender Identity
H406-A19 Discrimination in Healthcare

FISCAL IMPACT: $0

ACTION TAKEN: ___*First Read*_____

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE XI: SECTION 1 AND SECTION 2

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is important for all members to be notified of changes to the Bylaws and the Articles of Incorporation; and

WHEREAS, there are several mechanisms to provide notifications and having a broader term provides more opportunity to deliver the messages; and

WHEREAS, it is necessary to amend the AOA's Bylaws to provide clarity; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article ~~XI~~ **XII**[1] Amendments

Section 1-Bylaws

These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer **TO USE REASONABLE EFFORTS TO DISTRIBUTE IT** ~~to cause it to be distributed~~ by U.S. mail or electronic mail, to **ALL AOA MEMBERS AND** each divisional **SOCIETY** and **AFFILIATED ORGANIZATIONS** ~~specialty society~~ entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in **AN OFFICIAL PUBLICATION OF THE ASSOCIATION** ~~the on-line in *The DO* edition of *The Journal of Osteopathic Medicine*~~ at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

Section 2-Articles of Incorporation

The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes to be

[1] Will be updated to XII should resolution H-520-A/2023 be approved

effected thereby shall be posted on the AOA's website and delivered not less than two weeks nor more than 40 days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each delegate entitled to vote at such meeting.

Written or printed notice shall **FURTHER BE PUBLISHED IN AN OFFICIAL PUBLICATION OF THE ASSOCIATION AND SENT IN AN OFFICIAL EMAIL COMMUNICATION TO ALL AOA MEMBERS** ~~include the printing of the amendment in the electronic and/or printed issue of *The Journal of Osteopathic Medicine* published~~ not less than two weeks or more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE I: SECTION 1 AND 3

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is necessary that AOA's Bylaws provide a clear definition for both when a Charter may be issued and when it may likewise be revoked;

WHEREAS, the Bylaws currently do not detail when a Charter may be revoked and for the purposes of clarifying this process; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article I – Divisional AND District SOCIETIES and Affiliated ~~Societies~~ ORGANIZATIONS

Section 1-Divisional Societies

Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its Constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given **GEOGRAPHICAL** area**. THE ASSOCIATION ALSO HAS THE AUTHORITY TO REVOKE OR SUSPEND THE CHARTER OF ANY DIVISIONAL SOCIETY. THE BOARD OF TRUSTEES, UPON TWO-THIRDS AFFIRMATIVE VOTE, MAY SUSPEND A CHARTER FOR A PERIOD OF TIME UNTIL THE NEXT REGULARLY SCHEDULED MEETING OF THE HOUSE OF DELEGATES. THE HOUSE OF DELEGATES MAY, BY TWO-THIRDS VOTE, REVOKE A CHARTER**.

Section 3-Affiliated Organizations

Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such

organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any present affiliated organization. ~~All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.~~ **THE ASSOCIATION ALSO HAS THE AUTHORITY TO REVOKE OR SUSPEND THE CHARTER OF ANY AFFILIATED ORGANIZATION. THE BOARD OF TRUSTEES, UPON TWO-THIRDS AFFIRMATIVE VOTE, MAY SUSPEND A CHARTER FOR A PERIOD OF TIME UNTIL THE NEXT REGULARLY SCHEDULED MEETING OF THE HOUSE OF DELEGATES. THE HOUSE OF DELEGATES MAY, BY TWO-THIRDS VOTE, REVOKE A CHARTER.**

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Referred to CAGOS_

DATE: ____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE II: SECTION 2 A

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the American Osteopathic Association's Commission on Osteopathic College Accreditation accredits programs; and

WHEREAS, there is no longer a Continuing Medical Education requirement for membership; and

WHEREAS, obtaining an endorsement and written letters of recommendations is a long process that would deter physicians from wanting to reinstate their membership; and

WHEREAS, it is necessary to amend the language in Article II, Section 2 a; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article II Membership
Section 2-Membership Requirements
a. Applicants for Regular Membership
An applicant for regular membership in this Association shall be a graduate of a college of osteopathic medicine ~~approved~~ **ACCREDITED** by the American Osteopathic Association's Commission on Osteopathic College Accreditation or a graduate of an allopathic medical school accredited by the Liaison Committee on Medical Education or a graduate of a school of medicine located outside of the United States who completed residency training in a program accredited by the Accreditation Council on Graduate Medical Education and shall be eligible for licensure as an osteopathic or allopathic physician and/or surgeon or shall be in a training program, which is a prerequisite for licensure. Allopathic applicants should have an interest in promoting, advocating for and representing the interests of osteopathic medicine and osteopathic physicians.

Application shall be made on the prescribed form and shall be accompanied by payment of the appropriate dues amount.

Unless specifically noted, an applicant whose completed application and payment of appropriate dues has been received and processed shall be enrolled as a regular member. An applicant whose membership in this Association has previously been

withdrawn for reasons other than ~~failure to meet CME requirements or~~ non-payment of dues, or who has previously been convicted of a felony offense or whose license to practice has at any time been revoked, shall be further required **TO PROVIDE THE APPLICATION TO AND RECEIVE APPROVAL FROM THE BUREAU OF MEMBERSHIP; SUCH APPROVAL SHALL BE MADE BY THE BUREAU OF MEMBERSHIP IN ITS DISCRETION**. ~~to obtain the endorsement of the secretary of the divisional society in the state, province, or foreign country in which the applicant resides (or the endorsement of the secretary of the uniformed services divisional society in the case of applicants currently serving in the uniformed services of the United States), or, lacking this endorsement, an applicant who is in good standing in his community shall provide letters of recommendation from three members of the Association and provide a personal written statement as to why membership in the Association should be extended or restored. Such information and application shall be carefully reviewed by the Bureau of Membership, which shall make an appropriate recommendation for reinstatement to the Board of Trustees.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended

DATE: _____July 22, 2023_____

UBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE II: SECTION 3

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is important to distinguish that a member can be purposeful and/or persistent; and

WHEREAS, to conform the Bylaws with current practices and avoid inconsistencies with Article VII, Section 1(h) that provides that the Committee on Ethics is tasked with investigating complaints now therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article II Membership
Section 3-Disciplinary Action
The membership of any member of the Association who, in the opinion of the Executive Committee of the Association, purposely ~~and~~ **OR** persistently violates the established policy of the Association or who seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive Committee of the Association ~~upon the recommendation of the Committee on Membership~~, after the member has been given notice and an opportunity to be heard before such action is taken. Any individual whose membership has been so revoked, suspended, or placed on probation shall have the right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of the action of the Executive Committee, ~~and~~ the Board of Trustees, on review, may in its discretion take such action in regard thereto as it deems appropriate.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE II: SECTION 4

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, there is no longer a Continuing Medical Education requirement for membership; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article II Membership
~~Section 4-Continuing Medical Education~~
~~Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE III: SECTION 1 A AND 1 B, AND 3

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, to conform the Bylaws language with current and best practices; and

WHEREAS, the Bureau of Membership can develop the policy for hardship cases for the Board of Trustees to approve; and

WHEREAS, an assessment fee has a negative notation and to retain membership should not be considered; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article III - Dues and Assessments

Section 1-Dues

a. Members

The annual dues of all members of the Association (except for allied members discussed in **ARTICLE III**, Section 1(c) and student members discussed in **ARTICLE III**, Section 1(d) shall be determined by the House of Delegates. The Board of Trustees shall be responsible for administration of dues, including determination of the membership year, the schedule for payment of dues, and the suspension of membership for nonpayment of dues. A suspended member may be reinstated upon payment of dues and assessments, provided such payment is received prior to the end of the membership year.

b. Hardship Cases

Upon recommendation of the ~~Committee on~~ **BUREAU OF** Membership, the Board of Trustees, or its Executive Committee, may **APPROVE A POLICY THAT IDENTIFIES CIRCUMSTANCES UNDER WHICH THE AOA WILL** remit a part or all of the annual dues of a member in good standing who, **DUE TO A PHYSICAL OR MENTAL DISABILITY MAINTAINS A LIMITED PRACTICE OR IS UNABLE TO PRACTICE.** ~~because of physical disability, maintain a limited practice or no practice. For just cause, properly authenticated, similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular members not otherwise specifically covered by other provisions of this Article.~~

Section 2-Assessments

To meet emergencies the Board of Trustees may levy such assessments as may be necessary, provided that the total of such assessments in any one-year

33 shall not exceed the amount of the annual dues. Failure to pay such
34 assessments shall incur the same penalty as failure to pay dues. Those
35 dropped from membership for nonpayment of dues during the fiscal year in
36 which an assessment is levied shall be required to pay the assessment prior to
37 reapplying for membership.

38 Section 3-Refunding Dues
39 No dues will be refunded if a membership is terminated for cause **AS PROVIDED**
40 **IN ARTICLE II, SECTION 3 OR ARTICLE VII, SECTION 1, PART H OF THESE**
41 **BYLAWS** or because of resignation.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE IV: SECTION 2

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is desirable to allow for methods of communicating pertinent changes to the AOA's Code of Ethics beyond publication in *The Journal of Osteopathic Medicine*; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article IV Code of Ethics
Section 2
The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds vote of the total number of delegates accredited for voting, provided a copy of the proposed amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting at which it is to be voted upon.

It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by electronic communication or first class mail, postage prepaid, to each divisional **SOCIETY** and ~~specialty society~~ **AFFILIATED ORGANIZATION** entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and **COMMUNICATED IN AN OFFICIAL PUBLICATION OF THE ASSOCIATION** ~~published in *The Journal of Osteopathic Medicine*~~ not later than one month before the annual meeting at which the amendment is scheduled for consideration.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE V: SECTION 3

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, to ensure accuracy, the name of the committee has been updated; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article V House of Delegates
Section 3-Committee on Credentials
The Committee on Credentials shall consist of three or more members appointed by the President and it shall be the duty of the Committee to receive and validate the credentials of the delegates to the House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall furnish the ~~Credentials~~ Committee **ON CREDENTIALS** a list showing the number of delegates to which each divisional society is entitled. In case any organization has selected more than its legal representation, the Chief Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of this action.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII: SECTION 5

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, updating the indemnification section to be concise is a standard practice; and

WHEREAS, it is necessary to amend the AOA's Bylaws to provide clarity; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VII Board of Trustees
Section 5-Indemnification
~~Each trustee, officer, and employee of this Association now or hereafter in office and his heirs, executors, and administrators, and each trustee, officer, and employee of this Association and his heirs, executors, and this Association as employee, trustee, director, or officer of another corporate entity controlled by this Association, shall be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in which he may be or become involved by reason of his acts of omission or commission, or alleged acts of omission or commission as such trustee, officer, or employee, or, subject to the subsequent provisions of the section, any settlement thereof, whether or not he continues to be such trustee, officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts, provided that such indemnification shall not apply with respect to any matters as to which such trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of Trustees has determined that such settlement and reimbursement appear to be for the best interests of this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs) by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in addition to and not exclusive of any and all other rights~~

~~as to which any such trustee, officer, or employee may be entitled under any bylaw, agreement, or otherwise.~~

~~Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Association in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized in this section.~~

EACH TRUSTEE, OFFICER, BUREAU MEMBER, COUNCIL MEMBER, COMMITTEE MEMBER, OR EMPLOYEE OF THE ASSOCIATION SHALL BE HELD HARMLESS AND INDEMNIFIED BY THE ASSOCIATION AGAINST ALL CLAIMS AND LIABILITIES AND ALL COSTS AND EXPENSES, INCLUDING ATTORNEYS' FEES AND DEFENSE COSTS, REASONABLY INCURRED OR IMPOSED UPON SUCH PERSON IN CONNECTION WITH OR RESULTING FROM ANY ACTION, SUIT OR PROCEEDING, OR THE SETTLEMENT OR COMPROMISE THEREOF, TO WHICH SUCH PERSON MAY BE MADE A PARTY BY REASON OF ANY ACTION TAKEN OR OMITTED TO BE TAKEN BY SUCH PERSON AS A TRUSTEE, OFFICER, COUNCIL MEMBER, COMMITTEE MEMBER, EMPLOYEE OR AGENT OF THE ASSOCIATION, IN GOOD FAITH. THIS RIGHT OF INDEMNIFICATION SHALL INURE TO SUCH PERSON WHETHER OR NOT SUCH PERSON IS A TRUSTEE, OFFICER, BUREAU MEMBER, COUNCIL MEMBER, COMMITTEE MEMBER, OR EMPLOYEE AT THE TIME SUCH LIABILITIES, COSTS OR EXPENSES ARE IMPOSED OR INCURRED AND, IN THE EVENT OF SUCH PERSON'S DEATH, SHALL EXTEND TO SUCH PERSON'S LEGAL REPRESENTATIVES.

TO THE EXTENT AVAILABLE, the Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of any person who is or was a trustee, **OFFICER, BUREAU MEMBER, COUNCIL MEMBER, COMMITTEE MEMBER, OR** employee of the Association or is or was serving at the request of the Association as a trustee, director, officer, employee, or agent of another corporate entity controlled by the Association against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Association would have the authority or power to indemnify him against such liability under the provisions of this section.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 22, 2023

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VIII SECTION 9 AND NEW ARTICLE XI: SECTION 1 AND 2

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it is not common business practice to have the Editor-in-Chief as an administrative officer as this position is not intricately involved in the daily operations of the Association; and

WHEREAS, it is common business practice to have an Editor-in-Chief oversee a scholarly journal and report to the Board of Trustees and Chief Executive Officer; and

WHEREAS, if approved any reference to the Editor-In-Chief under the Administrative Officers sections will be removed; and

WHEREAS, it is necessary to amend the AOA's Bylaws to reflect common business practice; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VIII Duties of Officers

~~Section 9-Editor-in-Chief~~

~~The Editor-in-Chief shall:~~

~~a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of *The Journal of Osteopathic Medicine*, other periodical publications of the Association under the general supervision of the Chief Executive Officer and shall cooperate with all departments of the central office.~~

~~b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.~~

ARTICLE XI PUBLICATIONS

SECTION 1 — SCHOLARLY JOURNAL

THE ASSOCIATION SHALL MAINTAIN A SCHOLARLY JOURNAL, *THE JOURNAL OF OSTEOPATHIC MEDICINE*, ALONG WITH ANY OTHER SCIENTIFIC PUBLICATONS AS THE BOARD OF TRUSTEES MAY DEEM APPROPRIATE. ANY SUCH PUBLICATONS SHALL BE OVERSEEN BY AN

EDITOR, APPOINTED BY THE BOARD OF TRUSTEES, WHO SHALL BE RESPONSIBLE FOR OVERSEEING THE EDITORIAL DECISIONS OF ANY SUCH PUBLICATIONS.

SECTION 2 – EDITOR

THE EDITOR SHALL:

a. **HAVE THE EDITORIAL DIRECTION, IN ACCORDANCE WITH THE ESTABLISHED POLICIES OF THE BOARD OF TRUSTEES AND HOUSE OF DELEGATES, OF *THE JOURNAL OF OSTEOPATHIC MEDICINE*, OTHER PERIODICAL PUBLICATONS OF THE ASSOCIATION UNDER THE GENERAL SUPERVISION OF THE CHIEF EXECUTIVE OFFICER AND SHALL COOPERATE WITH ALL DEPARTMENTS OF THE CENTRAL OFFICE.**

b. **BE PROVIDED WITH SUCH ASSISTANCE AS IS NECESSARY TO THE PROPER CONDUCT OF THEIR OFFICE, SUBJECT TO THE DIRECTIVES OF THE BOARD OF TRUSTEES THROUGH THE CHIEF EXECUTIVE OFFICER**.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Postpone to 2024___

DATE: ____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VIII: SECTION 6 F and 7 A AND 7 D

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, should the House of Delegates elect to remove the Editor-In-Chief as an Administrative Officer, this position would need to be removed; and

WHEREAS, it is not common practice to file a bond with a surety company; and

WHEREAS, it is necessary to amend the AOA's Bylaws; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VIII Duties of Officers

Section 6 – Chief Executive Officer

The Chief Executive Office shall:

f. Be authorized to provide such assistance as is necessary for the proper conduct of the central office, subject to the directives of the Board of Trustees, and at the expiration of his term shall deliver to his successor all property and papers pertaining to his office. ~~He shall file bond with such surety company and in such amount as the Board of Trustees shall determine.~~

Section 7— Chief Financial Officer

The Chief Financial Officer **SHALL**:

a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive Officer ~~and Editor-In-Chief~~ under the direction of the Board of Trustees, and disburse such funds only in the manner prescribed by the Board of Trustees.

d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees ~~through~~ **AND** the Chief Executive Officer. ~~He shall file bond with such surety company and in such sum as the Board of Trustees may determine.~~

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII: SECTION 1 H

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the names of the committees have changed; and

WHEREAS, it is necessary to amend the AOA's Bylaws to reflect the current practice; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VII Board of Trustees
Section 1 - Duties

h. Decide finally all questions of an ethical or judicial character. It shall have investigated by the **BOARD APPEALS AND ETHICS REVIEW** Committee ~~on Ethics~~ all charges or complaints of violation of the Constitution, Bylaws, or of grossly unprofessional conduct of any member. The Board shall have the power to censure, place on probation for not exceeding a three-year period, suspend for not exceeding a three-year period or expel a member, as the findings warrant. A member may be cited to appear before it by the Board of Trustees or the **BOARD APPEALS AND ETHICS REVIEW** Committee ~~on Ethics~~ to answer charges or complaints of unethical or unprofessional conduct. Upon the final conviction of any member of an offense amounting to a felony under the law applicable thereto, or the final revocation of, or suspension of, his license to practice in a state on the grounds of having committed a violation of a disciplinary provision of the licensing law by a duly constituted state licensing agency, or the voluntary surrender of his license while under charges of having committed said violation, such member shall automatically be deemed expelled from membership in this Association; a conviction shall be deemed final for the purposes hereof when affirmed by an appellate tribunal of final jurisdiction or upon expiration of the period allowed for appeal. The ~~Committee on~~ **BUREAU OF** Membership shall be granted the authority to restore to membership a doctor whose license was revoked, and later retroactively reinstated by his licensing board.

If, because of a breach of the Code of Ethics, a member shall have been suspended, or expelled from a divisional society or affiliated organization by proper action of such divisional society or affiliated organization, the Board of Trustees of this Association shall review the record of such decision. The

36 decision may first be referred to the **BOARD APPEALS AND ETHICS**
37 **REVIEW** Committee ~~on Ethics~~ for recommendations. If the Board shall
38 concur in the action of the divisional society or affiliated organization, such
39 member shall be suspended for the same period of time or expelled from
40 this Association upon the same basis as in the decision of the divisional
41 society or affiliated organization. The Board is authorized to adopt and
42 amend from time to time, in the manner directed by the Board, a Guide for
43 Administrative Procedure regulating the procedure applicable to matters
44 involving violations of the Code of Ethics.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE XII

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, it has been recommended that the pronouns within the Bylaws be updated to 'their', 'them', 'they' to be gender neutral, show inclusivity, and eliminate implicit bias.

WHEREAS, the usage of such gender neutral pronouns would eliminate the need for a gender disclaimer; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

~~Article XII Gender Disclaimer~~
~~The American Osteopathic Association is open to all persons and does not discriminate against any person because of their gender identity; therefore, the wording herein importing the masculine or feminine gender is inclusive of all gender identities and imports no such discrimination.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
H439-A20 Gender Identity
H406-A19 Discrimination in Healthcare

FISCAL IMPACT: $0

ACTION TAKEN: __Postpone to 2024___

DATE: ____July 22, 2023_____

SUBJECT: CONFLICTS OF INTEREST

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Rules and Guidelines on Physician Professional Conduct and the AOA Code of Ethics recognizes that physicians have an obligation to act professionally; and

WHEREAS, the AOA Rules and Guidelines is vague in stating what that behavior entails, stating in the Rules and Guidelines that “appropriate management of potential conflicts of interest” be employed; and

WHEREAS, people serving on multiple boards overseeing different aspects of osteopathic medicine may create conflicts. Clarity on what constitutes a conflict of interest, and a process to address potential conflicts is needed to address disagreements on whether or not a conflict exists; and

WHEREAS, meaningful and clear policy can guard against potential conflicts of interest and clarify situations in which conflicts may exist; and

WHEREAS, it is in the best interests of the AOA to maintain fair and effective guidelines to protect against conflicts of interest; and

WHEREAS, this lack of clarity has resulted in disparate definitions of conflict ranging from acceptance of financial incentives of any kind or financial incentives deemed to be substantive enough to effect judgment without clarification of how these determinations would be made; now, therefore be it

RESOLVED, that the AOA work to identify these potential conflicts of interest, particularly in the AOA and affiliated organizations with a policy to be included in the Code of Ethics; and, be it further

RESOLVED, that the AOA accept that people in positions of leadership be asked to recuse themselves from discussion or voting on items in which they have a duality of interest, or conflict of interest, and that policies be developed to guard against decisions being made that could be influenced by conflicting interests, and that public sharing of annual declarations of conflicts be shared on the AOA webpage for members to see; and, be it further

RESOLVED, that a system of adjudicating conflicts of interest in dispute be developed by the AOA for situations where members do not agree on whether a conflict exists.

Background Information: Provided by AOA Staff
Current AOA Policy: The Conflict of Interest policy was approved by the AOA Board of Trustees in February 2022.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ____Not Adopted_____

DATE _____July 22, 2023_____

SUBJECT: INTERPRETATION OF THE AMERICAN OSTEOPATHIC ASSOCIATION CODE OF ETHICS FOR EMPLOYED PHYSICIANS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, according to a recent study[1], 74% of physicians are employed by hospitals/healthcare systems or corporations (Physician Employers); and

WHEREAS, employed physicians often face unique ethical challenges as a result of being an employee[2]; and

WHEREAS, having an interpretation of the American Osteopathic Association Code of Ethics which addresses the challenges unique to employed physician would help these physicians advocate for patients and themselves; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) Committee on Ethics is directed to produce a written interpretation guide to the AOA Code of Ethics which addresses the unique ethical challenges experienced by employed physicians.

Resources
1. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/Specialty%20Analysis%20Key%20Findings-final.pdf?ver=u7j_0pnUKpOdsvLf1i-siA%3d%3d April 2022, accessed May 4, 2023

2. **DeCamp, Matthew, etal.,** Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper From the American College of Physicians. Ann Intern Med. 16 March 2021. doi:10.7326/M20-7093

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Not Adopted

DATE: July 22, 2023

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (600 SERIES) -w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Centers For Medicare and Medicaid Services Policies (SR–Source:H600-A/18)	BFHP	Ad Hoc	Adopted
H-601	Combating Pharmaceutical Evergreening to Decrease Healthcare Costs and Increase Quality, Competition (SR–Source:H629-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-602	Comprehensive Gun Violence Reform (SR–Source:H630-A/18)	BFHP	Ad Hoc	Adopted
H-603	Increasing the Education and **AVAILABILITY** ~~Preventative Prescribing~~ of Naloxone Use for Opioid Overdose (SR–Source:H632-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-604	Recognizing Sexual Assault Survivors -Rights (SR–Source:H634-A/18)	BFHP	Ad Hoc	Adopted
H-605	Urge Congress to Retain DACA Protections (SR–Source:H637-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-606	Veterans – Health Care for U.S. (SR–Source:H614-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-607	AOA Accreditation of Sponsors Providing Osteopathic Continuing Medical Education (AOA Category 1-A) (SR-Source:H618-A/18)	BOE	Ad Hoc	Adopted
H-608	Tenets of Osteopathic Medicine (SR-Source:H617-A/18)	BOE	Ad Hoc	Adopted
H-609	Taser Safety (SR-Source:H615-A/18)	BORPH	Ad Hoc	Referred to BORPH
H-610	Tobacco Use in Entertainment Media (SR-Source:H613-A/18)	BORPH	Ad Hoc	Adopted
H-611	Cancer Screening- Payment for (SR-Source:H603-A/18)	CERA	Ad Hoc	Adopted
H-612	Qualifications for the Practice of OMT and the Coding and Billing for (SR-Source:H608-A/18)	CERA	Ad Hoc	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (600 SERIES) -w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-613	ICD-10 Codes for Laboratory Tests-Assignment of Appropriate (SR-Source:H610-A/18)	CERA	Ad Hoc	Adopted
H-614	Opposing Policies by Third Party Payors that may Negatively Impact the Provision of Healthcare (SR-Source:H607-A/18)	CERA	Ad Hoc	Adopted as Amended
H-615	Physician Co-Management of a Patient (SR-Source:H604-A/18)	CERA	Ad Hoc	Adopted as Amended
H-616	Recovery Audit Contractors (RAC)- Payment of (SR-Source:H606-A/18)	CERA	Ad Hoc	Adopted
H-617	Criminal Liability for Clinical Decisions (SR-Source:H605-A/18)	CSHA	Ad Hoc	Adopted as Amended
H-618	Osteopathic Graduate Medical Education (SR-Source:H611-A/18)	BOE	Ad Hoc	Adopted as Amended
H-619	Board Certification of Insurance Company Peer Reviewers	MAOPS	Ad Hoc	Adopted as Amended
H-620	Licensure of Insurance Company Employed Physicians	MAOPS	Ad Hoc	Adopted as Amended
H-621	Reducing Burdens in the Utilization of Step Therapy	MOA	Ad Hoc	Not Adopted
H-622	Protection of the Patient-Physician Relationship and Opposition to Physician Penalties for the Provision of Gender Affirming Care	OOA	Ad Hoc	Adopted as Amended
H-623	Invisible Disabilities	OOA	Ad Hoc	Adopted as Amended
H-624	Improving Pharmaceutical Formulary Accessibility	OOA	Ad Hoc	Adopted as Amended
H-625	Conflicts Between Employed Physicians and Employers	IOMA	Ad Hoc	Referred to IOMA
H-626	Non-Physician Clinician Medical Liability	IOMA	Ad Hoc	Adopted as Amended
H-627	CAQ for Bariatric Surgery	ACOS	Ad Hoc	Not Adopted

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (600 SERIES) -w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-628	In Support of Training and Advocacy for Diverse Patient Populations Including but Not Limited to LGBTQ2+ Within Residency	OPSC	Ad Hoc	Adopted as Amended
H-629	Minimal Credentialing in Post-Acute and Long-Term Care (PALTC) Medicine	FOMA	Ad Hoc	Adopted as Amended
H-630	Requirement for Minimum Education Standards for Medical Directors	FOMA	Ad Hoc	Adopted as Amended
H-631	Implementing Land Acknowledgements at American Osteopathic Association (AOA) Events	SOMA	Ad Hoc	Referred to SOMA
H-632	Increasing Access to Affordable Insurance for Undocumented Immigrants	SOMA	Ad Hoc	Not Adopted
H-633	Non-Compete Clauses in Healthcare Employment Contracts	BFHP	Ad Hoc	Adopted as Amended

SUBJECT: CENTERS FOR MEDICARE AND MEDICAID SERVICES POLICIES – SOURCE: H600-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association will continue to inform state associations
7 and their members on policies and rules being considered by the Centers for
8 Medicare and Medicaid Services and/or other federal agencies on major
9 patient/physician issues and encourages the state associations to provide
10 their members with the information and take an active role in responding to
11 CMS on policies and rules pertinent to their members, their practices, and
12 patients.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: COMBATING PHARMACEUTICAL EVERGREENING TO DECREASE HEALTHCARE COSTS AND INCREASE QUALITY, COMPETITION – SOURCE: H629-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) advocate**S** for and support**S** all
7 efforts to combat evergreening defined as the practice of extending the patent on a
8 drug by filing a new patent for a marginal modification in shape, dose, or
9 color in such a way that no efficacious benefit is made~~, in the pharmaceutical~~
10 ~~sector~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: COMPREHENSIVE GUN VIOLENCE REFORM – SOURCE: H630-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and determined that it is duplicative; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be SUNSET.

The American Osteopathic Association join physician like-minded organizations in the call for Congressional legislation that:

1. Labels gun violence as a national public health issue.
2. Funds appropriate research on gun violence as part of future federal budgets.
3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity.

Background Information: Provided by AOA Staff
Current AOA Policy: H630-A/18 was incorporated in H409-A/21 FIREARM POLICY COMPENDIUM, which is the comprehensive white paper on firearms by BFHP.

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: INCREASING THE EDUCATION AND **AVAILABILITY** ~~PREVENTATIVE PRESCRIBING~~ OF NALOXONE ~~USE~~ FOR OPIOID OVERDOSE – SOURCE: H632-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and determined that it remains relevant; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) supports **THE CONTINUED AVAILABILITY OF NALOXONE AS AN OVER-THE-COUNTER MEDICATION,** ~~preventive 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.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: RECOGNIZING SEXUAL ASSAULT SURVIVORS' RIGHTS – SOURCE: H634-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) advocate for the legal protection of
7 sexual assault survivors' rights as defined by the Survivors' Bill of Rights Act of
8 2016.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: URGE CONGRESS TO RETAIN DACA PROTECTIONS – SOURCE: H637-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports Deferred Action for
7 Childhood Arrivals (DACA) medical students, residents, and physicians; and
8 the AOA support and urge Congress to pass comprehensive immigration
9 legislation that accommodates and resolve**S** DACA status.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: VETERANS – HEALTH CARE FOR U.S. – SOURCE: H614-A/18

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports adequate health care funding by
7 the federal government to provide health care for all U.S. Veterans at Veterans
8 Health Administration **(VHA)** facilities and supports federal funding for veterans to
9 utilize ~~community~~ **NON-VHA EMPLOYED** physicians for care **IN ORDER TO**
10 **IMPROVE ACCESS AND QUALITY OF CARE FOR AMERICAN VETERANS**
11 when ~~Veterans' Health Administration~~ **VHA** facilities cannot provide adequate ~~or~~
12 timely, **OR REASONABLE GEOGRAPHIC** access.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008; 2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: AOA ACCREDITATION OF SPONSORS PROVIDING OSTEOPATHIC CONTINUING MEDICAL EDUCATION (AOA CATEGORY 1-A) – SOURCE:H-618-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) be barred from divesting itself of,
7 through merger, sale or other action, the responsibility of accrediting osteopathic
8 continuing medical education sponsors to any entity other than an AOA recognized
9 osteopathic affiliated organization.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2018)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: TENETS OF OSTEOPATHIC MEDICINE – SOURCE: H617-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association approves the following consensus statement
7 on the tenets of osteopathic medicine:
8 1. The body is a unit; the person is a unity of body, mind and spirit.
9 2. The body is capable of self-regulation, self-healing and health maintenance.
10 3. Structure and function are reciprocally interrelated.
11 4. Rational treatment is based upon an understanding of the basic principles of
12 body unity, self-regulation and the interrelationship of structure and function.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: TASER SAFETY - SOURCE: H-615-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association encourages further research on cardiac
7 arrest, death, and other adverse health effects associated with shocks from taser
8 electronic control devices.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _Referred to BORPH_____

DATE: _____July 22, 2023_____

SUBJECT: TOBACCO USE IN ENTERTAINMENT MEDIA
- SOURCE: H-613-A/18

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association encourages media producers to eliminate
7 the use of tobacco products in entertainment media.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2003; 2008; 2013 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H-308-A/18 Alcohol and Tobacco – Advertising Ban on

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: CANCER SCREENING- PAYMENT FOR - SOURCE: H603-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports cancer screening payment by all
7 payers according to the current evidence-based guidelines.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008 Amended and Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: QUALIFICATIONS FOR THE PRACTICE OF OSTEOPATHIC MANIPULATIVE TREATMENT AND THE CODING AND BILLING FOR- SOURCE: H608-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; and

WHEREAS, certifying boards now provide option for family medicine certification with or without NMM certification. Physicians should still be able to practice and get paid for OMT, regardless of board certification status/type; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association believes that only fully licensed physicians are qualified to perform and report osteopathic manipulative treatment (OMT) with **CURRENT** CPT Codes~~. 98925-98929.~~ **LICENSED PHYSICIANS QUALIFIED TO PROVIDE OMT SHOULD NOT BE DENIED PAYMENT BASED ON WHETHER OR NOT A PHYSICIAN HAS CHOSEN TO PURSUE OMT BOARD CERTIFICATION.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: ICD-10 CODES FOR LABORATORY TESTS — ASSIGNMENT OF APPROPRIATE - SOURCE: H610-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the use of appropriate single ICD
7 codes to justify the ordering of laboratory tests, if those tests are ordered as part of
8 the evaluation of a disease process or in the context of an already known disease;
9 and the AOA will communicate this policy to the Centers for Medicare and Medicaid
10 Services, the Department of Health and Human Services, health insurance
11 companies, and to the U.S. Congress.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: OPPOSING POLICIES BY THIRD PARTY PAYORS THAT MAY NEGATIVELY IMPACT THE PROVISION OF HEALTHCARE - SOURCE: H607-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; now. therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association **IN ORDER** to preserve the physician-patient relationship and physician clinical judg~~e~~ment as the basis for formulating an individual plan of care, supports policy requiring that third party payors should assist physicians ~~by publishing~~ **TO PUBLISH UTILIZATION MANAGEMENT POLICIES, COVERAGE CRITERIA, THEIR CORRESPONDING** guidelines, ~~and~~ rationales **AND POLICIES** for exceptions to expedite care; **AND BE IT FURTHER RESOLVED, THAT THE AMERICAN OSTEOTPATHIC ASSOCIATION** opposes **ANY** policies and any practice**S** of third party payors that replace physician clinical judgment with a fixed protocol or potentially less effective medication~~s~~ for required trial of treatment~~; and opposes **ANY** policies and any practice**S** of third party payors that replace physician clinical judgment with a fixed protocol~~ **OR** ~~of~~ prerequisite of diagnostic procedures

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: PHYSICIAN CO-MANAGEMENT OF A PATIENT
- SOURCE: H604-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy and determined that it remains relevant; now. therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association's supports co-management of a patient, requiring the patient to have an examination by the physician who will be performing the procedure; the physician providing the procedure be available for the follow-up care of the patient; and if for any reason the physician providing the procedure cannot provide the pre- and post-procedural care to the patient, that ~~he/she~~ **THEY/THEM** arrange for an osteopathic or allopathic physician to provide for the pre-procedural and post-procedural care. In cases where a physician is unavailable, non-physician clinicians should be under physician supervision, in accordance with the state law.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2002, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 22, 2023_____

SUBJECT: RECOVERY AUDIT CONTRACTORS (RAC)- PAYMENT OF - SOURCE: H606-A/18

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy and determined that it remains relevant; now. therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports removing the contingency payment
7 of Recovery Audit Contractors (RACs) replacing with a flat-rate compensation.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2013; 2018 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: _____July 22, 2023_____

SUBJECT: CRIMINAL LIABILITY FOR CLINICAL DECISIONS - SOURCE: H605-A/18

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy and
3 determined that it remains relevant; now therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED WITH AN EDITORIAL CORRECTION.

6 The American Osteopathic Association opposes criminal ~~of~~ liability for a physician
7 whose clinical decisions were made without malice and in good faith.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2020 Referred to CSHA)

Prior HOD action on similar or same topic:
Resolution H300-A/20 Intractable and/or Chronic Pain (Not Associated with End of Life Care) was referred to CSHA.

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 22, 2023_____

SUBJECT: OSTEOPATHIC GRADUATE MEDICAL EDUCATION
-SOURCE:H611-A/18

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association urges its member physicians to support
7 hospitals that provide osteopathic postdoctoral training ~~programs, including those~~
8 with osteopathic recognition through ACGME, which are an integral part of
9 osteopathic medical education.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1998; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended)

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 22, 2023_____

SUBJECT: BOARD CERTIFICATION OF INSURANCE COMPANY PEER REVIEWERS

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Ad Hoc Committee

WHEREAS, peer-to-peer reviews are discussions between a physician and an insurance company physician employee that generally occur after an initial prior authorization/pre-certification request has been denied[1]; and

WHEREAS, a 2021 American Medical Association physician survey found that 91% perceived that the prior authorization process, which includes peer-to-peer reviews, had a “somewhat” or “significant” negative impact on patient clinical outcomes[2]; and

WHEREAS, a 2019 survey by the American Medical Association found that physicians responded that in only 15% of peer-to-peer reviews did they feel the health plan’s “peer” ‘always or often’ had the appropriate qualifications to assess and make a determination regarding the prior authorization request[3]; and

WHEREAS, **INITIAL** board certification ~~of physicians~~ helps demonstrate to the public that physicians and medical specialists meet nationally recognized standards for education, knowledge, experience, and skills and ~~maintains~~ **MAINTAINING** their certification through continuous learning and practice improvement ~~in order~~ **ENABLE THEM** to provide high quality care ~~in~~ in a specific medical specialty or subspecialty[4] and ensures the advancement of clinical knowledge and skills throughout a physician’s career[5]; and

WHEREAS, physicians employed by insurance plans who are participating in peer-to-peer reviews may not be required (depending on the state) to be board certified in the specialty and/or subspecialty of the requesting physician or specialty and/or subspecialty related to the medical need(s) of the patient[6]; and

WHEREAS, ~~it is not unprecedented for~~ **MANY** states ~~to~~ **DO** require a physician making medical determinations for insurance companies to be of the same specialty and/or subspecialty as the requesting physician and/or specialty or subspecialty related to the patient’s specific medical needs[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports state and federal requirements that all insurance company medical directors and any physicians employed by a plan that make medical determinations, including

peer-to-peer reviews, be board certified by the American Osteopathic Association or the American Board of Medical Specialties in a specialty or subspecialty related to the requesting physician's specialty and/**OR** subspecialty and to the specific medical needs of the patient for which the requesting physician is seeking prior authorization/pre-certification.

References

[1,3]2021. Report of the Council on Medical Service. American Medical Association. Promoting Accountability in Prior Authorization. https://www.ama-assn.org/system/files/2021-06/j21-cms-report-4.pdf

[2]2021 AMA Prior Authorization Physician Survey. American Medical Association. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[4]American Board of Medical Specialties. Importance of board certification and maintaining certification. Abms.org/faq/importance-of-board-certification-and-maintaining-certification.

[5]American Osteopathic Association. Why choose AOA board certification? Certicifcation.osteopathic.org/why-AOA/

[6,7]2021. Prior Authorization State Law Chart. American Medical Association. 2021. https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf

Background Information: Provided by AOA Staff

Current AOA Policy: H642 A/20 Prior Authorization

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ___July 22, 2023_____

SUBJECT: LICENSURE OF INSURANCE COMPANY-EMPLOYED PHYSICIANS

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Ad Hoc Committee

WHEREAS, physician licensing ensures that all practicing physicians have appropriate education and training, and that they abide by recognized standards of professional conduct while serving their patients[1]; and

WHEREAS, practicing physicians are required to have a medical license from the state licensing board in which they are practicing, and these Boards have the responsibility of determining when a physician's professional conduct or ability to practice medicine warrants modification, suspension, or revocation of a license to practice medicine[2]; and

WHEREAS, the Federation of State Medical Boards considers neglect of a patient, failure to meet the accepted standard of care in a state, and failure to meet continuing medical education requirements (which differ from state to state), as unprofessional conduct[3]; and

WHEREAS, **SOME** states such as California, Missouri, North Carolina, and Texas require state licensure of medical directors and/or other physicians employed by the plan and involved in determining clinical appropriateness of noncertifications in the specific state[4]; and

WHEREAS, without licensure in the state the patient is located, it is difficult for **A** state licensing Board to hold physicians accountable for unprofessional conduct related to their medical decision making, including lack of knowledge of standards of care in the state; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports state and federal requirements that all insurance company physicians and medical directors participating in reviewing, approving, and denying prior authorization and pre-certification requests, and engaging in peer-to-peer reviews and appeals processes, be licensed to practice medicine in the state in which the patient ~~resides.~~ **IS RECEIVING MEDICAL CARE.**

References

[1]Federation of State Medical Boards. About Physician Licensure. FSMB website, www.fsmb.org.
[2]Federation of State Medical Boards: About Physician Discipline. FSMB Website, www.fsmb.org.
[3]Federation of State Medical Boards: About Physician Discipline. FSMB Website, www.fsmb.org.
[4]2021 Prior Authorization State Law Chart. American Medical Association. 2021. https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf

Background Information: Provided by AOA Staff
Current AOA Policy: H301-A-22 State Licensure of Managed Care Organizations Medical Directors

This proposed policy aligns with H602-A/21 which supports requiring MCO medical directors to be fully licensed in the state where the care is being provided.

We have submitted comments to CMS supporting any peer reviews, and especially prior to adverse decisions, be conducted by a relevant specialist and expert in the item/service being reviewed. AOA resolution for action on prior authorization (H602-A/21) is broad but does not include explicit language on peer-to-peer review.

Prior HOD action on similar or same topic**:** None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: REDUCING BURDENS IN THE UTILIZATION OF STEP THERAPY

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, Step therapy is a process by which medical insurers (private or public) provide coverage for more expensive medications, only after less expensive medications have been prescribed first, even if the lower cost medications may be less effective in the management of the medical condition; and;

WHEREAS, By the time the patient has exhausted treatments as dictated by the step therapy, their medical condition could clinically worsen as well as suffering adverse symptoms as a consequence; and

WHEREAS, difficulty in obtaining exceptions by physicians to the step therapy dedicated regimen, may ultimately increase health care costs; and

WHEREAS, Insurance-mandated step therapy is likely to impede access to newer, innovative therapies; and

WHEREAS, while utilization management like step therapy defines access for patients, it often does not keep pace with clinical guidelines*; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with relevant stakeholders to ensure step therapy protocols are based on medical criteria and clinical guidelines developed by independent experts; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) work with relevant stakeholders to streamline the exemption process for patients to move from step therapy.

References

1. https://www.steptherapy.com/step-therapy-legislation-by-state/
2. https://rarediseases.org/state/michigan/
3. https://rarediseases.org/wp-content/uploads/2022/04/20220310_Safe-Step-Coalition-RFI-Comments_Healthy-Futures-Task-Force-Subcommittee-on-Treatments.pdf
4. *Researchers at Tufts Medical Center recently found that step therapy was applied to 38.9% of drug coverage decisions, and more than half (55.6%) of those decisions required more steps than the clinical guidelines for diseases like multiple sclerosis, psoriasis, psoriatic arthritis, or chronic migraines

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
Resolution H602-A2021_Prior Authorization was an approved resolution with action assigned to the Public Policy team.

The Public Policy team was involved in drafting legislation to address this issue, the Safe Step Act. The team has been involved since the beginning with drafting of the Safe Step Act, August of 2019, with Sen. Murkowski's office.

Since its initial introduction in late 2019, the AOA has been supportive of the legislation, and continues to be part of our legislative priority in PAC events.

Most recently, the AOA sent endorsement/support letters to sponsors of the legislation for its reintroduction this Congress. The legislation was reported out of the HELP Committee in May of 2023.

FISCAL IMPACT: $0

ACTION TAKEN: _____Not Adopted____

DATE: _____July 22, 2023_____

SUBJECT: PROTECTION OF THE PATIENT-PHYSICIAN RELATIONSHIP AND OPPOSITION TO PHYSICIAN PENALTIES FOR THE PROVISION OF GENDER AFFIRMING CARE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, gender affirming care for transgendered individuals includes one or more of the following components: social affirmation, puberty blockers, cross-sex hormone therapy, gender affirming surgery, and legal affirmation; and

WHEREAS, transgendered individuals of all ages consider and attempt suicide at rates significantly higher than the general population. Factors associated with lower risk of suicide include supportive families, receive gender affirming care, and living in a state with a gender identity nondiscrimination statute; and

WHEREAS, the AOA has adopted Policy ~~H445-A/15~~ **H439-A/20** which supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity; and

WHEREAS, the **AMERICAN OSTEOPATHIC ASSOCIATION, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS,** American Medical Association, American Academy of Pediatrics, American College of Physicians, and American Psychiatric Association object to policies that interfere with the patient-physician relationship and penalize evidence based gender affirming care; now, therefore, be it

RESOLVED, that the American Osteopathic Association supports policy that all patients~~, including emancipated minors and minors with parental consent,~~ continue to have access to medically ~~appropriate~~ **COMPREHENSIVE EVIDENCE-BASED** gender affirming ~~evidence based~~ care; and be it further

RESOLVED, that the American Osteopathic Association opposes any policy that penalizes physicians for **RECOMMENDING AND/OR** providing requested medically ~~appropriate~~ **COMPREHENSIVE EVIDENCE-BASED** gender affirming ~~evidence based~~ care to their patients.

Background Information: Provided by AOA Staff

Current AOA Policy:

H439-A/20 Gender Identity Non-Discrimination

AOA policy supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity.

H325-A/22 Interference Laws – Amendment to American Osteopathic Association

This policy opposes legislative interference in the physician-patient relationship.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: _____July 22, 2023_____

SUBJECT: ~~INVISIBLE~~ **NON APPARENT** DISABILITIES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, ~~about 20% of people (approximately 66 million Americans) live with a condition which could be considered an invisible disability; and~~ **THE TERM ~~INVISIBLE~~ NON APPARENT DISABILITIES ~~AS CREATED AND DEFINED BY THE INVISIBLE DISABILITIES ASSOCIATION (IDA)~~, DISTINGUISHES DISABILITIES NOT READILY APPARENT BASED ON JUST LOOKING AT A PERSON, LEADING THE PERSON TO FIGHT A BATTLE SELDOM ACKNOWLEDGED BY THE OUTSIDE WORLD; AND**

WHEREAS, A SIGNIFICANT NUMBER OF AMERICANS ARE LIVING WITH A CHRONIC MEDICAL CONDITION; DISABILITIES, CHRONIC ILLNESS, CHRONIC PAIN AND INJURIES CAN ALL BE CONSIDERED INVISIBLE DISABILITIES AS THEY IMPACT PEOPLE IN A RANGE OF SEVERITIES FROM MINOR IMPAIRMENTS TO COMPLETE DISABILITY; AND

WHEREAS, WITHOUT THE OBVIOUS SIGNS OF DISABILITY, MANY OF THOSE WITH INVISIBLE DISABILITIESA MAY BE ACCUSED OF FAKING AND/OR EXAGGERATING THEIR CONDITIONS WHICH COULD RESULT IN A LACK OF FUNDING, ACCOMODATIONS, MEDICAL RESOURCES, AND/OR OVERALL SUPPORT; NOW, THEREFORE BE IT

~~WHEREAS, nearly half of Americans are living with a chronic medical condition, totaling 165 million people. Disabilities, chronic illnesses, chronic pain and injuries can all be considered invisible disabilities as they impact people in a range of severities from minor impairments to complete disability; and~~

~~WHEREAS, the term invisible disabilities as created and defined by Invisible Disabilities Association (IDA), distinguishes disabilities not readily apparent based on just looking at a person, leading the person to fight a battle seldom acknowledged by the outside world; and~~

~~WHEREAS, without the obvious signs of disability, many of those with invisible disabilities are accused of faking and/or exaggerating their conditions, resulting in a lack of funding, accommodations, medical resources, and overall support; and~~

~~WHEREAS, the Invisible Disabilities Association strives to encourage, educate, and connect people and organizations touched by illness, pain and disability. With the help of IDA, we may envision a world where people living with illness, pain, and disability will be "Invisible No More;" now, therefore be it~~

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION ENCOURAGES INCREASED AWARENESS FOR PATIENTS WITH INVISIBLE DISABILITIES; AND BE IT FURTHER

RESOLVED, that the American Osteopathic Association **SUPPORTS** ~~encourages~~ osteopathic physicians to continue to listen to the patient without bias or judgment and provide support as needed.~~; and be it further~~

~~RESOLVED, that the American Osteopathic Association encourages increased awareness for patients with invisible disabilities.~~

Background Information: Provided by AOA Staff

Current AOA Policy:

H203-A/22 Education for Performance of Disability Assessment Policy Statement

H209-A/20 Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities Policy Statement

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: IMPROVING PHARMACEUTICAL FORMULARY ACCESSIBILITY

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, payors have variable pharmaceutical coverage which changes routinely; and

WHEREAS, cost of medications is a factor considered by physicians when prescribing; and

WHEREAS, medicine formularies are inconsistently available to physicians, pharmacists, and patients or require secure login; and

WHEREAS, payor coverage and financial burden may deter patients from obtaining prescribed prescriptions; and

WHEREAS, discontinuation or delays in initiating medications can be detrimental to patients' health; and

WHEREAS, variance from preferred medications leads to requests for substitute prescriptions leading to increased administrative burden for physicians, pharmacists, and medical staff; and

WHEREAS, deterrents to compliance with medications can directly negatively impact physician quality metrics; now therefore be it

RESOLVED, that the American Osteopathic Association supports efforts to mandate payors to timely publish updated medicine formularies online **WITH** ~~in~~ open **ACCESSIBILITY.** ~~accessible means.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: Resolution H325-A/16 Formularies – Notification to Physicians was approved in 2016 as an action item.

AOA requires all entities maintaining formularies to provide regularly updated plan-specific formulary information to physicians in a timely manner; and urge entities to provide patients with access to all information needed to identify the specific formulary the patient is required to utilize.

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 22, 2023_____

SUBJECT: CONFLICTS BETWEEN EMPLOYED PHYSICIANS AND EMPLOYERS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, according to a recent study[1], 74% of physicians are employed by hospitals/healthcare systems or corporations (Physician Employers); and

WHEREAS, during the COVID-19 pandemic, some Physician Employers failed to provide physicians and others with appropriate personal protective equipment (PPE), placing the physician, their co-workers, their families, and patients at risk for infection; and

WHEREAS, the American Osteopathic Association Code of Ethics states in part, "A physician should make a reasonable effort to partner with patients to promote their health and **shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts** (emphasis added)[2]."

WHEREAS, caring for patients with potentially infectious diseases without appropriate PPE would violate the AOA Code of Ethics; and

WHEREAS, many physicians who refused to work without adequate PPE were disciplined, fined, or even fired by their Physician Employer[3]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) declares that a physician acts ethically when the physician refuses a directive of a Physician Employer that could reasonably be expected to place the physician, the physician's family, coworkers, or patients at risk of harm.

References

1. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/Specialty%20Analysis%20Key%20Findings-final.pdf?ver=u7j_0pnUKpOdsvLf1i-siA%3d%3d April 2022, accessed May 4, 2023
2. https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/, Section 5, accessed May 4, 2023
3. https://www.medscape.com/viewarticle/927590, March 26, 2020, accessed May 4, 2023

Background Information: Provided by AOA Staff
Current AOA Policy: AOA Code of Ethics

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Referred to IOMA____

DATE: _____July 22, 2023_____

SUBJECT: NON-PHYSICIAN CLINICIAN MEDICAL LIABILITY

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association's policy H640-A/20 NON-PHYSICIAN CLINICIANS addresses several issues related to non-physician clinicians including some aspects of medical legal liability; and

WHEREAS, current AOA policy does not adequately address who should be held liable when a non-physician clinician who is supposed to be working under the supervision of or in collaboration with a physician fails to seek consultation or collaboration with the physician; now, therefore be it

RESOLVED, that the American Osteopathic Association's H640-A/20 NON-PHYSICIAN CLINICIANS policy be amended as follows:

H640-A/20 NON-PHYSICIAN CLINICIANS
The American Osteopathic Association has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, revised 2005; revised 2010; reaffirmed 2015; revised 2018; adopted as amended 2020.

Policy Statement - 2018
NON-PHYSICIAN CLINICIANS

Over the course of the past century, scientific and technological advancements have led to improvements in the treatment of disease and standards of patient care. As a result, the standardized medical education, supervised postgraduate ("residency") training and examination series that physicians in the United States are required to complete in order to obtain an unlimited medical license has increased as well. At the same time, however, some states are creating legislative pathways to independent medical practice for other types of clinicians, despite the absence of nationally standardized education, training and testing pathways for these clinician groups, or evidence regarding patient safety outcomes. The current DO/MD medical model, in which medical students and resident physicians are required to demonstrate their ability to safely provide care to patients under the supervision of fully licensed physicians, leading to greater autonomy over time, has proven its ability to provide Physicians with the complete knowledge and skill base needed to ensure patient safety and optimize outcomes. in addition, most states impose additional continuing medical education (CME) requirements, and many physicians elect to undergo rigorous certifying board examinations to demonstrate excellence in a particular specialty, which helps to ensure that physicians remain trained to provide the current highest standard of patient care over the course of their careers.

Thus, it is appropriate that the practice of medicine and the quality of medical care remain the responsibility of physicians, who are the only clinician group properly trained, licensed, and regulated according to uniform laws governing medical licensure in the United States. The American Osteopathic Association (AOA) values the unique training and contributions of all members of the patient care team and supports the concept of uniform licensure pathways for all clinician groups, based upon scope of practice. The AOA further supports appropriate physician involvement in patient care provided by non-physician clinicians and opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates **THAT** patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability, and reimbursement, among others – are addressed.

A. **Patient Safety.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of relevant state statutes.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established state-level supervisory protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates and patients can rest assured that physician involvement in their care will remain the same regardless of practice setting within the state. Further, all non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. **Liability**. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality and degree of supervision being provided and should not exonerate the non-physician clinician from liability. **WHEN NON-PHYSICIAN CLINICIANS ARE REQUIRED TO WORK UNDER THE SUPERVISION OF, OR IN COLLABORATION WITH A PHYSICIAN BUT FAIL TO DO SO, THE NON-PHYSICIAN CLINICIAN SHOULD BEAR THE FULL LIABILITY FOR THEIR ACTIONS.** It is the AOA's position that non-physician clinicians providing care in independent practice states should be regulated and disciplined by the entities responsible for regulating and disciplining physicians (i.e. state medical boards), to ensure that all clinicians who are independently practicing medicine are held to the same standard of care and the equivalent degree of liability to that end, the AOA also believes that non-physician clinicians should be required to obtain equivalent malpractice insurance to physicians in states that currently require physicians to possess malpractice insurance.

Background Information: Provided by AOA Staff
Current AOA Policy: H640-A/20 NON-PHYSICIAN CLINICIANS (as noted above)

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended_

DATE: _____July 22, 2023_____

SUBJECT: CAQ FOR BARIATRIC SURGERY

SUBMITTED BY: American College of Osteopathic Surgeons

REFERRED TO: Ad Hoc Committee

WHEREAS, Many Osteopathic Surgeons Certified by the AOA/ AOBS practice in the field of Bariatric Surgery; and

WHEREAS, The American Board of Surgery in conjunction with the American Society of Metabolic and Bariatric Surgery have created a Focused Practice Designation for physicians practicing Bariatric Surgery and DO's Certified by the American Osteopathic Board of Surgery are ineligible to sit for the exam or be recognized; and

WHEREAS, we have already observed competitors advertising their recognition and implying that they are more qualified than their Osteopathic competitors, and

WHEREAS, there is significant financial risk if unable to demonstrate equivalency, and

WHEREAS, attempts to remedy this inequitable situation through dialogue over the last two years, have all been unsuccessful; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) grant permission for the AOBS to create a Certificate of Added Qualifications (CAQ) for Bariatric Surgery to allow Osteopathic Surgeons the same recognition and opportunities to have a level playing field and, be it further

RESOLVED, that the Examination will be administered by the American Osteopathic Board of Surgery and consist of a written exam administered every ten years.

Background Information: Provided by AOA Staff

Current AOA Policy: AOA Bureau of Osteopathic Specialists (BOS) Handbook Article VIII: Petition for Jurisdiction in a New Specialty Field and Article IX. Petition Review Process, page 14-15. AOBS has made request to the BOS Jurisdiction Committee for the approval of the development of a Bariatric Surgery Certificate of Added Qualification in April 2023. The Jurisdiction Committee will meet July 11, 2023 to review the petition.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $150,000
It is an estimated $150,000 expense to create a new subspecialty exam. This includes conducting a job task analysis, recruiting subject matter experts, purchasing reference materials, honorarium for item writers/subject matter experts, staff time, and exam publishing and administrating fees.

ACTION TAKEN: ___Not Adopted_____

DATE: ____July 22, 2023_____

SUBJECT: IN SUPPORT OF TRAINING AND ADVOCACY FOR DIVERSE PATIENT POPULATIONS INCLUDING BUT NOT LIMITED TO LGBTQ+ WITHIN RESIDENCY

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Ad Hoc Committee

WHEREAS, the population of individuals identifying as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) is rapidly growing within the United States, underscoring the importance of physician competency when working with these patients[1]; and

WHEREAS, lack of provider competency and fear of provider discrimination have been cited as leading contributors to barriers of LGBTQ+ healthcare access since data has been collected in these populations[2,3], especially within transgender/gender non-conforming populations, who disproportionately experience health inequities, in part, due to the exclusion of transgender-specific health needs from medical school and residency curricula[2]; and

WHEREAS, the American Osteopathic Association (AOA) supports the inclusion of the evolving understanding of sex and gender based medicine in the medical education programs and curricula across the continuum as stated in H214-A/18 SEX AND GENDER BASED MEDICINE[4]; and

WHEREAS, the American Osteopathic Association (AOA) supports osteopathic medical training by promoting inclusion of diverse standardized patient panels, including patients of all sexual orientations and gender identities as stated in Resolution H-625-A/2022 INCLUSION OF DIVERSE PATIENT POPULATIONS INCLUDING BUT NOT LIMITED TO LGBTQ+ WITHIN STANDARDIZED PATIENT EDUCATION [5], and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) core competency IV.B.1.a).(1).(e) emphasizes respect and responsiveness to diverse populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origins, socioeconomic status, and sexual orientation[6]; and

WHEREAS, didactic modules and isolated workshops do not lead to improved comfort or competency in residents with regards to LGBTQ+ care, and are not sufficient in addressing sexual and gender minority health over the course of their medical career[7,8,9]; now, therefore be it

31 RESOLVED, that the American Osteopathic Association (AOA), encourages all
32 graduate medical education programs to implement ~~a more~~ inclusive
33 **CURRICULA** ~~curriculum~~, promoting advocacy for patients of all sexual
34 orientations and gender identities.

References

1. Morris, M., Cooper, R.L., Ramesh, A. et al. 2019.Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. BMC Med Educ 19: 325.
2. Dubin, S. N., Nolan, I. T., Streed, C. G., Jr, Greene, R. E., Radix, A. E., & Morrison, S. D. (2018). Transgender health care: improving medical students' and residents' training and awareness. Advances in medical education and practice, 9, 377–391. https://doi.org/10.2147/AMEP.S147183
3. Lambda Legal. When healthcare isn't caring: Lambda Legal's survey on discrimination against LGBT people and people living with HIV. New York: Lambda Legal 2010
4. *H214-A/18 SEX AND GENDER BASED MEDICINE [PDF*]. (2018). The American Osteopathic Association (AOA)
5. H625-A/2022 *INCLUSION OF DIVERSE PATIENT POPULATIONS INCLUDING BUT NOT LIMITED TO LGBTQ+ WITHIN STANDARDIZED PATIENT EDUCATION [PDF]*. (2022). The American Osteopathic Association (AOA)
6. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (residency). Effective July 1, 2019, Accessed Feb 10, 2023
7. Streed CG Jr, Hedian HF, Bertram A, Sisson SD. Assessment of internal medicine resident preparedness to care for lesbian, gay, bisexual, transgender, and queer/questioning patients. J Gen Intern Med. 2019; 34:893–898
8. Kidd JD, Bockting W, Cabaniss DL, Blumenshine P. Special-"T" training: Extended follow-up results from a residency-wide professionalism workshop on transgender health. Acad Psychiatry. 2016; 40:802–806
9. Pregnall, Andrew M.; Churchwell, André L. MD; Ehrenfeld, Jesse M. MD, MPH. A Call for LGBTQ Content in Graduate Medical Education Program Requirements. Academic Medicine 96(6):p 828-835, June 2021. | DOI: 10.1097/ACM.0000000000003581

Background Information: Provided by AOA Staff
Current AOA Policy: H214 A/18 Sex and Gender Based Medicine

Prior HOD action on similar or same topic:
H625 A/22 Inclusion of Diverse Patient Populations Including But Not Limited to LGBTQ+ within Standardized Patient Education **–** This resolution was referred to Osteopathic Physicians and Surgeons of California

FISCAL IMPACT: $0

ACTION TAKEN _Adopted as Amended_

DATE _____July 22, 2023_____

SUBJECT: MINIMAL CREDENTIALING IN POST-ACUTE AND LONG-TERM CARE (PALTC) MEDICINE

SUBMITTED BY: Florida Osteopathic Medical Association (FOMA)

REFERRED TO: Ad Hoc Committee

WHEREAS, unlicensed and fraudulent health care providers exist in the **POST-ACUTE AND LONG-TERM CARE (PALTC)** arena; and

WHEREAS, PALTC patients/residents and their families have the appropriate expectation that providers caring for them have been properly vetted; and

WHEREAS, a minimal set of credentialing for medical practitioners in PALTC should be efficient and effective; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **SUPPORT LAWS AND/OR POLICIES TO REQUIRE EMPLOYERS IN THE POST ACUTE AND LONG TERM CARE (PALTC) ARENA TO OBTAIN** ~~promote a professional standard that all health care providers practicing in the PALTC setting will present,~~ at a minimum, proof of identification, i.e., a current government issued photo identification (e.g., driver's license), a current state issued professional license, and, as appropriate, malpractice insurance certificate and a current DEA certificate **FOR ALL HEALTHCARE PROVIDERS BEFORE ALLOWING THEM TO PROVIDE CARE IN THEIR FACILITIES**.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: ___July 22, 2023_____

SUBJECT: REQUIREMENT FOR MINIMUM EDUCATION STANDARDS FOR MEDICAL DIRECTORS **IN POST-ACUTE AND LONG-TERM CARE FACILITIES**

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, it is well established that Medical Directors in Post-Acute and Long-Term Care (PALTC) must possess an adequate specific fund of knowledge and unique skill set to optimally perform the functions and tasks mandated by this position; and

WHEREAS, there exists evidence-based literature suggesting that the presence of a Medical Director with additional training may improve care quality and is generally more engaged; and

WHEREAS, in the past several years there has been an influx of specialists into the PALTC arena serving in the role of Medical Director, often without any formal supplemental training; and

WHEREAS, it is the desire of the American Osteopathic Association (AOA) to promote the highest quality of care to patients/residents in the PALTC setting; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support ~~and encourage all initiatives (Federal, State and Local) to promote~~ minimum education standards for physicians serving in the role of Medical Director in Post-Acute and Long-Term Care.~~, to include the completion of a specified number of initial and maintenance education credits within a defined time period~~.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 22, 2023_____

SUBJECT: IMPLEMENTING LAND ACKNOWLEDGEMENTS AT AMERICAN OSTEOPATHIC ASSOCIATION (AOA) EVENTS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, Indigenous Peoples are "those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived[1]; and

WHEREAS, a Land Acknowledgment is a formal statement that respects and honors Indigenous Peoples as "the original stewards of the lands on which we now live" and acknowledges their ties to their ancestral territories[2]; and

WHEREAS, Land Acknowledgements can bring awareness to the cultural erasure of Indigenous Peoples and the health disparities they currently face as a result[3,4]; and

WHEREAS, organizations such as the American Medical Association (AMA) and Association of American Medical Colleges (AAMC) have introduced Land Acknowledgements as a standard part of their equity practice[5]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with relevant stakeholders to implement Land Acknowledgements at the beginning of every major event, including, but not limited to, conferences.

References

1. United Nations. (n.d.). *Who are indigenous peoples?* . Retrieved May 5, 2023, from https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf.
2. Smithsonian National Museum of the American Indian. (n.d.). Honoring Original Indigenous Inhabitants: Land Acknowledgment. Native Knowledge 360. Retrieved May 5, 2023, from https://americanindian.si.edu/nk360/informational/land-acknowledgment.
3. Farrell, J., Burow, P. B., McConnell, K., Bayham, J., Whyte, K., & Koss, G. (2021). Effects of land dispossession and forced migration on indigenous peoples in North America. *Science*, *374*(6567). https://doi.org/10.1126/science.abe4943.
4. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. Appendix A, Native American Health: Historical and Legal Context. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425854/.
5. AMA Center for Health Equity. (2021, October). *Advancing Health Equity: A guide to language, narrative and concepts*. American Medical Association. Retrieved May 5, 2023, from Advancing Health Equity: A Guide to Language, Narrative and Concepts (ama-assn.org) .

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

Additional resources regarding land acknowledgements:
https://www.pcma.org/indigenous-peoples-land-acknowledgements-purposeful/
https://nativegov.org/news/a-guide-to-indigenous-land-acknowledgment/

FISCAL IMPACT: $0
There would be no direct fiscal impact assuming a land acknowledgement could be created, printed and placed in an existing sign frame.

There will be a staff resource impact to research, verify and validate the correct information within the location of the major event to craft the land acknowledgement.

ACTION TAKEN: __REFERRED TO SOMA_

DATE: ___July 22, 2023_____

SUBJECT: INCREASING ACCESS TO AFFORDABLE INSURANCE FOR UNDOCUMENTED IMMIGRANTS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, immigration status is an important limiting factor in determining the
2 provision of health care[1]; and

3 WHEREAS, undocumented immigrants nationwide are ineligible for Marketplace
4 insurance coverage or financial assistance plans through the Affordable Care
5 Act[2]; and

6 WHEREAS, the resulting and predominant reliance on emergency services for
7 medical treatment leads to negative health outcomes while adding significant
8 cost and strain to an already taxed system[3,4]; and

9 WHEREAS, inability to provide needed services for patients based on citizenship
10 status contributes to the emotional, financial, and physical burden placed on
11 physicians[5]; now, therefore be it

12 RESOLVED, that the American Osteopathic Association (AOA) advocate for
13 increased access and availability of affordable health care services for
14 undocumented immigrants seeking care.

References

1. Rizzolo, K., & Cervantes, L. (2020, October 21). Immigration status and end-stage kidney disease: Role of policy and access to care. PubMed. Retrieved March 6, 2023, from https://pubmed.ncbi.nlm.nih.gov/33089565/.
2. U.S. Centers for Medicare & Medicaid Services. (n.d.). Health coverage for immigrants. HealthCare.gov. Retrieved March 6, 2023, from http://www.healthcare.gov/immigrants/.
3. Beck, T., Le, T.-K., Henry-Okafor, Q., & Shah, M. (2019, January). Medical Care for Undocumented Immigrants - PMC. NCBI. Retrieved March 6, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7141175/.
4. Ornelas IJ, Yamanis TJ, Ruiz RA. The Health of Undocumented Latinx Immigrants: What We Know and Future Directions. Annu Rev Public Health. 2020 Apr 2;41:289-308. doi: 10.1146/annurev-publhealth-040119-094211. PMID: 32237989; PMCID: PMC9246400.
5. Kuczewski, M., Mejias-Beck, J., & Blair, A. (2019, January 1). Good Sanctuary Doctoring for Undocumented Patients | Journal of Ethics | American Medical Association. AMA Journal of Ethics. Retrieved March 6, 2023, from https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-12/pfor1-1901_1.pdf

Background Information: Provided by AOA Staff
Current AOA Policy: H338-A/18 Uninsured – Access Health Care

AOA policy supports federal and state efforts to increase access to affordable health care coverage through initiatives that expand coverage to the uninsured through the efficient use of both private and public resources and supports efforts to reform programs such as Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) to provide coverage to populations that would otherwise lack health care coverage and ultimately, access to needed health care services.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _NOT ADOPTED_

DATE: ___July 22, 2023_____

SUBJECT: NON-COMPETE CLAUSES IN HEALTHCARE EMPLOYMENT CONTRACTS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, the use of non-compete clauses in physician employment contracts can have a negative impact on patient access to care, physicians' career mobility, and the overall practice of medicine; and

WHEREAS, nearly 45% of physicians are bound by non-compete agreements in employment contracts;[1] and

WHEREAS, evidence indicates that, within the healthcare industry, as enforceability of non-compete clauses across states increased, concentration at the firm level and price of final goods also increased;[2] and

WHEREAS, the U.S. healthcare system is currently grappling with the challenge of greater consolidation, including the vertical integration of physician practices with larger health systems, and between 2010 and 2016, the proportion of primary care practices owned by hospitals nationwide grew from 28% to 44%;[3] and

WHEREAS, the Bureau on Federal Health Programs (BFHP) recognizes the diverse perspectives across the medical community on non-compete clauses, and the function they may serve in contractual agreements across the industry. However, non-compete clauses are often used in the healthcare industry to limit competition, particularly in physician contracts, having the effect of driving consolidation among providers and limiting access to patient care; and

WHEREAS, in some instances, patients may lose access to a physician due to the scope of geographic limitations within the non-compete **CLAUSE**. In others, physicians face restrictions that limit valid business operations and patient access due to restrictive covenants that function as a non-compete **CLAUSE**; and

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[1] Kurt Lavetti, Carol Simon, & William D. White, "The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians", 55 J. Hum. Res. 1025, 1042 (2020)

[2] Naomi Hausman & Kurt Lavetti, "Physician Practice Organization and Negotiated Prices: Evidence from State Law Changes", 13 Am. Econ. J. Applied Econ. 258, 284 (2021)

[3] Brent D. Fulton. "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses." Health Affairs 36, no. 9 (September 1, 2017): 1530–38.

26 WHEREAS, physician practices often have limited resources to compete with large
27 enterprises, and non-compete clauses are just one tool that vertically
28 integrated systems utilize to limit competition and grow their market share;
29 now, therefore be it

30 RESOLVED, that the American Osteopathic Association (AOA) opposes the use of
31 those non-compete clauses that can hinder fair market competition. The AOA
32 supports policies seeking to reform the use of non-compete clauses to
33 ensure that they are used in a manner that does not harm patient care or
34 place an unreasonable burden on physicians' ability to practice medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: None

This resolution is consistent with the AOA Board adopted position statement from February 2023, and the BFHP recommendation in April. AOA submitted comments to FTC consistent with this language in April.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: _____July 22, 2023_____

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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osteopathic.org

103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (700 SERIES) – w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:
Joint Board/House Budget Review Committee (700 series)
This committee reviews the AOA Strategic Plan and Budget.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-700	Approval to Concur with the AOA FY2024 Expenditures	Finance Committee	Joint Board House Budget Review Committee	Adopted as Amended

SUBJECT: Approval to Concur with the AOA FY2024 ~~Expenditures~~ ANNUAL BUDGET

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board of Trustees "have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, with the annual budget for the fiscal year"; and

WHEREAS, the Joint Board/House Budget Review Committee will convene on July 21, 2023 to review and take action on the AOA FY2024 Operating Budget, the AOA FY2024 Capital Expenditures Budget and the AOA FY2024 142 E. Ontario Building budget reports as submitted; now therefore be it

RESOLVED, the American Osteopathic Association House of Delegates concur with the **AOA** FY2024 ~~expenditures~~ **ANNUAL BUDGET** as provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 22, 2023_____

AMERICAN OSTEOPATHIC ASSOCIATION

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER WITH ACTION (ALL SERIES)

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

- Committee on Educational Affairs (200 series)
  This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.
- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.
- Committee on Public Affairs (400 series)
  This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.
- Committee on Constitution and Bylaws (500 series)
  This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.
- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.
- Joint Board/House Budget Review Committee (700 series)
  This committee reviews the AOA Strategic Plan and Budget.
- Committee on Resolutions
  This committee drafts the resolutions expressive of the sense of the HOD meeting.
- Credentials Committee
  This Committee receives and validates the credentials of the delegates and alternates, maintains a continuous roll call, determines the presence of a quorum, supervises voting and election procedures and makes recommendations on the eligibility of delegates and alternates to a seat in the House when a seat is contested.

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER WITH ACTION (ALL SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Ensuring that Graduate Medical Education (GME) Programs Continue to Select Residents Based on Merit (SR- Source: H200-A/17)	BOE	Educational Affairs	Adopted as Amended
H-201	Ambulatory-Based Primary Care Residency Programs (SR- Source: H201-A/17)	BOE	Educational Affairs	Adopted
H-202	Joining Forces Initiative (SR- Source: H205-A/17)	BOE	Educational Affairs	Adopted
H-203	Disability Determinations (SR- Source: H206-A/17)	BOE	Educational Affairs	Adopted as Amended
H-204	Non-Gender Discrimination (SR - Source : H207-A/17)	BOE	Educational Affairs	Adopted for Sunset
H-205	Supervision for Osteopathic Manipulative Treatment (SR- Source: H209-A/17)	BOE	Educational Affairs	Adopted
H-206	Training Reaffirmation of Primary Care Physicians (SR - Source: H210-A/17)	BOE	Educational Affairs	Adopted as Amended
H-207	Clearly Articulated Protocol for Sleep Facilities and Safe Transportation in All Physician Residencies (SR- Source: H213-A/17)	BOE	Educational Affairs	Adopted for Sunset
H-208	Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities (SR - Source: H215-A/17)	BOE	Educational Affairs	Adopted as Amended
H-209	United States Immigration Executive Order Impact on Medical Education (SR-Source: H222-A/17)	BOE	Educational Affairs	Adopted
H-210	Importance of Empathy in Osteopathic Medical Education and Practice (SR- Source: H226-A/17)	BOE	Educational Affairs	Adopted as Amended
H-211	Equivalency Policy for Osteopathic Continuous Certification (SR- Source: H227-A/17)	BOS	Educational Affairs	Adopted
H-212	Loan Deferment During Residency (SR - Source: H202-A/17)	BFHP	Educational Affairs	Adopted
H-213	Osteopathic Licensing (SR - Source: H208-A/17)	CSHA	Educational Affairs	Adopted
H-214	Osteopathically Recognized Graduate Medical Education Programs (SR - Source: H212-A/17)	BFHP	Educational Affairs	Adopted as Amended

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H-215	Promoting Osteopathic Principles and Practices (OPP) in Continuing Medical Education (CME)	MOMA	Educational Affairs	Referred
H-216	Osteopathic Principles and Practices (OPP) and Educational Efforts to Incorporate Value-Based Care in All Levels of Osteopathic Medical Education	MOMA	Educational Affairs	Referred
H-217	Equality In Away Rotations/Sub-Internships for Osteopathic Medical Students	BEL	Educational Affairs	Adopted as Amended
H-218	Maintenance of Primary Board Certification for Subspecialty Certification	AOAAM	Educational Affairs	Disapproved
H-219	ABIM Board Eligibility	OPSC	Educational Affairs	Adopted as Amended
H-220	Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post Graduate Medical Training 2022	NYSOMS	Educational Affairs	Adopted as Amended
H-221	WITHDRAWN BY AUTHOR			
H-222	WITHDRAWN BY AUTHOR			
H-223	Osteopathic Education	IOMA	Educational Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Defining New Physicians in Practice (SR - Source: H349-A/17)	BEL	Professional Affairs	Adopted
H-301	State Licensure of Managed Care Organizations (MCO) Medical Directors (SR-Source: H302-A/17)	BFHP	Professional Affairs	Adopted
H-302	Administrative Rule-Making Process (SR- Source: H304-A/17)	BFHP	Professional Affairs	Adopted
H-303	Advance Directives (SR- Source: H305-A/17)	BFHP	Professional Affairs	Adopted
H-304	Interstate Opioid Database (SR- Source: H331-A/17)	BORPH	Professional Affairs	Adopted as Amended
H-305	Improve Life-Saving Access to Epinephrine (SR- Source: H333-A/17)	BORPH	Professional Affairs	Adopted as Amended
H-306	Family And Medical Leave Act (FMLA) Documentation (SR- Source: H307-A/17)	BFHP	Professional Affairs	Disapproved (Sunset)
H-307	Prescription Drugs (SR - Source: H308-A/17)	BFHP	Professional Affairs	Adopted
H-308	Federally Funded Health Clinics (SR - Source: H309-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-309	Disparities Between Rural and Urban Practices (SR - Source: H311-A/17)	BFHP	Professional Affairs	Adopted
H-310	Preservation of Antibiotics for Medical Treatment (SR - Source: H312-A/17)	BFHP	Professional Affairs	Adopted
H-311	Guidelines for Nutritional and Dietary Supplements (SR - Source: H315-A/17)	BFHP	Professional Affairs	Adopted
H-312	Sexual Harassment (SR- Source: H316-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-313	Due Process in Agency Determinations (SR- Source: H317-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-314	Ethical And Sociological Considerations for Medical Care (SR - Source: H318-A/17)	BFHP	Professional Affairs	Adopted
H-315	Regulation of Health Care (SR- Source: H319-A/17)	CSHA	Professional Affairs	Adopted as Amended

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H-316	Occupational Safety and Health Administration (OSHA) Regulations (SR - Source: H320-A/17)	BFHP	Professional Affairs	Adopted
H-317	Patient Safety (SR - Source: H321-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-318	Promotion of School Based Health Education (SR - Source: H325-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-319	Recoupment Laws (SR - Source: H326-A/17)	BFHP	Professional Affairs	Adopted
H-320	Right to Practice and Payment for Osteopathic Manipulative Treatment (SR - Source: H329-A/17)	CSHA	Professional Affairs	Adopted
H-321	Equity in Medicare & Medicaid Payments (SR - Source: H339-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-322	Naloxone (SR - Source: H340-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-323	Shared Principles of Primary Care (SR - Source: H342-A/17)	BFHP	Professional Affairs	Adopted
H-324	Eugenic Selection with Preimplantation Genetic Diagnosis (SR -Source: H349-A/16)	BFHP	Professional Affairs	Adopted as Amended
H-325	Interference Laws - Amendment to American Osteopathic Association Policy H358-A/19	IOMA	Professional Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Drugs-Prescription Discounts (SR - Source: H400-A/17)	BFHP	Public Affairs	Adopted
H-401	AOA Support of Public Health Service (SR- Source: H406-A/17)	BFHP	Public Affairs	Adopted
H-402	Counseling Female Patients on Reproductive Issues (SR - Source: H407-A/17)	CSHA	Public Affairs	Adopted as Amended
H-403	Genetic Testing (SR- Source: H412-A/17)	BFHP	Public Affairs	Adopted
H-404	Substance Impaired and Distracted Driving (SR- Source: H413-A/17)	CSHA	Public Affairs	Adopted
H-405	Accessibility to Breast Cancer Prevention, Detection, Diagnosis and Treatment (SR – Source: H408-A/17)	BORPH	Public Affairs	Adopted
H-406	Support For Prenatal and Pediatric Hospice and Palliative Care (SR - Source: H409-A/17)	BORPH	Public Affairs	Adopted
H-407	AOA Support for Hospice Care Programs (SR - Source: H411-A/17)	BORPH	Public Affairs	Adopted as Amended
H-408	Treatment of Obesity (SR- Source: H414-A/17)	BORPH	Public Affairs	Adopted as Amended
H-409	Women's Contraceptive Coverage Legislation (SR- Source: H416-A/17)	BORPH	Public Affairs	Adopted as Amended
H-410	Promotion for the Requirement of All Sporting Events to Have Access to an Automated External Defibrillator (AED) To Treat Commotio Cordis (SR - Source: H418-A/17)	BORPH	Public Affairs	Adopted as Amended
H-411	Meningococcal Vaccine Recommendations (SR- Source: H419-A/17)	BORPH	Public Affairs	Adopted
H-412	PSA-Based Screening for Prostate Cancer (SR- Source: H422-A/17)	BORPH	Public Affairs	Adopted
H-413	Mandates on School Lunches (SR - Source: H423-A/17)	BORPH	Public Affairs	Adopted
H-414	Judicious Use of Antimicrobial (SR- Source: H425-A/17)	BORPH	Public Affairs	Adopted as Amended

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H-415	Anti-Bullying Law (SR- Source: H426-A/17)	BORPH	Public Affairs	Adopted as Amended
H-416	Promotion, Protection and Support of Breastfeeding (SR - Source: H428-A/17)	BORPH	Public Affairs	Adopted as Amended
H-417	Protocol and Guidelines for Emergency Medical Identification (SR- Source: H429-A/17)	BORPH	Public Affairs	Adopted as Amended
H-418	Organ Donation – Opposition to Financial Incentives for Organ Donors (SR - Source: H430-A/17)	BORPH	Public Affairs	Adopted as Amended
H-419	Violence in the Entertainment Media (SR - Source: H432-A/17)	BORPH	Public Affairs	Adopted
H-420	Stem Cell Research (SR - Source: H433-A/17)	BORPH	Public Affairs	Adopted
H-421	Education on Human Papillomavirus Vaccination (SR- Source: H434-A/17)	BORPH	Public Affairs	Adopted
H-422	Daily Physical Education for Grades K-12 (SR- Source: H435-A/17)	BORPH	Public Affairs	Adopted
H-423	Use of Tobacco Products (SR- Source: H436-A/17)	BORPH	Public Affairs	Adopted as Amended
H-424	Policy Statement on End of Life Care (SR- Source: H438-A/17)	BORPH	Public Affairs	Referred
H-425	Powdered Caffeine (SR - Source: H439-A/17)	BORPH	Public Affairs	Adopted
H-426	Health Insurance Coverage for Residential Treatment and Inpatient Treatment of Eating Disorders (SR- Source: H440-A/17)	BORPH	Public Affairs	Adopted
H-427	Violence and Abuse Prevention and Education (SR- Source: H441-A/17)	BORPH	Public Affairs	Adopted
H-428	Recreational Marijuana Use by Physicians, Students and Patients – White Paper (SR- Source: H442-A/17)	BORPH	Public Affairs	Adopted as Amended
H-429	Harm Reduction Modalities for People Who Inject Drugs – White Paper (SR- Source: H443-A/17)	BORPH	Public Affairs	Adopted as Amended
H-430	Medication For Indigent Patients (SR- Source: H444-A/17)	BORPH	Public Affairs	Adopted

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H-431	AOA Policies on Opioids and Substance Use – White Paper	BORPH	Public Affairs	Adopted as Amended
H-432	Addressing Diversity, Equity and Inclusion as a Profession	POMA	Public Affairs	Referred
H-433	Support Interpretation of Medical Information among the General Public	OOA	Public Affairs	Referred
H-434	Recognizing the Disproportionate Prevalence of Cardiovascular Disease in the African American Population as a Public Health Issue	SOMA	Public Affairs	Adopted as Amended
H-435	Standardized Screening for Intimate Partner Violence for all Individuals	SOMA	Public Affairs	Referred
H-436	Support for Increased Crisis Intervention Team Training for Law Enforcement	SOMA	Public Affairs	Adopted as Amended
H-437	Increased Research on the Public Health Impacts of Decriminalizing Possession of all Illicit Drugs	SOMA	Public Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-500	Improving Resident Member Inclusion and Retention in House of Delegates Proceedings	NJAOPS	Constitution & Bylaws	Disapproved
H-501	WITHDRAWN BY AUTHOR			
H-502	American Osteopathic Society for Rheumatic Disease - Charter of Affiliation Revocation	CAGOS	Constitution & Bylaws	Adopted
H-503	Amendment to the American Osteopathic Association Constitution-New Physician in Practice Definition (***Second Read***)	BEL	Constitution & Bylaws	Adopted as Amended
H-504	Amendments to the American Osteopathic Association Constitution- Name of The AOA Journal (***Second Read***)	CAGOS	Constitution & Bylaws	Adopted as Amended
H-505	WITHDRAWN BY AUTHOR			
H-506	Amendments to the Article VI-Section 1 B of the American Osteopathic Association Constitution ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-507	Amendments to the Article VI-Section 1 D of the American Osteopathic Association Constitution ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-508	Amendments to the Article VII-Section 2 of the American Osteopathic Association Constitution ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-509	Amendments to the Article X of the American Osteopathic Association Constitution ***(First Read)***	CAGOS	Constitution & Bylaws	First Read
H-510	Amendment to the American Osteopathic Association Bylaws-Article II-Section 2f	BOM	Constitution & Bylaws	Adopted as Amended
H-511	Amendments to the American Osteopathic Association Bylaws-Delete References to AOA Yearbook & Directory	CAGOS	Constitution & Bylaws	Adopted as Amended
H-512	Amendments to the American Osteopathic Association Bylaws-Article II-Section 2h	CAGOS	Constitution & Bylaws	Adopted as Amended

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H-513	Amendments to the American Osteopathic Association Bylaws- Article VI-Section 1	CAGOS	Constitution & Bylaws	Adopted as Amended
H-514	Amendments to the American Osteopathic Association Bylaws-Article VI-Section 4	CAGOS	Constitution & Bylaws	Adopted as Amended
H-515	Amendments to the American Osteopathic Association Bylaws-Article VII-Section 1B, Article VIII-Section 7, Article VIII-Section 9	CAGOS	Constitution & Bylaws	Adopted as Amended
H-516	Amendments to the American Osteopathic Association Bylaws-Article VII-Section 1C	CAGOS	Constitution & Bylaws	Adopted as Amended
H-517	Amendments to the American Osteopathic Association Bylaws- Article VII-Section 1E	CAGOS	Constitution & Bylaws	Adopted as Amended
H-518	Amendments to the American Osteopathic Association Bylaws- Article IX	CAGOS	Constitution & Bylaws	Adopted as Amended
H-519	Amendments to the American Osteopathic Association Bylaws-Article XI-Section 2	CAGOS	Constitution & Bylaws	Adopted as Amended
H-520	Amendments to the American Osteopathic Association Bylaws-Article XII	CAGOS	Constitution & Bylaws	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Osteopathic Neurologic and Psychiatric Standard of Care (SR- Source: H604-A/17)	BORPH/ CSHA	Ad Hoc	Adopted
H-601	Physician / Patient Educational Materials Received from Pharmaceutical Companies that Produce and/or Market Generic Medications (SR - Source: H615-A/17)	BORPH	Ad Hoc	Adopted
H-602	Osteopathic Musculoskeletal Evaluation (SR- Source: H623-A/17)	BORPH	Ad Hoc	Adopted as Amended
H-603	Adjustment to Primary Care Incentive Program (SR - Source: H602-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-604	Physician Depositions (SR - Source: H605-A/17)	CSHA	Ad Hoc	Adopted
H-605	The Practice of Osteopathic Medicine Discrimination (SR - Source: H608-A/17)	CSHA	Ad Hoc	Adopted
H-606	Drug Prescribing, Including Elderly Patients (SR - Source: H609-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-607	Human Immunodeficiency Virus (HIV) – Positive Status as a Disability for Physicians (SR - Source: H610-A/17)	CSHA	Ad Hoc	Adopted
H-608	Health Care Fraud and Abuse (SR - Source: H611-A/17)	CSHA	Ad Hoc	Adopted
H-609	Military Medical Readiness (SR- Source: H613-A/17)	BFHP	Ad Hoc	Adopted
H-610	Payment For Psychiatric Diagnoses and Treatment by Primary Care Physicians (SR- Source: H618-A/17)	CSHA	Ad Hoc	Adopted
H-611	Physician Fines Imposed by Third Party Payors (SR- Source: H621-A/17)	BFHP	Ad Hoc	Adopted
H-612	Health Care Insurance Options (SR - Source: H622-A/17)	CSHA	Ad Hoc	Adopted
H-613	Physician Payment in Federal Programs (SR - Source: H624-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-614	Human Immunodeficiency Virus (HIV) Consent Form Elimination (SR - Source: H625-A/17)	BFHP	Ad Hoc	Adopted

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H-615	Direct Primary Care (SR- Source: H628-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-616	Opposition to the Practice of LGBTQIA+ Conversion Therapy or Reparative Therapy (SR- Source: H629-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-617	Standing Against Sexual Orientation Change Efforts (SOCE) (SR- Source: H635-A/17)	BFHP	Ad Hoc	Adopted for Sunset
H-618	Patient Interpreters (SR - Source: H636-A/17)	BFHP	Ad Hoc	Adopted
H-619	AOA Opposition to Merging of State Osteopathic Licensing Boards with State Medical Licensing Boards (SR - Source: H637-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-620	Prescription Drug Pricing (SR - Source: H638-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-621	WITHDRAWN BY AUTHOR			
H-622	Addressing Insurance Denials	MAOPS	Ad Hoc	Referred
H-623	WITHDRAWN BY AUTHOR			
H-624	Reducing the Waiting Period for Credentialing, Re-Credentialing and Enrollment of Health Care Professionals by Health Plans	MOA	Ad Hoc	Adopted as Amended
H-625	Expanding Seven Core Competencies to Include Diverse Patient Populations Including but not limited to LGBTQ+ within Standardized Patient Education	OPSC	Ad Hoc	Referred
H-626	Expanding Scheduled Dialysis Services to all Patients with End Stage Kidney Disease	SOMA	Ad Hoc	Disapproved

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-700	Approval to Concur with the AOA FY2023 Expenditures	Finance Committee	JBHB	Adopted
H-701	Budget Adjustment Parameters	Finance Committee	JBHB	Adopted as Amended

SUBJECT: ENSURING THAT GRADUATE MEDICAL EDUCATION (GME) PROGRAMS CONTINUE TO SELECT RESIDENTS BASED ON MERIT - SOURCE: H200-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Education believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMMENDED.

The American Osteopathic Association will work with the American Medical Association ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME), the American Association of Colleges of Osteopathic Medicine (AACOM), the Association of American Medical Colleges (AAMC) and other US RELEVANT stakeholders to ensure that US-based graduate medical education programs maintain their ability to select residents based on merit **AND HOLISTIC REVIEW, INCLUDING THAT, FOR OSTEOPATHIC APPLICANTS TO RESIDENCY PROGRAMS , THE COMLEX-USA LICENSURE EXAMINATION BE CONSIDERED EQUIVALENTLY BY RESIDENCY PROGRAM DIRECTORS.** ~~AND TO CONSIDER BOTH THE USMLE AND COMLEX-USA AS EQUIVALENT COMPETENCY EXAMINATIONS~~**.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed).

Prior HOD action on similar or same topic:
H231-A/19 COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs – Recognition of; And as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED_

DATE: ___July 16, 2022_____

SUBJECT: AMBULATORY-BASED PRIMARY CARE RESIDENCY PROGRAMS
SOURCE: H201-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports and advocates for development
7 and implementation of ambulatory-based primary care residency programs;
8 encourages the US Congress and state legislatures to strengthen its
9 graduate medical education reimbursement policies to, at least, equivalently
10 fund ambulatory-based primary care residency programs; and will lobby
11 Congress and state legislatures to support legislation funding demonstration
12 models of ambulatory-based primary care residency programs.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H359-A/19 State Graduate Medical Education (GME) Funding Alternatives
H218-A/21 Graduate Medical Education Funding and Incentives; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED____

DATE: _____July_16, 2022_____

SUBJECT: JOINING FORCES INITIATIVE - SOURCE: H205-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED

6 The American Osteopathic Association (AOA) will continue to encourage the
7 American Association of Colleges of Osteopathic Medicine (AACOM) to
8 partner with the Association of American Medical Colleges (AAMC) to
9 promote and develop curriculum that will help osteopathic and allopathic
10 medical students prepare to care for the unique issues returning veterans
11 and their families face; will encourage practicing osteopathic physicians to
12 care for veterans and their families and to accept Tri-Care; will help develop
13 continuing medical education that will help prepare the existing osteopathic
14 work force to comprehend and be prepared to manage the unique issues
15 faced by the veteran population and military families; will encourage the
16 National Board of Osteopathic Medical Examiners (NBOME) to incorporate
17 military service-related conditions in the development of case-based
18 evaluation items for testing; and will support efforts to support veterans and
19 military families by partnering with organizations such as Joining Forces and
20 other organizations that help military members and their families.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed)

Prior HOD action on similar or same topic:
H329-A/21 Tricare Health Insurance for our Military

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: ~~DISABILITY DETERMINATIONS~~ **EDUCATION FOR PERFORMANCE OF DISABILITY ASSESSMENT** - SOURCE: H206-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

WHEREAS, The Bureau of Osteopathic Education recommends striking "and medical students" in the policy because the trend in AOA policy to not make prescriptions on what is taught in the schools, preferring to leave that to the Commission on Osteopathic College Accreditation (COCA); now therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association supports education, training, and involvement of osteopathic physicians ~~and medical students~~ in the ~~discipline~~ **PROCESS** of **IMPAIRMENT RATINGS AS THEY MAY BE USED TO ESTABLISH** disability determinations.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED__

DATE: July 16, 2022_____

SUBJECT: NON-GENDER DISCRIMINATION - SOURCE: H207-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

3 WHEREAS, The Bureau of Osteopathic Education recommends that this policy be
4 sunset because it already included in the AOA Code of Ethics, the COCA
5 Accreditation Standards, AOA Basic Documents for Postdoctoral Training, as
6 well as AOA policies H608-A/17 and H304-A/18; now, therefore be it

7 RESOLVED, that the Bureau of Osteopathic Education recommends that the
8 following policy be SUNSET.

9 The American Osteopathic Association requires all of its recognized training
10 institutions, both osteopathic and allopathic, to provide equality for their all
11 physicians and students.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed as Amended; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended)

Prior HOD action on similar or same topic:
H608-A/17 Discrimination – The Practice of Osteopathic Medicine
H304-A/18 Discrimination Against Osteopathic Physician; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED (*for sunset*)
DATE: July 16, 2022

SUBJECT: SUPERVISION FOR OSTEOPATHIC MANIPULATIVE TREATMENT - SOURCE: H209-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association strongly encourages all qualified supervising
7 physicians to foster the appropriate utilization of osteopathic diagnosis and
8 osteopathic manipulative treatment by students, interns and residents
9 assigned to them.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1997; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: TRAINING REAFFIRMATION OF PRIMARY CARE PHYSICIANS – SOURCE: H210-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED AS AMENDED.

6 The American Osteopathic Association (AOA) reaffirms its commitment to train
7 competent and compassionate primary care physicians THROUGH
8 UNDERGRADUATE MEDICAL EDUCATION, GRADUATE MEDICAL
9 EDUCATION AND CONTINUING MEDICAL EDUCATION.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed)

Prior HOD action on similar or same topic:
H210-A/21 ACCESS TO HEALTHCARE – DEVELOPING A NEW MODEL OF ADMINISTERING OSTEOPATHIC PRIMARY CARE RESIDENCIES IN THE UNITED STATES: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED

DATE: _____July 16, 2022_____

SUBJECT: CLEARLY ARTICULATED PROTOCOL FOR SLEEP FACILITIES AND SAFE TRANSPORTATION IN ALL PHYSICIAN RESIDENCIES – SOURCE: H213-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be ~~REAFFIRMED~~ SUNSET.

The American Osteopathic Association supports the provision of safe transportation for residents, who may be too fatigued to safely return home and encourages all physician residency programs to create and make publicly available via the internet and in internal literature, such as resident physician program handbooks, a clearly articulated protocol for the use of their sleep facilities and transportation services for residents.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED (*for sunset*)

DATE: ____July 16, 2022_____

SUBJECT: LONGITUDINAL APPROACH TO CULTURAL COMPETENCY DIALOGUE ON ELIMINATING HEALTH CARE DISPARITIES
SOURCE: H215-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Education believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association encourages ~~INSTITUTIONS FOR osteopathic medical EDUCATION institutions to engage in expert facilitated~~, evidence-based **EDUCATION AND** dialogue in cultural competency, **THE SOCIAL DETERMINANTS OF HEALTH**, and the physician's role in eliminating ~~racial~~ health care disparities ~~in medical treatment as part of a longitudinal curriculum throughout undergraduate medical education years one thru four~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED

DATE: __July 16, 2022_____

SUBJECT: UNITED STATES IMMIGRATION EXECUTIVE ORDER IMPACT ON MEDICAL EDUCATION - SOURCE: H222-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Education recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association strongly opposes any potential travel bans
7 created against medical students, interns, residents, fellows, and physicians
8 with visas or green cards and will work to support its patients, students,
9 residents, fellows, and physicians affected by such policies.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: IMPORTANCE OF EMPATHY IN OSTEOPATHIC MEDICAL EDUCATION AND PRACTICE - SOURCE: H226-A/17

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

The American Osteopathic Association recognizes the importance of empathy in osteopathic medical education and practice and the relationship between empathy and well-being ~~in~~ **OF** physicians-in-training and in-practice.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_____

DATE: _____July 16, 2022_____

SUBJECT: EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION - SOURCE: H227-A/17

SUBMITTED BY: Bureau of Osteopathic Specialist

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Specialist has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Osteopathic Specialist recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA), through its bureaus, councils, and
7 committees, will ensure that Osteopathic Continuous Certification (OCC) is
8 comparable to other maintenance of certification programs so that OCC can
9 be recognized by the federal government, state governments and other
10 regulatory agencies and credentialing bodies as an equivalent of other
11 national certifying bodies' "maintenance" or "continuous" certification
12 programs.
13
14 While the AOA supports the use of board certification as a mark of academic
15 achievement, the AOA opposes any efforts to require OCC as a condition for
16 medical licensure, insurance reimbursement, hospital privileges, network
17 participation, malpractice insurance coverage or as a requirement for
18 physician employment.
19
20 That the AOA through the Bureau of Osteopathic Specialists (BOS) will review the
21 OCC process so as to make it more manageable and economically feasible.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2010; 2015 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: LOAN DEFERMENT DURING RESIDENCY - SOURCE: H202-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports legislation that would allow
7 medical students and resident physicians to defer the repayment of their
8 federal medical school loans interest free until the completion of residency
9 training.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: OSTEOPATHIC LICENSING - SOURCE: H208-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association reaffirms its position that the only
7 examinations able to fully evaluate the ability and competency of osteopathic
8 physicians for licensure are the examinations developed by the National
9 Board of Osteopathic Medical Examiners, Inc.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1982; 1987 Reaffirmed as Amended; 1987 Reaffirmed as Amended, 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED__

DATE: __July 16, 2022_____

SUBJECT: OSTEOPATHICALLY RECOGNIZED GRADUATE MEDICAL EDUCATION PROGRAMS - SOURCE: H212-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association opposes any federal or state lawS or
7 regulationS that would prevent the development of additional osteopathically
8 recognized graduate medical education programs or training positions and
9 THE AOA will continue to take all measures possible to prevent the
10 termination of distinctive osteopathic training programs.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED_AS AMENDED_____

DATE: ___July 16, 2022_____

SUBJECT: PROMOTING OSTEOPATHIC PRINCIPLES AND PRACTICES (OPP) IN CONTINUING MEDICAL EDUCATION (CME)

SUBMITTED BY: Montana Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, the American Osteopathic Association (AOA) is continuing it's efforts to
2 promote osteopathic principles and practices, (OPP) in all levels of
3 osteopathic medical education; and

4 WHEREAS, Resolution H-220-A/19 addressed pathways to incorporating OPP into
5 specialty board certification, and Resolution H202-A/20 encouraged the
6 continued teaching of OPP in Graduate Medical Education (GME) through,
7 but not limited to, Osteopathic Recognition programs; and

8 WHEREAS, there remains a need to develop formal OPP in all levels of osteopathic
9 education, including Continuing Medical Education (CME), for all specialties;
10 and

11 WHEREAS, although the procedure of osteopathic manipulative treatment (OMT) is
12 a common example of OPP, it must be recognized that OPP is a much
13 broader subject area; and

14 WHEREAS, the AOA encourages all osteopathic physicians to incorporate the
15 tenants of osteopathic medicine into their practice; and

16 WHEREAS, efforts of incorporating OPP into CME requires an in-depth, thoughtful
17 approach to this issue; and

18 WHEREAS, one method of incorporating the full breadth of OPP into CME is
19 developing education that encourages better communication and
20 understanding between specialties; and

21 WHEREAS, historically, the osteopathic profession's education was structured in a
22 way that promoted communication and collaboration between specialties;
23 and

24 WHEREAS, with osteopathic physicians now being educated in Accreditation
25 Council for Graduate Medical Education (ACGME) accredited GME
26 programs, fewer osteopathic physicians are being educated in OPP during
27 their GME years; and

28 WHEREAS, providing CME that is intended to provide inter-disciplinary education
29 for all specialties with OPP as a focus will greatly improve
30 communication/collaboration between specialties; and

31 WHEREAS, the AOA is the overall accrediting body for all levels of education within
32 the osteopathic profession; and

33 WHEREAS, Article II, Section 4 of the AOA Bylaws authorizes the Board of
34 Trustees to determine and administer CME requirements for Regular
35 Members; now, therefore be it

36 RESOLVED, that the Board of Trustees shall include 5 hours per year of
37 interdisciplinary education focusing on osteopathic principles and practices in
38 any CME requirement administered by the Board in compliance with Article
39 II, Section 4 of the American Osteopathic Association Bylaws.

Background Information: Provided by AOA Staff

Current AOA Policy:

Accredited AOA CME must address one or more of the seven AOA core competencies, one of which is Osteopathic Principles and Practice. The AOA defines OPP as "the fundamental approach to patient health and wellness guided by the tenants of osteopathic medicine." There is not a current requirement that a specified amount of hours must address OPP.

The AOA is currently putting together methods to strengthen osteopathic distinctiveness in CME.

The Osteopathic Distinctive CME Task Force was constructed to strengthen osteopathic distinction in AOA accredited CME. The purpose is largely three-fold:

- To define osteopathic CME
  - Draft definition: Osteopathically distinct CME is evidence or practice-based medical education which includes the body of knowledge and skills essential to the osteopathic profession and patient care, that integrates osteopathic tenets and philosophy.
- To require osteopathic physicians to be faculty in a significant portion of AOA of accredited CME.
- To frame CME content to include osteopathic tenets and principles.

The Task Force is comprised of various CME sponsors and stakeholders, including members of AOSED, SOSE, COMs, and Hospitals.

Additionally, the AOA Bylaws (Article II, Section 4) provide the Board of Trustees with the responsibility and authority to set the requirement for CME; the Board of Trustees, on the recommendation from the Bureau of Membership after an extensive review, eliminated the supplementary CME requirement for membership in April 2016.

Members often found the various CME requirements confusing, and the Board of Trustees contends that the existing requirement for members to maintain a license in good standing provides sufficient evidence of compliance with CME expectations; the AOA shall not enforce a separate requirement for a minimum number of hours of CME for membership eligibility. This resolution will allow for members to satisfy their CME requirement by maintaining a license in good standing and meeting the requirements set by their respective state licensing boards.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $15,000 Initial Implementation; $14,000 Annual Maintenance
A mechanism would need to be created within the existing technology (TraCME and AMS) to monitor at the time of membership renewal and to review the CME activity submitted to verify it met the membership requirement.

The total fiscal impact is broken into two segments.

- The first segment is the initial implementation which would be $15,000 for the first year.
  - $15,000 Initial Implementation
    - Initial Implementation for additional TraCME and AMS updates.
    - Updating TraCME for an appropriate index for CME Staff/CME Sponsors to categorize activities that meet this requirement.
    - Updating Physician Portal to reflect completion of this requirement.
    - Updating database reporting to query and report on completion data.

- The second segment is the annual maintenance expense of $14,000 after the first year of implementation.
  - $14,000 Annually
    - $10,000 annually for marketing and communications.
    - $4,000 annually for customer service which is approximately 100 hours of service calls and tracking individual submissions.

ACTION TAKEN: REFERRED (*Montana Osteopathic Medical Association*) _

DATE: _____July 16, 2022_____

SUBJECT: OSTEOPATHIC PRINCIPLES AND PRACTICES (OPP) AND EDUCATIONAL EFFORTS TO INCORPORATE VALUE-BASED CARE IN ALL LEVELS OF OSTEOPATHIC MEDICAL EDUCATION

SUBMITTED BY: Montana Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the cost of health care in the United States has increased dramatically over the last few decades, with the cost of healthcare increasing 75% from 2000 through 2021[1]; and

WHEREAS, education in value-based care has become increasingly important; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) defines value based care as, "*paying for health care services in a manner that directly links performance on cost, quality and the patient's experience of care".*[2]; and

WHEREAS, Osteopathic Principles and Practices (OPP), as an approach to patient care, is intrinsically related to a value-based care approach; and

WHEREAS, the American Osteopathic Association (AOA) is actively involved in developing OPP into all levels of Osteopathic education; and

WHEREAS, the AOA is the overall accrediting body for Osteopathic education; and

WHEREAS, the AOA carries out this oversight advocating to the Commission on Osteopathic College Accreditation (COCA) for colleges of Osteopathic medicine, Accreditation Council for Graduate Medical Education (ACGME) for graduate medical education (GME), and directly in oversight of Osteopathic CME; now, therefore be it

RESOLVED, the American Osteopathic Association, in its efforts to promote Osteopathic Principles and Practices (OPP) in all levels of Osteopathic education, include efforts to incorporate value-based care as part of OPP and the Osteopathic approach to patient care.

References

1. United States Bureau of Labor Statistics, https://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths, accessed April 11, 2022

2. United States Health Resources and Services Administration https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/meetings/2018/nacnep-sept2018-CMS-Value-Based-Care.pdf, accessed April 11, 2022

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _REFERRED (*Montana Osteopathic Medical Association*)_

DATE ____July 16, 2022_____

SUBJECT: EQUALITY IN AWAY ROTATIONS/SUB-INTERNSHIPS FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

WHEREAS, after a five year transition period, all U.S. osteopathic and allopathic residencies are accredited under a single graduate medical education (GME) system that is facilitated under a single National Resident Matching Program (NRMP)[1]; and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) states that the benefits of the single GME accreditation system include offering all U.S. medical graduates a uniform education pathway, increasing collaboration among the medical education community, providing consistency across all residency programs, reducing costs and increasing opportunities for osteopathic graduate medical education[2]; and

WHEREAS, the Executive Summary of the Agreement among ACGME, American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) specifically outlines that graduates of osteopathic medical schools will be eligible for all ACGME-accredited programs[3]; and

WHEREAS, that Elective visiting clinical rotations also known as ‘Sub-Internships’ or ‘Away Rotations’ are beneficial to fourth year medical students by providing additional clinical experiences in varying specialties, often at their residencies of interest, promoting networking opportunities, and allowing students to obtain letters of recommendations to submit with their residency program application[4]; and

WHEREAS, according to the NRMP 66% of all programs cited audition/elective rotation within the department as a citing factor with an average rating of 4.3 out of 5 of mean importance rating[5]; and

WHEREAS, it has been noted that several School/College of Medicine programs throughout the United States require separate and more expensive application and processing fees for Osteopathic students as compared to their Allopathic counterparts[6]; and

WHEREAS, the American Medical Association (AMA) does not support this practice as stated in H-295.876 Equal Fees for Osteopathic and Allopathic Medical Students[7] ; and

WHEREAS, The AMA Policy H-295.876 "discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training...[and]...encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives" and requested the AMA's Council on Medical Education to work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against OMS[8]; and be it

RESOLVED, that the AOA ~~encourages~~ **ADVOCATES FOR** ~~equitable~~ **EQUAL FEES AND EQUAL** access ~~and fees~~ for clinical electives for **STUDENTS ENROLLED IN LCME AND COCA-ACCREDITED MEDICAL SCHOOLS**. ~~allopathic and osteopathic medical students; and be it further~~

~~RESOLVED, that the AOA works with the AMA to encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students.~~

References:

1. https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System/Benefits-of-Single-GME
2. https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System/Benefits-of-Single-GME
3. https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Executive_Summary_of_the_Agreement_between_ACGME_and_AOA.pdf
4. https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Executive_Summary_of_the_Agreement_between_ACGME_and_AOA.pdf
5. https://www.nrmp.org/wp-content/uploads/2021/08/2020-PD-Survey.pdf
6. https://osa.med.ufl.edu/students/visiting-medical-student-clerkships/visiting-student-learning-opportunities/
7. https://policysearch.ama-assn.org/policyfinder/detail/visiting?uri=%2FAMADoc%2FHOD.xml-0-2175.xml
8. https://policysearch.ama-assn.org/policyfinder/detail/visiting?uri=%2FAMADoc%2FHOD.xml-0-2175.xml

Background Information: Provided by AOA Staff
Current AOA Policy: None.

Prior HOD action on similar or same topic:
H-214-A/20 - Audition Rotations for Osteopathic Medical Students

The AOA champions on behalf of its members to ensure Osteopathic physicians, residents and students are treated fairly. A few examples that demonstrate this include:

The AOA Professional Advocacy resource website (Professional Advocacy - American Osteopathic Association) provides the mechanism for physicians to report discrimination to the AOA. This resource website also provides examples of professional advocacy work the AOA has completed on behalf of the membership.

Since December of 2020, there have been seven instances of recent AOA advocacy efforts on behalf of osteopathic students and trainees. These efforts can be viewed in further detail on the website.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: MAINTENANCE OF PRIMARY BOARD CERTIFICATION FOR SUBSPECIALTY CERTIFICATION

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Educational Affairs

WHEREAS, in 2020 the Subspecialty and Conjoint Certification Task Force was formed, and their charge included determining if the requirement for maintaining primary certification could be dropped upon successfully passing the Osteopathic Continuous Certification (OCC) Component 3 cognitive assessment of any subspecialty, CAQ, or conjoint. Their recommendations were sent to the Bureau of Osteopathic Specialist (BOS) for consideration; and

WHEREAS, several ABMS boards, such as the American Board of Preventive Medicine (ABPM) and ABIM do not require diplomates to retain their primary board certification to remain certified in subspecialties. With the single graduate medical education system, new DOs (and MDs) can choose whether to be certified through the AOA or an ABMS member board. The AOA policy to require DOs (and MDs) to keep their primary board certification which they may not use up to date, may detract new DOs (and MDs) from choosing the AOA for board certification; and

WHEREAS, the AOA website on osteopathic continuous certification (https://certification.osteopathic.org/faqs) states, "…DOs should not have to pay more to be certified as an osteopathic physician and [the AOA is] committed to keeping costs competitive." Requiring DOs to keep primary board certification that they are not using creates an undue financial hardship that is not in place in the ABMS. Again, this will deter DOs from choosing the AOA for board certification which is counter to the AOA's strategic plan to bring DOs home; and

WHEREAS, The BOS approved Resolution #2 that states "…conjoint certifications be maintained as they are currently and continue to require maintenance of primary certification as a requirement to maintain an active conjoint certification..."; and

WHEREAS, The AOA discussed the topic at their April 2021 Midyear meeting and accepted the BOS resolution; and

34 WHEREAS, the American Board of Preventive Medicine (ABPM) and several other
35 American Board of Medical Specialties (ABMS) boards do not require
36 Diplomates certified a subspecialty to maintain their primary board in order to
37 maintain their subspecialty board certification; and

38 WHEREAS, maintaining a primary board certification as a condition of obtaining and
39 maintaining subspecialty certification puts DOs at an unfair disadvantage
40 from their ABPM diplomates certified in addiction medicine; and

41 WHEREAS, this disadvantage will steer future DOs to not get AOA certification in a
42 primary specialty, resulting in future financial hardships for the AOA; and
43

44 WHEREAS, the maintenance of two board certifications after becoming certified in a
45 subspecialty creates a financial hardship for DOs who may not otherwise
46 practice in their primary board; now, therefore be it

47 RESOLVED, that the requirement for maintaining primary certification is dropped
48 upon successfully becoming recertified in any subspecialty, CAQ, or conjoint.

Background Information: Provided by AOA Staff

Current AOA Policy:

The BOS has the authority to take final action on specialty certifying board recommendations for certification, subspecialty certification and Osteopathic Continuous Certification (OCC) completion, subject to appeal, and report these actions to the Board of Trustees for information only. (B-02/94)

In 2020, at the direction of the BOS, the Subspecialty and Conjoint Certification Task Force was formed, and their charge included determining if the requirement for maintaining primary certification could be dropped upon successfully passing the Osteopathic Continuous Certification (OCC) Component 3 cognitive assessment of any subspecialty, CAQ, or conjoint. The task force solicited input from each AOA specialty certifying board and submitted their recommendations to the BOS for consideration.

At its Midyear meeting in April 2021, the BOS approved Resolution #2 that states "…conjoint certifications be maintained as they are currently and continue to require maintenance of primary certification as a requirement to maintain an active conjoint certification..." The resolution includes an opportunity for the boards to submit a request to the BOS to drop the requirement for its diplomates to maintain primary certification while still maintaining their subspecialty/CAQ (non-conjoint) certification if they meet certain requirements.

The AOA Addiction Medicine subspecialty certification is a conjoint certification. The American Osteopathic Conjoint Examination Committee on Addiction Medicine (Conjoint Committee) administers the Addiction Medicine subspecialty certification and Osteopathic

Continuous Certification (OCC) examinations. The Conjoint Committee is made up of representatives from each specialty certifying board that participates in the creation and administration of the Addiction Medicine subspecialty certification exam.

Prior HOD action on similar or same topic:
This resolution was reviewed by the 2021 HOD and it was disapproved. The explanatory statement was: "The Education Reference Committee believes that this resolution bypasses the authority of the Bureau of Osteopathic Specialists and its approved mechanism for certifying boards to eliminate the requirement of maintaining the primary certificate for their sub-specialists. The individual conjoint examination committees should go through the appropriate BOS process if all the certifying boards participating in that conjoint committee agree to eliminate the requirement to maintain primary certification for subspecialty certification."

FISCAL IMPACT: $646,400
For FY23, the fiscal impact was reassessed and the anticipated expense remains unchanged from the previous assumption in FY22.

In 2021, the AOA estimated a $646,400 fiscal impact of resolution H-200-A21.
This was based on an estimated 3,232 diplomates not renewing their primary boards at $200/year.

ACTION TAKEN ___DISAPPROVED_____

DATE _____July 16, 2022_____

SUBJECT: ~~ABIM~~ **CERTIFYING RESIDENTS FOR** BOARD ELIGIBILITY

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Educational Affairs

WHEREAS, Residents pursuing board certification must have their residency competencies certified by the residency program director prior to taking a board examination; and

WHEREAS, currently all residents, regardless of degree, are eligible to pursue either osteopathic or allopathic board certification; and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) oversees residency review committees which establish standards for residency programs and program directors; and

WHEREAS, ACGME internal medicine program director requirements state: "The review committee only accepts current Board certification in internal medicine from the ABIM [American Board of Internal Medicine] or AOBIM[1]. [American Osteopathic Board of Internal Medicine], and

WHEREAS, Currently, the ABIM will not allow program directors board certified by AOBIM to certify graduating internal medicine residents as eligible for ABIM examination, thereby limiting their options for certification and fellowship; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate **WITHIN ITS RESOURCES** on behalf of internal medicine residents and fellows, **AND PROGRAM DIRECTORS AT THE FEDERAL, STATE AND LOCAL LEVEL** so that they be able to sit for internal medicine board certification of their choosing; and, be it further

RESOLVED, that the AOA **ADVOCATE FOR** ~~internal medicine~~ **ALL** ~~directors to be able~~ **AOA BOARD CERTIFIED PROGRAM DIRECTORS TO BE ABLE TO CERTIFY THAT THEIR RESIDENTS ARE ELIGIBLE FOR THE RELEVANT AOA AND/OR ABMS** ~~the internal medicine~~ **BOARD CERTIFICATION OF THEIR CHOOSING;**

27 **AND BE IT FURTHER RESOVED, THAT THE AOA CONTINUE TO WORK WITH**
28 **OTHER ABMS BOARDS TO DEFEND THE EQUIVALENCY OF ABMS**
29 **AND AOA CERTIFICATION OF PROGRAM DIRECTORS.**

Reference

1. [1]https://acgme.org/specialties/internal-medicine/program-requirements-and-faqs-and-applications/

Background Information: Provided by AOA Staff

Current AOA Policy:

H608-A-17 Discrimination – The Practice of Osteopathic Medicine (2017 policy reaffirmed as amended).

H318-A/18 Osteopathic Discrimination by Payors (2018 policy reaffirmed as amended).

Prior HOD action on similar or same topic: None

The AOA champions on behalf of its members to ensure Osteopathic physicians, residents and students are treated fairly. A few examples that demonstrate this include:

The AOA Professional Advocacy resource website (Professional Advocacy - American Osteopathic Association) provides the mechanism for physicians to report discrimination to the AOA. This resource website also provides examples of professional advocacy work the AOA has completed on behalf of the membership.

In order to advocate for the osteopathic profession and the impacted ACGME internal medicine program directors, The American Osteopathic Association (AOA), along with seven osteopathic program directors, filed suit against the American Board of Internal Medicine (ABIM) on December 20, 2020 regarding their longstanding policy requiring that residency completion attestations qualifying residency graduates to sit for ABIM examination can only be made by ABIM certified program directors. A five-year enforcement grace period was published at the beginning of the 5-year single accreditation system transition. This policy was scheduled to go into effect on January 1, 2022. Although the AOA's still supports the qualifications of AOBIM-certified program directors, the legal matter has run its course and has been resolved with the following provisions. ABIM will continue to accept attestations from current program directors of Single GME Accreditation System internal medicine residencies and fellowships who are not ABIM certified in 2022 and 2023, thus giving them two additional years to become certified by ABIM in their discipline. Also, ABIM will waive its examination fee for one administration of its internal medicine certification examination and one administration on a subspecialty certification examination in 2022 or 2023 for any such program director. Beginning in 2024, all clinical competence attestations must come from program directors who are ABIM certified in the discipline of their program.

FISCAL IMPACT: $0

ACTION TAKEN _ADOPTED AS AMENDED

DATE ___July 16, 2022_____

SUBJECT: PHYSICIAN DESIGNATION, TRUTH IN ADVERTISING AND RESIDENCY/FELLOWSHIP TRAINING NON-PHYSICIAN POST GRADUATE MEDICAL TRAINING 2022

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Medical Association (AMA) recently compiled data regarding public perceptions and understanding of the term physician and doctor; and

WHEREAS, Data collected by the AMA's Scope of Practice Partnership (the American Osteopathic Association [AOA] is a partner member) Truth in Advertising campaign report that nearly 90% of patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician"[i]; and

WHEREAS, In the same campaign, nearly 80% of patients "support legislation to require all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promising their services"[ii]; and

WHEREAS, The Center for Medicare and Medicaid Services defines 'resident' as "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board"[iii] ; and

WHEREAS, The term 'medical students' should apply exclusively to students who are enrolled in educational programs provided by a college of osteopathic medicine or allopathic medicine accredited by the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education leading to the DO or MD degree; and

WHEREAS, there has been an increase in the number of physician assistant (PA) and nurse practitioner (NP) postgraduate programs, many of which are inappropriately referred to as "residencies" or "fellowships"; and

WHEREAS, On September 3rd 2020, every major academic emergency medicine association issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship' in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs"[iv]; now, therefore be it

RESOLVED, that the AOA work with the AMA and other relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician (Graduate Medical Education) GME; and, be it further

~~RESOLVED, that the AOA partner with the AMA and appropriate stakeholders to create standards requiring Program Directors and Designated Institutional Officials to notify the Accreditation Council for Graduate Medical Education (ACGME) of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and, be it further~~

RESOLVED, that the AOA oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals; and, be it further

~~RESOLVED, that the AOA work with the AMA and other stakeholders to protect the Titles "Doctor," "Resident" and "Residency.".~~

References:

1. [i] https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
2. [ii]https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
3. [iii] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf
4. [iv] https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/

Background Information: Provided by AOA Staff

Current AOA Policy: H203-A/21 Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post-Graduate Medical Training: policy adopted in 2021.

Prior HOD action on similar or same topic:

H346-A/16 Non-Physician Health Care Clinician: policy reaffirmed in 2016
H640-A/20 Non-Physician Clinicians: policy adopted as amended in 2020
H336-A/20 Use of The Term “Physician” Doctor” and “Provider”: policy adopted in 2020

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED

DATE: ___July 16, 2022_____

SUBJECT: OSTEOPATHIC EDUCATION

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the transition to the single accreditation system was completed in 2020; and

WHEREAS, graduate medical education (GME) programs in the United States are now accredited by the Accreditation Council for Graduate Medical Education (ACGME); and

WHEREAS, the loss of American Osteopathic Association accredited GME has resulted in decreased exposure of osteopathic graduates to osteopathic mentors and exposure to osteopathic principles and practices, and osteopathic history during graduate medical education training; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) shall ~~strongly~~ recommend to ~~both~~ the American Association of Colleges of Osteopathic Medicine (AACOM) ~~and the Commission on Osteopathic College Accreditation (COCA)~~ that significant effort and resources be devoted during undergraduate osteopathic medical education to both teach and reinforce the following tenets: 1. the unique identity of the osteopathic physician, 2. the role osteopathic medicine has played in shaping healthcare in the United States, 3. the patient care principles that distinguish an osteopathic physician, and 4. the value of an osteopathic medical education in any chosen specialty; and, be it further

RESOLVED, that the AOA will ~~strongly~~ recommend to ~~both~~ AACOM ~~and COCA~~ that osteopathic medical colleges strive to instill pride in their graduates by exposing them not only to the historical background of the profession but also to the challenges the profession has faced, the hurdles it has overcome, and to the achievements of its current practitioners; and, be it further

RESOLVED that the AOA will ~~strongly~~ recommend to ~~both~~ AACOM ~~and COCA~~ that significant effort and resources be devoted during undergraduate osteopathic medical education to expose students to osteopathic physicians who have distinguished themselves through clinical practice, research, and/or medical education, by way of regular guest lectures, campus visits, direct student interactions and/or opportunities for mentoring after graduation.

Background Information: Provided by AOA Staff
Current AOA Policy:
H617-A/18 Tenets of Osteopathic Medicine (2018 reaffirmed).

Prior HOD action on similar or same topic: None

Beginning last year, the AOA, NBOME and AACOM collaborated and began development of a welcome program that is included in COMs first-year medical student orientations.

FISCAL IMPACT: $0

ACTION TAKEN _ADOPTED AS AMENDED

DATE ___July 16, 2022_____

SUBJECT: DEFINING NEW PHYSICIANS IN PRACTICE - SOURCE: H349-A/17

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Emerging Leaders has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of Emerging Leaders recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association defines a new physician in practice as a
7 physician WHO is no more than 5 years past the completion of postdoctoral
8 training.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: First Read of H502-A/21 which amends the AOA Constitution to update the New Physicians in Practice definition to match the 2017 policy; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: STATE LICENSURE OF MANAGED CARE ORGANIZATIONS (MCO) MEDICAL DIRECTORS- SOURCE: H302-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports legislation or regulations that
7 would require all Managed Care Organization (MCO) medical directors to be
8 fully licensed physicians of the state where the care is being provided; and
9 supports state medical boards' rights to oversee and discipline any medical
10 director of an MCO licensed as a physician in their state.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed; 2009 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: ADMINISTRATIVE RULE-MAKING PROCESS – SOURCE: H304-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports closer federal and state legislative
7 scrutiny of the administrative rule-making process to more effectively monitor
8 the development of regulations and assure their conformity with expressed
9 legislative intent.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1986; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: ADVANCE DIRECTIVES - SOURCE: H305-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports advance directives and will
7 proactively assist in introducing this concept into federal legislation.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: INTERSTATE ~~OPIOID DATABASE~~ **PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)** - SOURCE: H331-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports an ~~integrated national opioid database~~ **INTERSTATE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)** that allows prescribers, dispensers, or their designated staff in any state to access a patient's **RELEVANT** prescription history, regardless of their residing state at no cost to the prescriber or dispenser.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED

DATE: __July 16, 2022_____

SUBJECT: IMPROVE LIFE-SAVING ACCESS TO EPINEPHRINE – SOURCE: H333-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association will advocate for states to enact
7 comprehensive epinephrine training protocols **FOR USE DURING AN**
8 **ALLERGIC REACTION** for medical and non-medical professionals working
9 in public facilities and supports increased availability of epinephrine in all
10 forms to properly trained individuals.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic:
H352-A/18 Epinephrine Products
H350-A/17 Epinephrine – Cost Savings to; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: FAMILY AND MEDICAL LEAVE ACT (FMLA) DOCUMENTATION
SOURCE: H307-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association will work with patient advocacy groups and other similar groups to assure uniform family and medical leave act documentation requirements that provide adequate information for employers while ensuring the patient's right to privacy.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed as Amended; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: DISAPPROVED (Sunset)

DATE: July 16, 2022

SUBJECT: PRESCRIPTION DRUGS - SOURCE: H308-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association will: urge the FDA to strengthen its
7 inspection and approval procedures and equivalency standards to ensure
8 that generic drugs approved by the FDA are therapeutically equivalent to the
9 brand drug for which they are to be substituted; oppose mandatory use of
10 generic drugs or generic substitution programs that remove control of the
11 treatment program from the physician; urge the development and enactment
12 of public policy that would mandate that prescription drug plans cover name-
13 brand medications when evidence-based treatment protocols recommend
14 their use; act to educate healthcare insurers and managed care companies
15 on the potential dangers of formulary substitutions; support public policy that
16 requires a physician be available for consultation in a timely manner on
17 pharmaceutical formulary and drug substitution decisions; oppose any
18 attempt by federal or state governments to restrict, prohibit, or otherwise
19 impede the prerogative of physicians to prescribe and dispense appropriate
20 medications to their patients; urge the FDA to ensure safe and consistent
21 drug supply that avoids shortages and ensures adequate generic
22 pharmaceutical manufacture and supply for U.S. patients and physicians.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1990; 1995 Reaffirmed, 1997; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: FEDERALLY FUNDED HEALTH ~~CLINICS~~ **CENTERS**
- SOURCE: H309-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs recognizes the ongoing need to address staffing as well as scope of practice issues in federally funded health clinics; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

The American Osteopathic Association supports adequate staffing for the physicians providing medical care in federally funded health ~~clinics~~ **CENTERS** and opposes ~~requirements to have~~ **HAVING** a nurse practitioner or physician assistant in LIEU OF PHYSICIANS IN federally funded health centers. **THE AOA CONTINUES TO SUPPORT PHYSICIAN -LED TEAM HEALTHCARE DELIVERY IN ALL FEDERALLY FUNDED HEALTH CARE CENTERS.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: DISPARITIES BETWEEN RURAL AND URBAN PRACTICES – SOURCE: H311-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports federal legislation that would
7 sustain a minimum geographic cost-of-practice index value for physicians'
8 services at or above 1.000.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: PRESERVATION OF ANTIBIOTICS FOR MEDICAL TREATMENT - SOURCE: H312-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports legislation or regulatory efforts that
7 would ban feed additive uses of antibiotics for non-therapeutic uses in
8 animals such as for growth promotion, feed efficiency, weight gain, routine
9 disease prevention or other routine purposes.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: GUIDELINES FOR NUTRITIONAL AND DIETARY SUPPLEMENTS – SOURCE: H315-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association requests: the Food and Drug Administration
7 (FDA) to be diligent in their monitoring of all products marketed for human
8 consumption, including nutritional supplements, and that there be close
9 attention to reported adverse events directly caused by any of these
10 products; and that the US Congress pass legislation requiring dietary
11 supplements to undergo pre-market safety and efficacy evaluation by the
12 FDA.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Amended; 2011 Reaffirmed as Amended; 2012; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: SEXUAL HARASSMENT- SOURCE: H316-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association **SUPPORTS STATE AND FEDERAL LEGISLATION THAT PROHIBITS SEXUAL HARASSMENT** ~~urges the enactment of appropriate legislation to eliminate all sexual harassment~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: DUE PROCESS IN AGENCY DETERMINATIONS – SOURCE: H317-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy;

WHEREAS, the Bureau on Federal Health Programs recognizes the ongoing need to support due process for physicians subject to any administrative review; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

The American Osteopathic Association **OPPOSES** ~~declares its opposition to~~ any and all existing or proposed federal and state rules or procedures, and their underlying laws~~, which vest any administrative personnel with final authority, in matters affecting the rights and/or property of individuals,~~ where no provision is made for a prior, fair, **AND** formal hearing.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1982; 1987 Reaffirmed as Amended; 1992 Reaffirmed, 1997 Reaffirmed, 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE - SOURCE: H318-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages Congress and the Department
7 of Health and Human Services to consult with the osteopathic and allopathic
8 medical professions to determine the necessary, proper and acceptable role
9 of government in ethical and sociological matters regarding medical care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1985; 1990 Reaffirmed, 1995, 1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: REGULATION OF HEALTH CARE – SOURCE: H319-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports regulation in health care as follows:

1. The need for any new regulation must demonstrate that access to care, or **PATIENT SAFETY**, or the quality of health care provided, will be improved by the proposed regulatory action and that the claimed improvement can be accomplished at an acceptable cost to the public.

2. In all matters where the health profession has demonstrated its capacity for quality self-regulation, government at all levels should not impose additional or preemptive regulation.

3. Where the need for regulation has been demonstrated, it should emanate from the lowest applicable level of government.

4. Where there is a demonstrated necessity for regulation of health care, such regulation must be drawn and implemented in such a way as to promote pluralism and preserve the free enterprise system in health care.

5. **EVERY EFFORT SHOULD BE MADE WHEN FORMULATING NEW REGULATIONS TO HARMONIZE THEM WITH EXISTING REGULATIONS TO PREVENT INCREASING EXISTING REGULATORY BURDEN.**

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_____

DATE: ____July 16, 2022_____

SUBJECT: OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS - SOURCE: H320-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association urges that the Occupational Safety and
7 Health Administration (OSHA) prioritize education and training to create a
8 safe workplace before considering assessment of fines.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed as Amended, 2002; 2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ___July 16, 2022_____

SUBJECT: PATIENT SAFETY - SOURCE: H321-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy;

WHEREAS, the Bureau on Federal Health Programs recognizes the ~~linkage~~ **LINK** between adequate payment and patient access to quality care; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

The American Osteopathic Association endorses patient safety in health care that encourages payers to provide adequate **PAYMENT** ~~TO SUPPORT reimbursement~~ so that **PHYSICIANS AND** hospitals can provide **SAFE QUALITY CARE** ~~the best quality care in the safest of environments~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: PROMOTION OF SCHOOL BASED HEALTH EDUCATION
SOURCE: H325-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the reference to the Centers for Disease Control and Prevention's (CDC) definition of comprehensive school health education appears to be outdated; and

WHEREAS, the CDC has developed a new "Whole School, Whole Community, Whole Child" model as its current framework for addressing health in schools; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association will continue to urge the state legislatures to enact measures establishing programs that **FOLLOW** ~~meet with~~ the Centers for Disease Control and Prevention'**S WHOLE SCHOOL WHOLE COMMUNITY, WHOLE CHILD (WSCC) MODEL** ~~definition of comprehensive school health education~~.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: RECOUPMENT LAWS - SOURCE: H326-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports public policy which subjects all
7 parties to the same terms and time frame for billing, payment and appeal.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED_____

DATE: ___July 16, 2022_____

SUBJECT: RIGHT TO PRACTICE AND PAYMENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT - SOURCE: H329-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association will pursue any and all legal and legislative
7 recourse to protect patient access and the rights of its member physicians to
8 deliver approved and beneficial modalities of healthcare; will work with
9 legislators and state licensing boards to preserve the osteopathic
10 profession's right to establish and maintain standards of practice of
11 osteopathic manipulative treatment; objects to any attempt by third party
12 payers to deny or restrict payment for osteopathic manipulative treatment
13 when appropriately rendered by a physician with appropriate training in
14 osteopathic principles and practice; and will continue to oppose any attempt
15 by third-party payers to interchange and/or combine osteopathic manipulative
16 treatment codes with codes used to describe other forms of manual therapy.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1986; 1991 Reaffirmed as Amended, 1992, 1997, 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: EQUITY IN MEDICARE & MEDICAID PAYMENTS – SOURCE: H339-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the term "payment" for physician services is preferred to the term "reimbursement" throughout AOA policy; and

WHEREAS, Medicare and Medicaid payments are a cross-cutting federal and state issue; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association will actively support federal legislation, rules or regulations, to include socioeconomic risk stratification in public reporting and evaluation of **PHYSICIAN** ~~healthcare provider~~ **PAYMENT** ~~reimbursement~~ in all Medicare and Medicaid pay for performance value-based purchasing incentives or penalties to account for the challenges serving socioeconomically or medically underserved ~~disadvantaged~~ patient populations to ensure continued timely access to appropriate clinical services.

The AOA will support federal **AND STATE** legislation, rules or regulations to improve Medicare and Medicaid **PAYMENTS** ~~reimbursements~~ to physicians working in socioeconomic, ~~disadvantaged~~ **OR** medically underserved areas to ensure an adequate workforce to address the burden of care associated with complex comorbid conditions in these areas.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED_____

DATE: July 16, 2022_____

SUBJECT: NALOXONE **AND OTHER OPIOID ANTAGONISTS** - SOURCE: H340-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will work with legislators to give
7 statutory protection in evaluation for and prescription of Naloxone **AND**
8 **OTHER OPIOID ANTAGONISTS.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_____

DATE: __July 16, 2022_____

SUBJECT: SHARED PRINCIPLES OF PRIMARY CARE - SOURCE: H342-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) endorses the “Shared Principles of Primary Care” as developed and published by the Patient-Centered Primary Care Collaborative (PCPCC).

Shared Principles of Primary Care

Primary care is widely acknowledged to be essential for better health and wellbeing in the US health care system and should be foundational to all health care systems worldwide (WHO, 2008) (IOM, 1994) (Starfield, 1992). Access to high quality primary care can help people live longer, feel better, and avoid disability (Commonwealth Fund, 2013).

Primary care has experienced significant changes in the way it is organized, financed and delivered in response to greater demand for high quality services, rising health care costs, and increasing burden of disease across populations (Bitton et al 2016). Concepts such as the Patient Centered Medical Home emerged to describe a more advanced model of primary care. Based on lessons learned over the past decade and the continued rapid pace of change, the time is right to revisit the future of primary care.

Realizing the ideal vision of primary care occurs faster when all stakeholders can speak with one voice. These Shared Principles--developed by stakeholders representing all aspects of health care-- are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will help achieve the goals of better health, better care, and lower costs. Achieving this future requires a common vision as well as appropriate payment, investment, training, workforce and other resources to support it.

1. Person & Family Centered.

   - Primary care is focused on the whole person - their physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.

- Primary care is grounded in mutually beneficial partnerships among clinicians, staff, individuals and their families, as equal members of the care team. Care delivery is customized based on individual and family strengths, preferences, values, goals and experiences using strategies such as care planning and shared decision making.

- Individuals are supported in determining how their family or other care partners may be involved in decision making and care.

- There are opportunities for individuals and their families to shape the design, operation and evaluation of care delivery.

2. Continuous.

- Dynamic, trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care. There is continuity in relationships and in knowledge of the individual and their family/care partners that provides perspective and context throughout all stages of life including end of life care.

3. Comprehensive and Equitable.

- Primary care addresses the whole-person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.

- Primary care providers seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.

- Primary care practices partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution.

4. Team-Based and Collaborative.

- Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.

- Health care professional members of the team are trained to work together at the top of their skill set, according to clearly defined roles and responsibilities. They are also trained in leadership skills, as well as how to partner with individuals and families, based on their priorities and needs.

5. Coordinated and Integrated.

- Primary care integrates the activities of those involved in an individual's care, across settings and services.

- Primary care proactively communicates across the spectrum of care and collaborators, including individuals and their families/care partners.

- Primary care helps individuals and families/care partners navigate the guidance and recommendations they receive from other clinicians and professionals, including supporting and respecting those who want to facilitate their own care coordination.

- Primary care is actively engaged in transitions of care to achieve better health and seamless care delivery across the life span.

6. Accessible

- Primary care is readily accessible, both in person and virtually for all individuals regardless of linguistic, literacy, socioeconomic, cognitive or physical barriers. As the first source of care, clinicians and staff are available and responsive when, where and how individuals and families need them.

- Primary care facilitates access to the broader health care system, acting as a gateway to high-value care and community resources.

- Primary care provides individuals with easy, routine access to their health information.

7. High-Value

- Primary care achieves excellent, equitable outcomes for individuals and families, including using health care resources wisely and considering costs to patients, payers and the system.

- Primary care practices employ a systematic approach to measuring, reporting and improving population health, quality, safety and health equity, including partnering with individuals, families and community groups.

- Primary care practices deliver exceptionally positive experiences for individuals, families, staff and clinicians.

The vision outlined in these Shared Principles of Primary Care will result in excellent outcomes for individuals and families, and more satisfying and sustainable careers for clinicians and staff. It is a vision that is aspirational yet achievable when stakeholders work together.

105 The following organizations are committed to the implementation of these Shared
106 Principles:

107 Signers (in alphabetical order):
108 Family Medicine for America's Health
109 Patient-Centered Primary Care Collaborative
110 Works Cited
111 Commonwealth Fund. (2013). Primary Care: Our First Line of Defense. New York:
112 Commonwealth Fund.
113 IOM. (1994). Defining Primary Care: An Interim Report. Washington DC: National
114 Academies of Science.
115 Starfield, B. (1992). Primary Care: Concept, Evaluation, and Policy. New York: Oxford
116 University Press.
117 WHO. (2008). World Health Report 2008: Primary Care (Now More Than Ever). Geneva:
118 World Health Organization.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ___July 16, 2022_____

SUBJECT: EUGENIC SELECTION WITH PREIMPLANTATION GENETIC DIAGNOSIS - SOURCE: H328-A/21

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy was referred to the Bureau on Federal Health Programs by
2 the 2021 American Osteopathic Association House of Delegates during the
3 sunset review process; and

4 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

5 WHERAS, the Bureau on Federal Health Programs believes that retaining this
6 policy could support future American Osteopathic Association engagement
7 on federal policymaking; now, therefore be it

8 RESOLVED, that the Bureau on Federal Health Programs recommends that the
9 following policy be REAFFIRMED.

10 The American Osteopathic Association supports legislation **IN COLLABORATION**
11 **WITH THE MEDICAL COMMUNITY** that regulates the use of
12 Preimplantation Genetic Diagnosis (PGD) to choose a fetus' traits unrelated
13 to disease.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2016; 2021 Referred to BFHP).

Prior HOD action on similar or same topic: As noted above.

There has been no recent legislative activity on this topic.

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED__

DATE __July 16, 2022_____

SUBJECT: INTERFERENCE LAWS - AMENDMENT TO AMERICAN OSTEOPATHIC ASSOCIATION POLICY H358-A/19

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2019 the American Osteopathic Association (AOA) House of Delegates adopted resolution H358-A/19 which amended and reaffirmed AOA policy regarding Interference Laws; and

WHEREAS, this AOA policy specifically addresses laws which interfere with the patient-physician relationship; and

WHEREAS, this policy describes four types of interference laws which the AOA opposes: 1. Physician gag laws, 2. Laws which require physicians to have certain discussions with patients, 3. Required treatment laws, and 4. Laws which restrict the type of information which physicians are allowed to disclose to patients; and

WHEREAS, recent legislative and regulatory activities have brought to light a fifth type of interference law not described in the current AOA policy; and

WHEREAS, this fifth type of interference relates to legislation or regulation which prohibits physicians from discussing, recommending, or performing certain evidence based medical treatments which the physician deems to be in the best interest of the patient; and

WHEREAS, AOA Policy H358-A/19 anticipated the development of new types of interference in the patient-physician relationship stating, “The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as needed.”; now, therefore be it

RESOLVED, that American Osteopathic Association Policy H358-A/19 Interference Laws is hereby amended as shown in the attached policy.

INTERFERENCE LAWS (H358-A/19)
The American Osteopathic Association approved the following policy paper and recommendations to assist in responding to state and federal proposals and agencies that attempt to adopt interference laws (2013; 2019 Reaffirmed as Amended).

A number of states have pursued legislation that dictates how physicians treat and counsel patients during a medical exam. These laws interfere with the patient-physician relationship, and undermine physician judgment and represent a departure from evidence-based medicine. As a result, these laws are collectively referred to as “interference laws.”

Interference laws fall into one of four different classifications.[1] The first prevents physicians from asking their patients about risk factors that may affect their health or the health of their families (PHYSICIAN “GAG LAWS”). One example of a Gag Law is a 2011 Florida law which barred physicians from asking questions about a patient’s gun ownership.[2] The law was enjoined in 2012 on first amendments grounds, a decision which was upheld by a federal appeals court in 2017.[3] although 14 other states have considered similar laws, none have passed.[4]

The second type of interference law requires physicians to discuss specific treatments that may not be appropriate or medically necessary.[5] One example of this is New York’s Palliative Care Information Act of 2011, which requires health care providers to offer to discuss end-of-life options and palliative care services with terminally ill patients, without discretion as to how and when to raise the issues.[6] some argue that requiring physicians to discuss this subject with all patients is inappropriate, because physicians are not able to use their judgment to determine if or when patients should receive such sensitive information.

The third type of interference law requires physicians to provide tests or treatments which are not supported by evidence, including ones that are invasive or required without the patient's consent.[7] Examples of this are laws which require physicians who perform abortions to first perform a fetal ultrasound. It is argued that a fetal ultrasound is medically unnecessary and there is no legitimate medical purpose for requiring one in this circumstance.

The fourth ~~and final~~ type of interference law places restrictions on the content of information that physicians can disclose to patients.[8] Examples of this include laws which limit a physician from providing information about the dangers of chemicals used in the hydraulic fracturing process, also known as “fracking.”

~~RECENTLY~~ A FIFTH TYPE OF INTERFERENCE LAW HAS BEEN IDENTIFIED. THESE LAWS AND REGULATIONS INTERFERE IN THE PATIENT-PHYSICIAN RELATIONSHIP BY PROHIBITING, ~~OR~~ LIMITING, **OR MANDATING** PHYSICIANS ~~FROM DISCUSSING~~, ~~RECOMMENDING, AND/OR PROVIDING~~ **IN THE DISCUSSION , RECOMMEDATION AND/OR PROVISION OF** EVIDENCE BASED MEDICAL CARE OR TREATMENTS. AN EXAMPLE OF THIS ARE LAWS WHICH PROHIBIT OR LIMIT THE ABILITY OF PHYSICIANS TO PRESCRIBE CERTAIN MEDICATIONS BASED ON THE PHYSICIAN’S SPECIALTY.

Impact on the Osteopathic Medical Profession and the Patient-Physician Relationship

Interference laws threaten the osteopathic medical profession, in particular due to the intrusion into the patient-physician relationship, which is an essential component of the osteopathic care model's emphasis on preventive medicine and treatment of the whole patient.[9] The patient-physician relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open communication between the physician and patient.[10]

Another critical element of osteopathic medical practice in general and the patient-physician relationship in particular is the concept of physician and patient autonomy and "patient-centered" care. The Institute of Medicine (IOM) defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[11] Patient-centered care is an essential element in the practice of evidence-based medicine. The American Osteopathic Association (AOA) supports the use of evidence-based medicine and the implementation of appropriate methods to optimize natural healing and to address the primary cause of disease.

The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication. "Osteopathic physicians (DOs) consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. DOs are trained to look at the whole person, and osteopathic physicians integrate the patient into the health care delivery process as a partner."[13] Interference laws which prevent DOs from discussing certain health-related subjects such as the safe storage of firearms or the health implications of fracking undermine this partnership and violate the osteopathic principle of preventive medicine. DOs help prevent pediatric deaths by counseling caregivers on the importance of seatbelt and helmet use, but without the ability to adequately counsel a patient on the importance of safe firearm storage they may be unable to help prevent similar deaths from improperly stored firearms. "[T]he purpose of [a firearms] inquiry is so that the practitioner can determine what subject matters require further follow-up in the practice of preventive medicine.''[14] The AOA rejects any censorship of professional communication, supports enactment of legislation protecting the patient-physician relationship and opposes any attempt to interfere with the patient-physician relationship.[15]

Additionally, interference laws that require DOs to discuss treatments which are not medically necessary or are not supported by evidence-based guidelines violates the osteopathic principle of treating the whole patient and can undermine patient trust. In Kansas, for example, physicians are required to provide misleading information to patients regarding an unproven link between breast cancer and abortion.[16] Twenty-three states currently require health care providers to refer patients to state-created "informed consent" materials, and according to a 2016 audit by Rutgers University, 31 percent of the information included in these materials was found to be medically inaccurate.[17] Blanket requirements that DOs provide information on a particular treatment, or medically

inaccurate information, to all patients prevents them from exercising their independent medical judgment and treating the whole patient in an objective, evidence-based manner. Similarly, interference laws which require DOs to perform certain procedures or treatments violate the osteopathic principle of providing individualized patient-centered care. If a DO is required to perform a certain procedure or treatment for every patient, there is no individualized assessment as to what is in a particular patient's best interests and there is no discussion with the patient because the patient has no choice. Instead of individualized care, this is a "one size fits all" approach. Ultimately, DOs are prevented from rendering individualized, evidence-based care, and patients are prevented from being involved in patient-centered care.

Legal Challenges

Two types of interference laws have been challenged in court. Florida's controversial Firearm Owner's Privacy Act, which restricted physicians from asking patients about firearm ownership, was enjoined in June 2012 when a Florida district court found that it violated physicians' First Amendment rights, a decision which was upheld by a federal appeals court in 2017. In granting the injunction, the judge stated the law "chills practitioners' speech in a way that impairs the provision of medical care and may ultimately harm the patient."[18] The court also held that physician questioning did not violate patients' Second Amendment rights stating, "[t]he law does not affect nor interfere with a patient's right to continue to own, possess, or use firearms.

Protecting the right to keep and bear arms is irrelevant to this law."1[9] In addition, a similar 2012 law which prevented physicians in Pennsylvania from discussing how fracking chemicals may be affecting their patients' health was struck down by the state supreme court in 2016. [20]

Mandatory ultrasound laws have also been challenged on First Amendment grounds. North Carolina's mandatory ultrasound law was struck down as a violation of physician and patient First Amendment rights. The court held that "[t]he Act goes well beyond requiring disclosure of those items traditionally a part of the informed consent process. In this case, the state compels the provider to physically speak and show the state's non-medical message to patients unwilling to hear or see [that message]."[21]

Conversely, a nearly identical Kentucky law was upheld by a federal appeals court, which found that the law was reasonably related to the "informed consent" process and did not violate the First Amendment rights of physicians and patients.[22] Significantly, the circuit split between the courts sets up a probable hearing by the United States Supreme Court on the issue of mandatory ultrasound laws.

Mandatory ultrasound laws have also been challenged in court on Fourteenth Amendment Substantive Due Process grounds. A mandatory ultrasound law in Oklahoma was ruled to be unconstitutional as a violation of patients' Fourteenth Amendment due process rights, because it placed an "undue burden" on a woman's right to seek an abortion.[23]

Efforts of Medical Associations

Several medical associations have developed policies or taken action in opposition to interference laws. In 2015, the American Medical Association (AMA) reaffirmed a 2011 resolution which opposes any intrusion into patient-physician relationships and supports physician judgment. In May 2018, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American College of Physicians issued a set of joint principles based upon their organizations' policies which oppose governmental interference with physicians' obligations to provide comprehensive, evidence-based information to patients.[25]

The American Bar Association (ABA) also has policy specifically opposing laws which prevent physicians from asking patients about firearm ownership. The ABA policy states that these laws clearly violate the First Amendment rights of physicians and patients, and physician questioning does not in any way violate Second Amendment rights of patients.[26]

Finally, several state medical associations have adopted resolutions on the issue of interference laws. Many of these policies are very basic and simply state the association's opposition to any interference with the patient-physician relationship. Additionally, these policies often promote the use of evidence-based medicine, seek to preserve physician judgment and support litigation which blocks the enforcement of interference laws.

Conclusion

The AOA supports the protection of the patient-physician relationship as especially paramount to the osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole patient and the use of preventive medicine. The patient-physician relationship is a fundamental aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication and trust. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner that is based upon evidence they believe is best for their patients.

The AOA affirms that legislation which interferes with the patient-physician relationship impairs the autonomy of osteopathic physicians and prevents osteopathic physicians from using their independent medical judgment based on years of rigorous education and training.

The AOA asserts that physicians must be able to communicate freely with patients without fear of government intrusion in order to assure safe, comprehensive and effective medical treatment.

The AOA considers legislation that undermines physician judgment to be a barrier to evidence-based medicine.

The AOA supports the use of evidence-based medicine to ensure high quality patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating a "one size fits all approach," thereby preventing an individualized assessment of what is in a particular patient's best interests.

The AOA affirms that legislation which interferes with the patient-physician relationship undermines patient-centered care. Patient-centered care actively involves the patient in making decisions regarding their own medical care. Statutorily required medical practices prevent patients from being involved in making medical decisions, because the patient has no choice.

The AOA believes that the ethical principle of informed consent is undermined when patients are statutorily required to undergo certain treatments or procedures, because the patient has no choice.

The AOA opposes all legislation at the state and federal level that requires physicians to discuss or perform certain treatments or procedures not supported by evidence-based guidelines, because such legislation undermines physician judgment.

The AOA opposes all legislation at the state and federal level which prevents physicians from discussing certain health-related risk factors with their patients, because such legislation violates the First Amendment rights of physicians and patients and is in conflict with evidence-based medical best practices.

The AOA believes that physicians should be free to counsel patients on end-of-life care on a case-by-case basis rather than as a result of an across-the-board mandate.

The AOA supports legal challenges to interference laws that violate First Amendment and Fourteenth Amendment rights of physicians and patients under the State and Federal Constitutions.

THE AOA OPPOSES ALL LEGISLATION AT THE STATE AND FEDERAL LEVEL WHICH PREVENTS, **LIMITS, OR MANDATES PHYSICIANS** FROM DISCUSSING, RECOMMENDING, OR PROVIDING AN EVIDENCE BASED TREATMENT WHICH IN THE PHYSICIAN'S **CLINICAL** JUDGMENT IS IN THE PATIENT'S BEST INTEREST BECAUSE SUCH LEGISLATION **ERODES THE SANCTITY OF THE PATIENT-PHYSICIAN RELATIONSHIP AND** UNDERMINES THE PHYSICIAN'S **CLINICAL** JUDGMENT.

The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as needed.

References:

1. Weinberger, Steven, M.D., et al. *Legislative Interference with the Physician-Patient Relationship*, N Engl J Med 2012; 367:1557-1559, October 18, 2012. http://www.nejm.org/doi/full/10.1056/NEJMsb1209858#t=article.
2. Jenco, Melissa. *Federal Court Strikes Down 'Physician Gag Law' on Guns*. American Academy of Pediatrics News, Feb. 16, 2017. https://www.aappublications.org/news/2017/02/16/FloridaGun021617.
3. Id.

4. Id.
5. Weinberger, *supra*.
6. *Palliative Care Information Act*. New York State Department of Health, Feb. 9, 2011. https://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm.
7. Weinberger, *supra*.
8. Id.
9. *About Osteopathic Medicine*. AACOM, Last Accessed June 26, 2019. http://www.aacom.org/about/osteomed/Pages/default.aspx.
10. Chin, JJ. *Doctor-Patient Relationship: from Medical Paternalism to Enhanced Autonomy*. Singapore Med J. 2002 Mar;43(3):152-5. http://www.ncbi.nlm.nih.gov/pubmed/12005343.
11. *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, March, 2001. https://www.ncbi.nlm.nih.gov/pubmed/25057539.
12. AACOM, *supra*.
13. *Wollschlaeger v. Farmer* – Florida District Court Opinion issued June 29, 2012. https://casetext.com/case/wollschlaeger-v-farmer-2.
14. *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access in Kansas*, National Partnership for Women and Families, Feb. 2019. http://www.nationalpartnership.org/our-work/repro/reports/bad-medicine-kansas.html.
15. *Informed Consent: Women Considering Abortions in Many States Often Get Medically Inaccurate Information*, Rutgers Today, Feb. 29, 2016. https://news.rutgers.edu/informed-consent-women-considering-abortions-many-states-often-get-medically-inaccurate-information/20160228#.XNsiiY5Ki70.
16. *Wollschlaeger v. Farmer*, *supra*.
17. Id.
18. Deto, Ryan. *Pennsylvania Supreme Court Rules Parts of State Fracking Law Unconstitutional, Strikes Down Environmentally Unfriendly Rules*, Pittsburgh City Paper, Sept. 29, 2016. https://www.pghcitypaper.com/Blogh/archives/2016/09/29/pennsylvania-supreme-court-rules-parts-of-state-fracking-law-unconstitutional-strikes-down-environmentally-unfriendly-rules.
19. *Stuart v. Huff* - North Carolina District Court Opinion issued Dec. 22, 2011. https://casetext.com/case/stuart-v-huff-4.
20. https://www.courier-journal.com/story/news/politics/2019/06/28/abortion-in-kentucky-ultrasound-law-stand-appeals-court-says/1598195001/.
21. *Nova Health Systems v. Pruitt* - Supreme Court of Oklahoma Opinion issued Dec. 5, 2012. https://www.leagle.com/decision/inokco20121204522.
22. *Government Interference in Patient Counseling*. AMA Policy H-373.995. 2011. Amended 2015. http://134.147.247.42/han/JAMA/https/ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-373.995.HTM.

23. Protecting the Patient-Physician Relationship: Keeping External Interference Out of the Practice of Medicine.
24. *ABA Resolution 111*, August, 2012. http://www.americanbar.org/content/dam/aba/administrative/house_of_delegates/resolutions/2012_hod_annual_meeting_111.authcheckdam.doc.

Background Information: Provided by AOA Staff
Current AOA Policy:
H358-A/19 Interference Laws
H340-A/21 Lawful Off-Label Treatment of Patients Interference

Prior HOD action on similar or same topic: None

The AOA has been consistent for multiple years in its advocacy and approach on behalf of the osteopathic community and all physicians regarding interference with the patient-physician relationship. Positions taken on legislation, regulation, and participation in amicus briefs and statements are evaluated for potential conflicts with existing AOA policies.

In January 2022 a workgroup comprised of members of the Bureau on Federal Health Programs (BFHP), Council on Economic and Regulatory Affairs (CERA), and Council on State Health Affairs (CSHA) was appointed by AOA President, Joseph Giaimo, DO, MACOI. The workgroup was charged with reviewing existing AOA policy and identifying any policy development needs relating to interference laws. Following its review and discussion of AOA policies relating to interference laws, that may compromise the patient-physician relationship, the workgroup was in agreement that there are no inconsistencies between current AOA policies relating to interference laws and that no further action is needed relating to this issue.

FISCAL IMPACT: $0

ACTION TAKEN _ADOPTED AS AMENDED_

DATE ____July 16, 2022_____

SUBJECT: DRUGS-PRESCRIPTION DISCOUNTS - SOURCE: H400-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages pharmaceutical companies to
7 continue to provide prescription medicines at reduced or no cost to low-
8 income, uninsured, and under-insured patients through their patient
9 assistance programs.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed as Amended; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: AOA SUPPORT OF PUBLIC HEALTH SERVICE
SOURCE: H406-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association recognizes the contribution of the US Public
7 Health Service (PHS) Commissioned Corps to the healthcare of the United
8 States and supports the continued existence of the United States Public
9 Health Service Commissioned Corps.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1981; 1986 Reaffirmed as Amended; 1991 Reaffirmed, 1992 Reaffirmed, 1997 Reaffirmed, 2002 Reaffirmed; 2007 Reaffirmed, 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: COUNSELING ~~FEMALE~~ PATIENTS ON REPRODUCTIVE ISSUES – SOURCE: H407-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association will take whatever actions are necessary to
7 ensure that osteopathic physicians can continue to offer their patients
8 complete, objective, informed advice in a confidential, culturally sensitive
9 manner on all aspects of reproductive issues.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: GENETIC TESTING - SOURCE: H412-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the public interest in prohibiting
7 discrimination in employment, insurance coverage, and access to care on the
8 basis of genetic information.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: SUBSTANCE IMPAIRED AND DISTRACTED DRIVING – SOURCE: H413-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association pledges its support to law enforcement
7 agencies in their efforts to enforce substance impaired and distracted driving
8 statutes; encourages agencies in government and in the private sector to
9 promote greater public awareness of the problem; and encourages its
10 members, through discussions with their patients and their communities, to
11 actively assist in the effort by making the problem and its prevention more
12 visible to the public.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1974; 1978 Reaffirmed as Amended; 1983 Reaffirmed; 1986 Reaffirmed as Amended, 1991 Reaffirmed, 1992 Reaffirmed, 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: ACCESSIBILITY TO BREAST CANCER PREVENTION, DETECTION, DIAGNOSIS AND TREATMENT – SOURCE: H408-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports development and application of the
7 latest advances in breast cancer prevention, detection, diagnosis, and
8 treatment, with dissemination as rapidly as possible to the medical
9 community and the public it serves; and urges adoption of measures and
10 programs to improve access to breast cancer screening for all appropriate
11 patient populations.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic:
H603-A/18 Cancer Screening – Payment For
H438-A/16 Cancer Clinical Trials -- Explore Incentives to Increase Patient Involvement In; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ___July 16, 2022_____

SUBJECT: SUPPORT FOR PRENATAL AND PEDIATRIC HOSPICE AND PALLIATIVE CARE - SOURCE: H409-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association endorses the practice of hospice and
7 palliative medicine in prenatal and pediatric patient populations; urges that
8 osteopathic physicians providing prenatal care or consultation be
9 knowledgeable about the existence and availability of prenatal hospice and
10 palliative care, and offer it as an option to parents of a baby with a likely fatal
11 fetal anomaly; and supports organizations dedicated to the promotion,
12 education and provision of prenatal and pediatric hospice and palliative care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H411-A/17 Hospice Care Programs – AOA Support for; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: AOA SUPPORT FOR HOSPICE CARE PROGRAMS – SOURCE: H411-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association will: continue to encourage its membership to educate themselves and their patients regarding the availability and benefits of hospice care programs, in concurrence with traditional medical and palliative care; encourage its membership to advocate for participation in and/or utilization of hospice care programs; urge adoption of measures and programs to improve access to hospice care for all patient populations, including hospice and palliative care services as a benefit ~~under~~ **FOR** all.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H600-A/19 Hospice – Federal Payment for Required Face-to-Face Visits
H409-A/17 Prenatal and Pediatric Hospice and Palliative Care – Support for; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED___

DATE: ___July 16, 2022_____

SUBJECT: **PREVENTION AND** TREATMENT OF OBESITY – SOURCE: H414-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association recognizes obesity as a disease~~, and that obesity treatment and prevention~~ **WHICH** requires a chronic care model~~,~~ **TO ADDRESS PREVENTION AND TREATMENT** ~~AND PREVENTION. by~~ **THE** AOA encouragES~~ing~~ research at colleges of osteopathic medicine; endorses continued curriculum enhancement for osteopathic students, interns, and residents to receive specific training in obesity education and ~~approve~~ SUPPORTS continuing medical education for physicians with established practices.~~;~~ THE AOA supports efforts to close the gap between current and desirable practice patterns, by soliciting grants to collect and study the extent to which obesity treatment and prevention services are covered by third party insurers and **WILL** advocate for adequate coverage for obesity treatment and prevention. ~~and~~ **THE** AOA ~~will develop~~ **SUPPORTS** comprehensive efforts, commensurate with available funding, to disseminate knowledge to the treating community, media, legislature and employer groups directed at controlling the obesity epidemic by improving treatment access and encouraging physical activity ~~in the United States~~.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic:

H327-A/18 Obesity – Health Plans Should Include Benefits for Treatment Of
H419-A/18 Pediatric Obesity
H417-A/21 Obesity in Children
H429-A/21 Obesity Epidemic – Addressing the American; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_____

DATE: __July 16, 2022_____

SUBJECT: ~~WOMEN'S~~ CONTRACEPTIVE COVERAGE LEGISLATION
SOURCE: H416-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports health insurance coverage for federal Food and Drug Administration (FDA) approved contraceptive services ~~to women of child-bearing age~~ and supports language which would maintain co-payment for contraceptive services at a cost no higher than the ~~normal~~ set level of co-payment for any other prescription.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: PROMOTION FOR THE REQUIREMENT OF ALL SPORTING EVENTS TO HAVE ACCESS TO AN AUTOMATED EXTERNAL DEFIBRILLATOR (AED) ~~TO TREAT COMMOTIO CORDIS~~ – SOURCE: H418-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association encourages professional athletic programs, the National Collegiate Athletics Association, the National Association of Intercollegiate Athletics, the National Federation of State High School Associations, and local sporting organizations to have a readily accessible automated external defibrillator that has been annually tested, and when possible, **PROVIDE** training **IN ITS USE** ~~has been provided~~ to responsible individuals.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED__

DATE: __July 16, 2022_____

SUBJECT: MENINGOCOCCAL VACCINE RECOMMENDATIONS – SOURCE: H419-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the administration of
7 meningococcal vaccines as recommended by the Centers for Disease
8 Control and Prevention's (CDC) Advisory Committee on Immunization
9 Practices (ACIP); and urges adequate public and private insurance coverage
10 for vaccines in patient populations as recommended by the ACIP.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H417-A/19 Vaccines
H333-A/21 Vaccine Supply and Distribution; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: PSA-BASED SCREENING FOR PROSTATE CANCER – SOURCE: H422-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association recognizes and promotes the importance of
7 the integrity of the patient-physician relationship and recommends that
8 prostate cancer clinical preventive screenings be individualized.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed).

Prior HOD action on similar or same topic:
H603-A/18 Cancer Screening – Payment for; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: MANDATES ON SCHOOL LUNCHES - SOURCE: H423-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association advocates for a holistic approach with
7 respect to childhood nutrition and wellness without mandates that force
8 children to purchase school lunches.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: ~~JUDICIOUS USE OF~~ ANTIMICROBIAL **STEWARDSHIP** ~~AGENTS~~
SOURCE – H425-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports ~~the~~ **ANTIMICROBIAL STEWARDSHIP** education ~~for proper use of antimicrobial agents~~ in order to decrease drug-resistant organisms.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed as Amended; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: ANTI-BULLYING ~~LAW~~ **POLICY**- SOURCE: H426-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports anti-bullying policies enabling students to go to school in a peaceful manner without fear of **BEING** ~~tormenting~~ **TORMENTED** or ~~intimidating~~ **INTIMIDATED** ~~acts to themselves or others~~ and supports a policy to prevent bullying in schools and provide treatment for those involved.~~, thus furthering the cause of a peaceful education.~~

THE AOA ACKNOWLEDGES THAT SUCCESSFUL ANTIBULLYING INTERVENTIONS RECOGNIZE THE NATURE OF BULLYING BEHAVIOR AS COMPLEX AND RELATED TO MENTAL HEALTH AND SOCIETAL INFLUENCES, AND THAT ALL THOSE INVOLVED CAN SUFFER DETRIMENTAL PHYSICAL AND MENTAL HEALTH EFFECTS.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: PROMOTION, PROTECTION AND SUPPORT OF BREASTFEEDING - SOURCE: H428-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health believes there
5 is on-going need for the policy and has provided amendments to provide
6 clarity on the policy; now, therefore be it

7 RESOLVED, that the Bureau of Osteopathic Research and Public Health
8 recommends that the following policy be REAFFIRMED AS AMENDED.

9 The American Osteopathic Association ENCOURAGES ~~urges~~ its membership to
10 TAKE A ROLE TO ~~take a role in the~~ protect~~ion~~, promotE~~ion~~ and support ~~of~~
11 breastfeeding and encourageS the provision of breastfeeding friendly
12 environments in their places of study and work, including but not limited to
13 colleges, hospitals, and other healthcare facilities.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H426-A/18 Breastfeeding Mothers – Protecting
H425-A/18 Breastfeeding Exclusivity
H452-A/20 Breastfeeding While on Methadone Maintenance; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: ~~PROTOCOL AND GUIDELINES FOR~~ **PROMOTING** EMERGENCY MEDICAL IDENTIFICATION **PROGRAMS** – SOURCE: H429-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health believes there
5 is on-going need for the policy and has provided amendments to provide
6 clarity on the policy; now, therefore be it

7 RESOLVED, that the Bureau of Osteopathic Research and Public Health
8 recommends that the following policy be REAFFIRMED AS AMENDED.

9 The American Osteopathic Association supports ~~the concept of~~ ~~medical~~
10 ~~identification systems~~, ~~and urges~~ that osteopathic physicians encourage
11 THEIR patients to participate in ~~an~~ emergency medical identification
12 programS.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1981; 1985 Reaffirmed; 1991 Reaffirmed as Amended, 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: ORGAN DONATION – OPPOSITION TO ~~FINANCIAL~~ INCENTIVES FOR ORGAN DONORS - SOURCE: H430-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association **OPPOSES** ~~states its opposition to~~ direct payment or other financial inducement in exchange for donation of human organs and tissue and urges the ~~osteopathic medical profession investigate~~ **INVESTIGATION OF** other, more ethical alternatives to raising organ donor identification rates while ~~preserving its first duty to~~ protecting patient interests.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002; 2007 Reaffirmed, 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H332-A/21 Organ and Tissue Donation and Transplantation Initiatives – Commitment to; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_____

DATE: ___July 16, 2022_____

SUBJECT: VIOLENCE IN THE ENTERTAINMENT MEDIA – SOURCE: H432-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association opposes the presentation of gratuitous
7 violence in the entertainment media.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1977; 1982 Reaffirmed as Amended; 1987 Reaffirmed; 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: STEM CELL RESEARCH - SOURCE: H433-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports biomedical research on stem cells
7 and will continue to monitor developments in stem cell research and sources
8 of stem cell funding.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: EDUCATION ON HUMAN PAPILLOMAVIRUS VACCINATION – SOURCE: H434-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports efforts to educate the general
7 public regarding the Human Papilloma Virus (HPV) and its relationship to
8 certain cancers and genital warts; urges osteopathic physicians to educate
9 themselves and their patients regarding the availability and benefits of
10 administering HPV vaccine to patients as recommended by the Centers for
11 Disease Control and Prevention's (CDC) Advisory Committee on
12 Immunization Practices (ACIP); and urges adequate public and private
13 insurance coverage for HPV vaccines in patient populations as
14 recommended by the Advisory Committee on Immunization Practices (ACIP);
15 and supports ongoing research to determine whether HPV vaccine is
16 beneficial to other groups in the general population.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic:
H417-A/19 Vaccines
H333-A/21 Vaccine Supply and Distribution; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: DAILY PHYSICAL EDUCATION FOR GRADES K-12 – SOURCE: H435-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports daily physical education for all US
7 students in grades K-12.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1981; 1986 Reaffirmed; 1991 Reaffirmed as Amended, 1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007 Reaffirmed as Amended; 2012 Reaffirmed as Amended; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: USE OF TOBACCO PRODUCTS – SOURCE: H436-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports education on the hazards of tobacco products beginning at the elementary school level; encourages physicians to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health ENCOUNTER ~~supervision visit~~; strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; encourages its members to discuss the hazards of tobacco use with their patients; encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels suggesting that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; and that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports the elimination of free distribution of cigarettes or tobacco products in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; urge the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1990; 1995 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H421-A/21 Tobacco Control – The Framework Convention On
H215-A/21 Tobacco Free and Vaping Free Colleges / Schools of Osteopathic Medicine
H329-A/19 Tobacco Use Status – Reporting in The Medical Record
H335-A/18 Tobacco Use
H308-A/18 Alcohol and Tobacco – Advertising Ban On
H613-A/18 Tobacco Use in Entertainment Media; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED AS AMENDED_____

DATE: ___July 16, 2022_____

SUBJECT: POLICY STATEMENT ON END OF LIFE CARE
- SOURCE: H438-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association approves the white paper on end of life care and

- encourages all osteopathic physicians to maintain competency in end of life care through educational programs ~~such as the web-based osteopathic Education for Professionals on End of Life Care (Osteopathic EPEC) modules~~;
- supports the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end-of-life issues;
- urges osteopathic medical schools, and appropriate training programs to support innovative approaches to instruction in ~~geriatric medicine and~~ end-of-life care;
- encourages all osteopathic physicians to stay current with their individual state statutes on end of life care;
- supports public policies which upholds a patient's right to a "Do Not Attempt Resuscitation" (DNAR) and/or ~~a~~Allow ~~n~~Natural ~~d~~Death (~~and~~AND), designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or Durable Power Of Health Care Attorney (DPOA);
- encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions;

- will work to implement policies to ensure hospice and palliative services for all individuals, including the developmentally challenged, children, and other special populations;
- ~~and~~ urges ~~that~~ ENCOURAGES osteopathic physicians TO recognize the importance of cultural diversity in perspectives on death, suffering, bereavement and rituals at the end of life, and incorporate cultural assessment into their comprehensive evaluation of the patient and family; AND
- ~~the AOA~~ will work to identify sources of culturally appropriate information on advance directives, palliative care, and end of life ethical issues in populations served by osteopathic physicians.

American Osteopathic Association End of Life Care White Paper

The osteopathic approach to care can be particularly beneficial at the end of life. Attending to the patient and family holistically is a key principle of osteopathic medicine. Osteopathic palliative care improves the quality of life of patients and their families facing serious illness, through prevention and relief of physical, psychosocial and spiritual suffering. Osteopathic palliative care utilizes many modalities of treatment including osteopathic manipulative medicine.

End of life decisions should be the result of the collaboration and mutual informing of the patient, the patient's DEFINED family and health care professionals, each sharing his or her own expertise to help the patient make the best possible decision.

Adults with decision-making capacity should be informed of their choices and that they have the legal and ethical right to make their own decisions about their end of life care, including the right to receive or refuse recommended life-sustaining or life-prolonging medical treatment. This position honors the patient's autonomy and liberty as guaranteed in the United States Constitution and the Patient Self-Determination Act. This right exists even when the physician disagrees with the patient's decisions.

Patients without decision-making capacity have the right to assurance that their previously executed instructive advance directives, such as living wills, proxy directives (Durable Medical Power of Attorney -DMPOA) and Physician Orders for Life Sustaining Treatment (POLST) will be honored to guide others in delivering their health care. It should be noted that the term "physician" may also mean "medical" in this context. Advance directives delineate treatment options selected by an individual and enable decisions to be made by reviewing these documented wishes. The principle of "substituted judgment" allows for a proxy to speak for an individual who is unable to do so, based upon close personal knowledge of the incapacitated person. The principle of "best interests" (what the reasonable and informed patient would select) is invoked if the individual's wishes are not known. The over-riding issue is not what the family or friends want for the patient at end of life, but rather what would the patient want for himself or herself. If the patient were to awaken and be able to fully understand the circumstances, what decisions would the patient make? If the answer is clear, it is unethical, except in extraordinary circumstances, not to follow the patient's wishes.

Creating advance directives (living wills or designating a Durable Medical Power of Attorney) is to be encouraged IN advance of a life threatening situation with the assistance of trusted professionals. Persons holding the DMPOA/legally designated proxy should make decisions in accordance with the patient's previously expressed preferences. Living wills document the desired treatments but leave much room for interpretation when the situation doesn't match the directives, so a combination may be best. If no DMPOA/legally designated proxy has been selected and there is no state approved surrogate available and the patient has not executed an advanced directive or expressed preferences for care at end of life, then decisions should be made based on the principle of "best interests". When there is disagreement, confusion or a request for another opinion, the use of an ethics committee is to be encouraged. Quality of life should be viewed from the patient's perspective in all these decisions because quality of life can only be self-determined. Extreme caution must be exercised when trying to determine what constitutes quality of life for another person as research has shown that patients consistently assess their quality of life to be better than their caregivers think the patients do. Unfortunately, no documentation or proxy designation can definitively prevent or curtail disagreements between family members.

Palliative care is always appropriate when patients and families are facing a life threatening illness. The osteopathic physician understands that physical suffering from pain; dyspnea and other end of life symptoms can be relieved with good osteopathic medical management. The patient may also need psychosocial and spiritual assistance to address suffering in those domains as well. Hospice and palliative care services provide invaluable benefits to families and patients. The earliest possible involvement of hospice in the end of life care of patients should be encouraged.

The existence of a medical technology does not mandate its use. A physician is not required to provide futile medical care though it may be difficult to determine that a requested treatment is actually futile. A life-prolonging treatment may allow a terminally ill patient to achieve an important life goal such as seeing a grandchild, but in other cases aggressive therapies serve only to prolong suffering and expense associated with the dying process. The physician should employ full disclosure and compassionate honesty in discussing a treatment's likely benefits and burdens. If agreement cannot be reached, a consultation with an ethics committee is appropriate. If an ethics committee is not available, it may be necessary to seek the assistance of a court-appointed guardian. When a patient and physician cannot align their goals and treatment approaches, a congenial transfer of care may be necessary. Patient abandonment is unethical.

Withholding or withdrawing life sustaining treatments are considered morally, legally, and ethically identical because the end results are the same. When the benefit of a treatment is uncertain a time-limited trial is frequently advisable to help clarify prognosis. Offering treatment and then withdrawing it if it proves to be ineffective or burdensome is preferable to not offering the treatment at all.

Artificial nutrition and hydration may actually prolong the dying process. The use of artificial nutrition and hydration involves invasive medical procedures with potential side effects and complications. A decision to not provide or to discontinue this intervention may pose significant challenges to professional caregivers as well as to families. Physicians need to

assist patients and families to understand the role of artificial nutrition and hydration at the end of life. Research has shown that dying patients do not experience hunger or thirst.

"Do Not Resuscitate/DNR" status is appropriate for patients who are dying from a primary illness or injury, or for whom cardiopulmonary resuscitation (CPR) would not be effective or for whom the burden of treatment outweighs the benefit. It is important to ensure that patients with DNR status receive all comfort care and appropriate treatments. A DNR status does not preclude treatment of correctable conditions. ~~CPR efforts that involve a deliberate decision not to attempt aggressively to bring a patient back to life are not appropriate and a clear ethical violation~~ DELIBERATELY PERFORMING INEFFECTIVE CPR ("SLOW CODE") IS UNETHICAL.

Physician assisted suicide is generally defined as a patient obtaining the assistance of a physician to secure the means to cause his/her own death. Physician assisted suicide is legal only as determined by specific state law. The request for physician-assisted suicide is frequently a call for help. Individuals may request physician-assisted suicide for reasons other than pain, e.g., inability to cope, fear of being a burden, or lack of control. The alternative to physician-assisted suicide is physicians who are committed to providing excellence in end of life care and continuing to attend their dying patients. Community resources such as hospice programs should be made available to all patients. ~~Hospice and palliative care principles do not support physician assisted suicide and.~~ ~~e~~Euthanasia remains an illegal practice.

Legal involvement to resolve end of life conflicts is sometimes inevitable, but is usually not the approach of choice. Legislative "remedies" including single-person and single-situation laws are also inappropriate. By far, the best approach to prevention/resolution of conflict is by documented advanced planning, good communication, and the assistance of an ethics committee. Collection of "clear and convincing evidence" of the patient wishes as cited in a US Supreme Court decision, as well as the principles of "substituted judgment" and "best interests" discussed above apply to the decision-making process.

Families of patients living with a terminal illness also have needs: the need to understand the dying process, the need to have cultural and religious differences understood/RESPECTED ~~and respected~~, AND the need to process grief. The osteopathic physician understands the important contribution of the family to the patient's overall wellbeing and includes the family in the palliative plan of care.

Patients living with a life threatening illness as well as those who are terminally ill have a right to relief of pain as well as relief of other physical symptoms. Fear of regulatory scrutiny should never be a deterrent to the prescription of adequate doses of analgesic medications. State licensing boards of medicine and pharmacy should provide assurance to physicians that this care is appropriate and protected under the law. Osteopathic colleges and graduate medical education programs are encouraged to review curricula in order that adequate education in osteopathic pain management is provided to osteopathic trainees at all levels of their education. Physicians in practice will want to avail themselves of educational opportunities ~~such as Osteopathic-EPEC~~ to stay current in pain management and other aspects of end of life care. Osteopathic physicians should always assure their patients that they will provide safe and comfortable dying. Alternatively,

161 patients may elect to suffer significant pain so that they remain alert and engaged until
162 death. In every circumstance, patient autonomy for decision-making must be upheld.

163 At the end of life, the goal is comfort for the patient and psychosocial support of the family.
164 Osteopathic physicians, through their holistic approach, are well suited to provide quality
165 end of life care. DOs are in a unique position to provide important leadership in enhancing
166 end of life care in the United States. There is no finer gift that osteopathic physicians can
167 give than to provide excellent care through all phases of life and no one is better suited to
168 the task.

169 Nota bene: In an area as sensitive as end of life, no white paper can address all scenarios
170 and permutations. It should be understood that this white paper presents general
171 guidelines, and osteopathic physicians will always tailor appropriate management to the
172 needs of their individual patients and families.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic:
H322-A/19 End-Of-Life Care – Use of Placebos In
H600-A/19 Hospice – Federal Payment for Required Face-To-Face Visits
H409-A/17 Prenatal and Pediatric Hospice and Palliative Care – Support For
H411-A/17 Hospice Care Programs – AOA Support For
And as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _REFERRED (*Bureau of Osteopathic Public Health and Research*)__

DATE: _July 16, 2022_____

SUBJECT: POWDERED CAFFEINE - SOURCE: H439-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association opposes the use of concentrated powdered
7 caffeine for non-medical uses.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: __July 16, 2022_____

SUBJECT: HEALTH INSURANCE COVERAGE FOR RESIDENTIAL TREATMENT AND INPATIENT TREATMENT OF EATING DISORDERS – SOURCE: H440-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports improved access to treatment in
7 residential and inpatient facilities and efforts to reduce the financial barriers
8 of intensive treatment for patients suffering from eating disorders;
9 encourages residential and inpatient treatment facilities caring for patients
10 suffering from eating disorders, to manage care in consideration of the
11 patient's overall medical and mental health needs, and to continue treatment
12 until goals of weight restoration and physiologic status are obtained; and
13 supports continued care for individuals suffering from eating disorders
14 staying in residential and inpatient facilities, regardless of insurance criteria
15 requiring termination of treatment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: VIOLENCE AND ABUSE PREVENTION AND EDUCATION
SOURCE: H441-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association urges its members as well as government
7 agencies to continue to develop, expand, and participate in programs
8 targeted at: reducing, preventing, and managing violence, abuse, and
9 neglect of all kinds; educating medical students, residents, and practicing
10 physicians to improve their knowledge, attitudes, and skills in addressing
11 violence, abuse and neglect; treating, assisting, and advocating for victims;
12 rehabilitating abusers; and any other domain related to the welfare of victims
13 of violence, abuse, and/or neglect.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic:
H418-A/19 Domestic and Intimate Partner Violence – Development of Programs to Prevent; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: RECREATIONAL ~~MARIJUANA~~ **CANNABIS** USE BY PHYSICIANS, STUDENTS AND PATIENTS – WHITE PAPER - SOURCE: H442-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Recreational Marijuana Use by Physicians, Students, and Patients White Paper

Purpose

This policy paper addresses the potential risks and benefits of recreational marijuana, the potential risks and benefits of medical cannabis, and policy guidelines for the use of these substances by Osteopathic medical students, physicians, and patients. The policy paper provides the following:

1.Summary of current literature regarding risks and benefits of cannabis as a foundation for policy development around both medical and recreational marijuana use.

2. Discussion of the driving forces in the legalization/decriminalization of marijuana use at the state level.

3. Policy recommendations around risk/benefit of marijuana use and its potential impact on osteopathic physicians and students as well as patients.

Background

IN 2020, 17.9% **OF PEOPLE** AGED 12 AND OLDER USED MARIJUANA. THE PERCENTAGE OF PEOPLE WHO USED MARIJUANA IN THE PAST YEAR WAS HIGHEST AMONG YOUNG ADULTS AGED 18 TO 25 (34.5%) COMPARED WITH 16.3% OF ADULTS AGED 26 OR OLDER AND 10.1%OF ADOLESCENTS AGED 12 TO 17.[1] AS OF JANUARY 2022, 36 STATES, THE DISTRICT OF COLUMBIA, GUAM, PUERTO RICO AND THE U.S. VIRGIN ISLANDS HAVE APPROVED COMPREHENSIVE, PUBLICLY AVAILABLE MEDICAL MARIJUANA/CANNABIS PROGRAMS.[2]

~~Approximately 22.2 million Americans aged 12 and over reported using marijuana within the last 30 days.[1] This is an increase from 6.2 percent in 2002 to 8.3 percent in 2015. As of May 2017, twenty-nine states, the District of Columbia, Guam and Puerto Rico have legalized marijuana use for medicinal purposes.[2] Eight of these states and the District of Columbia have also legalized cannabis for recreational use.~~

The trend of legalizing marijuana illuminates two, often competing, forces which are: (1) a greater public acceptance of use of cannabis for both medicinal and recreational purposes; and (2) a concern for the impact of existing laws governing cannabis possession and use on the societal as well as personal level. As states continue to legalize medicinal and recreational cannabis use, it is important to take into consideration the potential public health threat cannabis use represents. Similar to alcohol consumption and tobacco use, osteopathic physicians must guide the care of patients as marijuana use moves from a criminal act to an acceptable behavior, albeit a behavior that may pose a public health threat.[2]

Risks and Benefits of Cannabis

A systematic review of cannabis was commissioned by the National Academy of Science, Engineering and Medicine (the Academies) in April 2016 and published on January 17, 2017, THE MOST UP TO DATE, COMPREHENSIVE REPORT.[3]

The commissioned report is the first comprehensive review of published literature since the 1999 Institute of Medicine (IOM) Report marijuana and medicine: Assessing the science base. The Academies' report is entitled, The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research.[3] This ~~395-page report~~ PUBLICATION represents the best current knowledge regarding the risks and benefits of cannabis synthesized by leading national researchers. In addition, the report describes gaps in the literature, identifies future research opportunities, and summarizes policy issues regarding the laws and uses of cannabis across the various states that have decriminalized marijuana. The report also discusses current federal activities such as the enforcement of the Controlled Substance Act.

The committee commissioned by the Academies conducted an extensive search of relevant databases which included Medline, Embase, the Cochrane Database of Systematic Reviews, and PsycINFO. The committee identified more than 24,000 abstracts of articles published since the 1999 IOM report. Only articles published in English were eligible for the study. Case reports, editorials, studies by "anonymous" authors, conference abstracts, and commentaries were excluded. Ultimately, the committee conducted an in-depth review of more than 10,700 abstracts in determining their relevance to the final report.

Summary of Major Findings[3]

Therapeutic Benefits. Research has demonstrated that cannabis use has therapeutic effects for patients. Oral cannabinoids are an effective antiemetic in treating nausea and vomiting resulting from chemotherapy treatment. With respect to chronic pain, cannabis and/or cannabinoids can significantly reduce pain symptoms for chronic pain (e.g., fibromyalgia) patients. For multiple sclerosis patients, short-term use of oral cannabinoids improves patient-reported spasticity symptoms. Other therapeutic benefits of cannabis

may be seen in patients that suffer from Tourette syndrome, Posttraumatic Stress ~~Disease~~ DISORDERS (PTSD) and social anxiety disorders. More research, however, is needed for the effects of cannabinoids on other conditions such as epilepsy, Parkinson's disease, and schizophrenia.[3]

Cancer Risks. Cannabis use poses health risks for various diseases and conditions as well as injury and death. There is modest evidence that marijuana use is associated with an increased incidence of a specific type of testicular cancer. There is insufficient evidence that marijuana use increases the risk of other cancers (e.g., esophageal, prostate, cervical, leukemia, or cancer in children whose mother used marijuana during her pregnancy), and there is no evidence that smoking marijuana increases the risk of such cancers as lung cancer or head and neck cancer.[3]

Pulmonary & Cardiometabolic Concerns. Cannabis use and its growing popularity raise questions regarding pulmonary and cardiometabolic issues. Evidence has shown that regular use of marijuana is associated with chronic cough and phlegm production. More research, however, is needed to determine whether smoking marijuana is associated with Chronic Obstructive Pulmonary Disease (COPD), asthma, and/or a decline in lung function. More research is also needed to determine the exact association of marijuana use with heart attack, stroke and diabetes.[3]

Effect on Infectious Diseases. There is a lack of evidence regarding the effects of marijuana on the human immune system. There has been some belief that marijuana use has adverse effects on the immune system of HIV patients. More research is needed to determine a statistical association. According to the limited evidence that does exist, smoking marijuana on a regular basis may have anti-inflammatory benefits. However, more research is needed.[3]

Effect on Cognitive Impairment. Marijuana use is associated with cognitive impairment which affects a person's performance. This altered state of mind can lead to injury that may, ultimately, result in death. Studies have found that marijuana use immediately prior to operating a vehicle increases the risk of getting into a motor vehicle accident.

Cognitive performance (i.e., learning, memory and attention) can be impaired up to 24 hours after the use of marijuana. A few studies have found that impairments in cognitive domains may continue even after a person has stopped smoking marijuana. The lingering effects of marijuana are especially concerning for adolescents. The evidence purports that the use of marijuana during adolescence can have lasting effects on a young person's academic achievement, future employment, and social interactions and productivity.[3]

Additional Concerns Regarding Children. In states where recreational marijuana has been legalized, the evidence indicates that children have an increased risk of unintentional adverse effects (e.g., respiratory distress). There are other concerns such as low birth weight. Studies have found that maternal recreational marijuana use during pregnancy is associated with low birthweight babies. More research is necessary to determine the association of marijuana use and other pregnancy and childhood outcomes.[3]

Mental Health Issues. Studies have found that the use of marijuana increases the risk of developing schizophrenia and other psychoses. The risk of developing a mental health issue increases with the dosage. Conversely, individuals with schizophrenia and other

psychoses prior to using cannabis may experience better performance on learning and memory tasks when they use marijuana. Studies have found bipolar disorder is an exception to this observation. Individuals diagnosed with bipolar disorder that use marijuana daily may experience intensified symptoms AS COMPARED TO ~~than~~ those diagnosed with bipolar disorder WHO do not use marijuana.[3]

Other mental health illness studies include depression, anxiety, suicide and posttraumatic stress disorder (PTSD). There is evidence that heavy marijuana users are more likely to report thoughts of suicide than non-users, and individuals that use marijuana regularly have an increased risk of developing social anxiety disorder. There is a lack of evidence that marijuana use increases the likelihood of developing other types of anxiety disorders, depression, or PTSD.[3]

Cannabis Addiction and Abuse of Other Substances. As individuals increase their frequency of cannabis consumption, there is a corresponding increased risk of becoming addicted to the substance. Additionally, it has been found that individuals that begin using marijuana at a young age are at an increased risk of developing an addiction to cannabis. Cannabis use has also been linked to an increased risk of an individual abusing other substances.[3]

Clinical Features of Cannabis Intoxication

Regardless of the positive and negative aspects of cannabis use, it is important to understand and recognize the clinical manifestations of cannabis intoxication. Similar to alcohol intoxication, cannabis intoxication can influence an individual's behaviors, perceptions and interaction with others. For example, a person experiencing cannabis intoxication may have a heightened sociability and sensitivity to certain stimuli (e.g., colors, music), altered perception of time, and an intensified appetite for sweet and fatty foods. Some users report feeling relaxed or experiencing a sensation described as a "rush" or "buzz" after smoking cannabis.[3] Such effects may be accompanied by decreased short-term memory, dry mouth, and impaired perception and motor skills. Other concerns regarding cannabis use focus on public safety. In light of the current trend in legalizing ~~medical and recreational~~ cannabis FOR MEDICAL AND RECREATIONAL USE, the potential for impaired driving due to acute intoxication is a genuine threat to public safety.

Acute cannabis intoxication has several major contributors. One of the key contributors is tetrahydrocannabinol (THC), a compound found in the marijuana plant that stimulates cells in the brain and cause psychological effects.[4] In incidents where a person using cannabis may have high blood levels of THC, the person may experience panic attacks, paranoid thoughts and hallucinations. In addition to the dosage of THC in a person's system, two other key factors that impact the intensity and duration of intoxication due to cannabis use are (1) individual differences in the rate of absorption and metabolism of THC, and (2) the loss of sensitivity to THC's effects.[3] Studies as synthesized in the Academies' report have found that "prolonged CB1 receptor occupation as a consequence of the sustained use of cannabis can trigger a process of desensitization, rendering subjects tolerant to the central and peripheral effects of THC and other cannabinoid agonists."[3] In studies conducted with animals, recurrent exposure to THC resulted in decreased CB1 receptor levels and connections between CB1 and its transducing G-proteins were compromised. Similar results were found in humans. In one study, researchers used imaging to study the brain of

humans who were considered chronic cannabis users and found a down-regulation of CB1 receptors in the cortical regions of the brain.[3]

Decriminalization of Marijuana Use

There has been a recent trend in states legalizing cannabis use for medical as well as recreational purposes. What once was criminalized is now becoming legal and acceptable in society. ~~As noted in the Academies report,~~ Public opinion appears to be the primary influence for many of the policy changes.

A NEW SURVEY, CONDUCTED BY PEW RESEARCH CENTER FROM APRIL 5-11, 2021 SHOWS AN OVERWHELMING SHARE OF U.S. ADULTS (91%) SAY EITHER THAT MARIJUANA SHOULD BE LEGAL FOR MEDICAL AND RECREATIONAL USE (60%) OR THAT IT SHOULD BE LEGAL FOR MEDICAL USE ONLY (31%). FEWER THAN ONE-IN-TEN (8%) SAY MARIJUANA SHOULD NOT BE LEGAL FOR USE BY ADULTS.[5]

MORE THAN TWO IN THREE AMERICANS (68%) SUPPORT LEGALIZING MARIJUANA. GALLUP HAS DOCUMENTED INCREASING SUPPORT FOR LEGALIZING MARIJUANA OVER MORE THAN FIVE DECADES, WITH PARTICULARLY SHARP INCREASES OCCURRING IN THE 2000S AND 2010S.[6]

~~The Gallup Poll began surveying Americans on the legalization of cannabis in the late 1960s when marijuana use began having a wider and more mainstream appeal.3 Over the span of approximately 50 years, support for the legalization of cannabis use increased to 28 percent in 1977, 31 percent in 2000, and 58 percent in 2015.~~

~~The support for legalizing marijuana use can be differentiated by medicinal use versus recreational use. As reflected in the polls, medicinal use, as prescribed by a physician, has received overwhelming support from the public. Results from national surveys conducted by ProCon have shown that since 1998, 60 to 85 percent of Americans are supportive of the use of medical cannabis.[9] Quinnipiac also conducted a poll where it was found that 89 percent of respondents supported medical cannabis.[10] It is clear that public perception of cannabis use has changed over the years and many support medicinal use.~~

~~Legalization of recreational marijuana use appears to have a different plight in the landscape of public opinion. Support has been slow, but has recently increased with the legalization of marijuana in several states. In 2016, the Pew Research Center which has conduct various surveys on the topic of legalizing marijuana found that 57 percent of Americans believe marijuana should be legalized compared to 12 percent in 1969.[10] While the 2016 percentage is lower than that in support of legalizing marijuana for medicinal purposes, based on trending data, the legalization for recreational use is becoming increasingly popular.~~

State and National Policies

Currently, states are the main players in changing policy regarding the medical and recreational use of marijuana. AS OF JANUARY 2022, 36 STATES, THE DISTRICT OF COLUMBIA, GUAM, PUERTO RICO AND THE U.S. VIRGIN ISLANDS HAVE APPROVED COMPREHENSIVE, PUBLICLY AVAILABLE MEDICAL MARIJUANA/CANNABIS PROGRAMS.[2] Some states have broad laws regarding

medicinal use, others have stricter laws that limit access, and then there are those states that still criminalize marijuana use, but may allow for a legal defense under specific circumstances.[7]

~~As indicated in the Academies' report, a large portion of the states have used the popular referendum approach as opposed to the deliberative legislative process to modify their cannabis use laws. States have adopted a variety of approaches in how they regulate marijuana use.[2]~~

State Broad Policies. In states with broad policies, access to medical cannabis is restricted to a specific population or condition/illness. Patients may access medical cannabis as their physician deems necessary. Many people may view this approach as de facto legalization of marijuana for recreational use.[2]

State Restrictive Policies. States that have implemented restrictions to access typically require patients to meet certain qualifying criteria before permitting them access. The states may also restrict the types of medical products available to patients. Such states like New York do not allow patients to smoke cannabis, but they may have access to tinctures, oils, concentrates, and other similar products.[2]

Other states may have non-THC policies which require products to have no-THC or low-THC/high-CBD such as CBD oil. Oftentimes, the states that have no-THC policies have exceptions to the law that can be used as a legal defense.[2]

State Policies – Production & Distribution. Not only do states have different policies on the ~~prescription~~ RECOMMENDATION/CERTIFICATION of cannabis products, but also, different policies on the production and distribution of products. For example, some states regulate the establishment and operation of dispensaries (storefronts). Patients with ~~prescriptions~~ PHYSICIAN RECOMMENTATION/CERTIFICATION may visit these dispensaries to obtain a wide array of cannabis products. Some dispensaries are allowed to advertise their products and services to patients, while others may promote their services to the broader general public. In other states, only patients and caregivers may cultivate cannabis solely for the purpose of using it as prescribed within their homes. Yet, there are other states that strictly prohibit the supply and distribution of any cannabis products.[2]

Federal Law. Unlike the states, the federal government has not implemented any national laws legalizing marijuana use nor have they challenged any laws implemented by the states. CONGRESS FAILED TO PASS FEDERAL LEGISLATION LEGALIZING CANNABIS IN 2021, INCLUDING THE CANNABIS ADMINISTRATION AND OPPORTUNITY ACT AND THE MARIJUANA OPPORTUNITY REINVESTMENT AND EXPUNGEMENT ACT. HOWEVER, A "COMPROMISE" BILL, THE STATES REFORM ACT, INTRODUCED IN NOVEMBER 2021, WOULD GIVE INDIVIDUAL STATES THE FULL AUTHORITY TO REGULATE OR PROHIBIT CANNABIS. AS A RESULT, CANNABIS WOULD BE DESCHEDULED UNDER THE CONTROLLED SUBSTANCES ACT.[8]

~~However, the federal government under the Obama Administration issued guidelines regarding the topic. Through the guidelines, the federal government has indicated it will not seek to prosecute individuals who are in compliance with their state laws; however, states~~

~~are charged with implementing additional policies to ensure the health and safety of the general public. Additionally, the guidelines prescribe specific incidents wherein the federal government reserved the right to take action against an individual or group under the Controlled Substances Act.[12] The federal government is encouraging research on cannabis use by allowing universities and state departments to grow industrial marijuana to conduct research on its benefits and risks.[13]~~

Existing AOA Policy and Previous Considerations

~~Currently,~~ The AOA has adopted a policy of "support[ing] 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~~[ing]~~ the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of cannabis" **(H424-A/2021)**. ~~(H-419 – A/2016).~~

The AOA also has policies governing the impaired behaviors of practicing physicians. (~~H-316 – A/2014; H-407- A/2016; and H-334 – A/2013~~). These policies, LISTED BELOW, broadly apply to physicians and non-physicians who are experiencing impairment resulting from use of any mind-altering substance, including marijuana.

H407-A/16 OPERATOR INTOXICATION/ IMPAIRMENT

H331-A/18 PHYSICIAN HEALTH ASSISTANCE

H424-A/21 MEDICAL CANNABIS – RESEARCH ON POLICY STATEMENT

H628-A/18 CANNABIS RECLASSIFICATION: EFFECT ON RESEARCH

AOA Policy

As marijuana decriminalization moves forward, there is a greater need to educate health professionals about the evidence-based benefits and risks of marijuana use for both medicinal and recreational purposes. All policies should focus on assuring that the public health threat of marijuana is minimalized and that the benefit of the drug, where indicated by evidence, is available to patients in need.

Physicians and students using cannabis for medical or recreational purposes will suffer cognitive impairment. Critical thinking, key to the ability to diagnose and treat patients, will be affected and patient safety will be jeopardized. Furthermore, though studies suggest cognitive dysfunction associated with cannabis use continues even after cessation of cannabis use, the duration of the impairment cannot be known. More empirical research is needed to clarify and quantify the overall impact of cannabis use and develop recommendations for use.

~~After review of the recently released report by the Academies regarding cannabis use, the~~ 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:~~

~~a."During acute cannabis intoxication, the user's sociability and sensitivity to certain stimuli (e.g., colors, music) may be enhanced, the perception of time is altered, and the appetite for sweet and fatty foods is heightened. Some users report feeling relaxed or experiencing a pleasurable "rush" or buzz" after smoking cannabis (Agrawal et al., 2014). These subjective effects are often associated with decreased short-term memory, dry mouth, and impaired perception and motor skills. When very high blood levels of THC are attained, the person may experience panic attacks, paranoid thoughts, and hallucinations (Li et al., 2014). Furthermore, as legalized medical and recreational cannabis availability increase nationwide, the impairment of driving abilities during acute intoxication has become a public safety issue."~~

~~b. "Psychosocial~~

~~i. Recent cannabis use impairs the performance in cognitive domains of learning, memory, and attention. Recent use may be defined as cannabis use within 24 hours of evaluation.~~

~~ii. A limited number of studies suggest that there are impairments in cognitive domains of learning, memory, and attention in individuals who have stopped smoking cannabis.~~

~~iii. Cannabis use during adolescence is related to impairments in subsequent academic achievement and education, employment and income, and social relationships and social roles."~~

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.

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Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic:
H407-A/16 Operator Intoxication/ Impairment
H331-A/18 Physician Health Assistance
H628-A/18 Cannabis Reclassification: Effect on Research
H424-A/21 Medical Cannabis – Research on Policy Statement
And as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED____

DATE: ___July 16, 2022_____

SUBJECT: HARM REDUCTION MODALITIES FOR PEOPLE WHO INJECT DRUGS – WHITE PAPER - SOURCE: H443-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Harm Reduction Modalities for People Who Inject Drugs White Paper

INTRODUCTION

IN 2019, 36,801 PEOPLE RECEIVED AN HIV DIAGNOSIS IN THE UNITED STATES (US) AND DEPENDENT AREAS. FROM 2015 TO 2019, HIV DIAGNOSES DECREASED 9% OVERALL IN THE US AND DEPENDENT AREAS. IN 2019, PWID ACCOUNTED FOR 7% (2,508) OF THE 36,801 NEW HIV DIAGNOSES.[1]

THE RECENT EPIDEMIC OF PRESCRIPTION OPIOID ABUSE HAS LED TO INCREASED NUMBERS OF PWID. IN 2019, NEARLY 50,000 PEOPLE IN THE UNITED STATES DIED FROM OPIOID-INVOLVED OVERDOSES. THE MISUSE OF AND ADDICTION TO OPIOIDS—INCLUDING PRESCRIPTION PAIN RELIEVERS, HEROIN, AND SYNTHETIC OPIOIDS SUCH AS FENTANYL—IS A SERIOUS NATIONAL CRISIS THAT AFFECTS PUBLIC HEALTH AS WELL AS SOCIAL AND ECONOMIC WELFARE.[2]

~~Though the annual number of new HIV infection diagnoses has declined significantly over the past 10 years, this trend is not consistent across all groups~~. Behaviors such as sharing needles, syringes, and other injection equipment cause people who inject drugs (PWID) to be at high risk for contracting and transmitting HIV, viral hepatitis and other infections. ~~In 2013, as many as 3,096 of the estimated 47,352 diagnoses of HIV infection in the United States were attributable to injection drug use (IDU).~~

~~The recent epidemic of prescription opioid abuse has led to increased numbers of PWID creating new populations of people at increased risk for infections such as HIV. Specifically, suburban and rural areas, which have historically been areas at low risk for~~

~~HIV, have been disparately impacted. This epidemic is one of the most significant public health problems that the United States has seen in decades.~~

~~Not only does the current opioid crisis place a new group at risk for infectious diseases, but it has created an epidemic of overdoses as well. Fatal drug overdoses are now the number one leading cause of injury death in the United States. In 2015, there were 33,091 opioid-related deaths, and since 1999, the number of opioid overdoses has quadrupled.~~

To mitigate the impact of injection drug use and its associated consequences, communities across the United States and abroad are considering harm reduction approaches, such as needle exchange programs and safe injection facilities. The goal of this paper is to discuss the benefits and risks of implementing such interventions, and to present the AOA's position on harm reduction as an approach for impacting the consequences of substance abuse among PWID.

PUBLIC HEALTH SIGNIFICANCE

According to the CDC, 1.2 million people in the US are living with HIV ~~and 1 in 8 (161,200) are not aware of their infection~~ AT THE END OF 2019. OF THOSE PEOPLE, ABOUT 87% KNEW THEY HAD HIV.[3]

PWID represent a significant percentage (13.8%) of persons living with HIV (PLWH) as well as those newly diagnosed with HIV (7%). HIV-negative persons who inject drugs have a 1 in 160 chance of contracting HIV each time they share a needle with an HIV-positive person.[4]

~~Overall, HIV diagnoses among PWID declined 48% from 2008 to 2014. However, this downward trend varied by race/ ethnicity. HIV incidence among Black and Hispanic/Latino PWID declined by nearly half, in both urban and nonurban areas. Among urban White PWID, however, there was a decrease of 28% during 2008–2012, but there was no change in incidence from 2012–2014. Similar trends were noted among nonurban Whites. Although there was some decline in HIV diagnoses among Whites since 2008, the CDC reports that heroin use and injection drug use among Whites is increasing.~~

~~In addition to HIV, there is significant hepatitis C (HCV) burden among PWID. As HCV is approximately ten times more infectious than HIV, 50% to 90% of HIV-positive PWID are co-infected with HCV. Recent increases in acute HCV infections suggest that progress made toward lowering rates of HIV infection over the years may be jeopardized by rising use of opioids and heroin.~~

In addition to being at risk for HIV and viral hepatitis, people who inject drugs can have other serious health problems, like skin infections and heart infections. People can also overdose and get very sick or even die from having too many drugs or too much of one drug in their body or from products that may be mixed with the drugs without their knowledge (for example, fentanyl).[4]

~~The costs associated with treating HIV and HCV over a life time require significant investment. In 2010 dollars, the cost of HIV treatment is approximately $379,668, and in 2014 the initial market prices of HCV treatment ranged from $84,000 to $96,000. Fortunately, the cost of HCV medications has dropped to approximately $40,000 for~~

~~Medicaid programs since 2014. Reportedly, HCV treatment can save $14.3 billion in health care expenses, but it costs $69.5 billion to initiate.~~

Addressing the burden of HIV and HCV requires facilitation of multiple public health strategies aimed at interrupting disease transmission and reducing risk of acquiring and transmitting HIV, HBV, HCV, and other blood-borne infections.[5]

Strategies to interrupt disease transmission for PWID include evidence-based practices of promoting the use of sterile needles or syringes for every injection, as well as ensuring access to medical treatment, behavior-change counseling and addiction treatment services.[6]

Injection drug use carries the consequence of inflicting considerable harm on PWID themselves and to society. As communities develop methods of reversing increasing mortality trends, public health officials, as well as federal, state, and local organizations are exploring harm reduction interventions aimed at preventing overdose deaths, interrupting disease transmission, and alleviating harm to people misusing drugs and their families.

HARM REDUCTION PHILOSOPHY AND APPROACHES

With respect to illicit drug use, harm reduction refers to a public health approach consisting of policies, programs, and practices directed at reducing the harms associated with the use of mind-altering drugs. The defining element is prevention of harm, rather than abstinence or prevention of drug use, and its targets are people who continue to use drugs and are at elevated risk for contracting and spreading diseases. [7]

Though components of it can be traced back to the early 1930's, the term 'harm reduction' gained popularity in the mid-1980s. As awareness grew about high incidences of HIV among PWID in many countries, European cities began pioneering interventions such as needle and syringe programs. During the 90's, harm reduction strategies gained acceptance around the world, and by 2000 they were vital components of drug policy guidance from the European Union. By 2009, 31 European countries provided needle/ syringe programs (NEP, NSP) and opioid substitution therapy (OST), or at least supported them by policy. Harm reduction in prisons was also established during this period with 6 countries offering needle and syringe exchange programs, and 23 providing OST. Europe was also a pioneer in establishing drug consumption rooms (DCR), opening nearly all of the DCRs in the world. Due in part to the efforts of Europe, harm reduction is now official policy of the United Nations. [8]

Rooted in the concept of harm reduction is the principle that drug use for some people is inevitable because they are either unable or unwilling to abstain. In the ~~2010~~ **2019** National Survey on Drug Use and Health, for example, ~~30%~~ 40% of illicit drug users who had not entered treatment responded that they simply were not ready to commit to stopping their drug use.[9] ~~regardless of the consequences.~~

To effectively serve people in different phases of addiction and abuse, harm reduction ideally involves multiple simultaneous interventions customized for locality and need. For example, a harm reduction package may be comprised of opioid substitution therapy, needle and syringe programs, drug consumption rooms and counseling services. They may also include peer interventions and advocacy for funding or policy change. Needle

and syringe programs are generally at the center of harm reduction interventions targeting PWID. [10]

NEEDLE-SYRINGE SERVICE PROGRAMS

The Centers for Disease Control and Prevention define Syringe Service Programs (SSPs), also referred to as syringe exchange programs (SEPs), needle exchange programs (NEPs) and needle-syringe programs (NSPs), as "…community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes."[11]

The first NEP was established in Amsterdam in 1983 in an attempt to quell a hepatitis B outbreak. Other European countries followed suit after the presentation of HIV/AIDS.[12] ~~In 2014, there were 158 countries around the world with documented PWID; however, only 90 countries were operating NSPs.~~

The first SSP in the United States was in New Haven, Connecticut in 1987. The program operated underground because of laws which made possession of drug paraphernalia illegal. In many states this is still the case. The first SSP to receive public funds opened in 1988 in Tacoma, Washington. Just 2 years later, in Hawaii, the first state-approved SSP was signed into law.[12] ~~According to the North American Syringe Exchange Network, more than 200 syringe services programs operate in 36 states, Washington, D.C., and the territories.~~ THROUGHOUT THE WORLD, HARM REDUCTION IMPLEMENTATION HAS NOT IMPROVED SINCE 2018. THE NUMBER OF COUNTRIES WHERE NEEDLE AND SYRINGE PROGRAMS (NSPS) ARE AVAILABLE REMAINED AT 86.[12]

In addition to providing sterile needles, syringes, other drug preparation equipment, and disposal services, syringe service programs offer clients a range of other services. Many programs provide health education and counseling, immunizations, access to substance abuse and mental health treatment, screening for tuberculosis, hepatitis, HIV and other STIs, and condom distribution, as well as referrals for social services and medical programs. Programs may also be equipped with naloxone to reverse opioid overdoses.[13]

~~Within the past 10 years, the~~ The United States has experienced an increase in drug injection. Of particular concern are persons who escalated to injecting prescription opioids and heroin after using oral analgesics. Much of this activity has been identified in suburban and rural areas. HCV and HIV infection in these nonurban areas correlate with noted injection patterns and trends.[14]

~~The 2015 HIV outbreak in Scott County, Indiana, and documented HCV epidemics in multiple locations around the country underscores the continued need for SSPs and highlights the limited coverage of prevention services for HIV and HCV among PWID in rural and suburban areas.~~

HISTORY OF THE BAN ON FUNDING NEEDLE EXCHANGE PROGRAMS

With the advent of the "War on Drugs" in 1988, the United States Congress implemented a ban on the use of federal funds to support syringe exchange. During the 1990s, however, an Institute of Medicine panel recommended that the federal prohibition of needle and syringe exchange programs be revoked. The idea was supported by findings that needle and syringe exchange programs contributed to lowered HIV incidence and did not amplify

155 injection drug use. The Centers for Disease Control and Prevention also assessed needle
156 and syringe exchange programs and concluded that they were effective in halting the
157 spread of HIV among PWID. Based on these endorsements, it was anticipated that the
158 ban would be repealed, but President Clinton chose not to pursue changes to the federal
159 law.[15]

160 In December 2009, President Obama signed the Consolidated Appropriations Act of 2010.
161 Though this act gave states permission to fund syringe services programs with federal
162 dollars, there was no money specifically earmarked. One year later, however, in December
163 of 2011, Congress restored the ban, reversing 2009 decision.[15]

164 Precipitated by the HIV outbreak in Indiana, along with sharp increases in rates of injection
165 drug use across the country, Kentucky and West Virginia legislators championed the
166 addition of language into an omnibus spending bill to revoke the ban. The bill was passed
167 by Congress at the end of December 2015. The modified law is theoretically a partial
168 repeal. Through the Consolidated Appropriations Act of 2016, states were given the ability
169 to use federal dollars to finance syringe service program operations, including staffing,
170 automobiles, gas, leases, and other operating expenses. The purchase of sterile needles
171 and syringes is still prohibited, but funds may be used to support comprehensive services
172 for PWID.[15]

173 THE CONSOLIDATED APPROPRIATIONS ACT OF 2018 PERMITS THE USE OF
174 FUNDS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS),
175 UNDER CERTAIN CIRCUMSTANCES, TO SUPPORT SSPS. HOWEVER, HHS FUNDS
176 MAY NOT BE USED TO PURCHASE NEEDLES OR SYRINGES.[16]

177 **PERCEIVED RISKS OF NEEDLE-SYRINGE EXCHANGE PROGRAMS**

178 Antagonists of needle and syringe exchange programs in the United States have primarily
179 focused on three ideological and moral arguments for justifying prohibition. The first
180 argument is that federal funding of needle and syringe exchange programs would signal
181 governmental acceptance of illegal drug use, conflicting with law enforcement efforts. The
182 second argument is that federal funding of needle and syringe exchange programs could
183 encourage drug abuse and jeopardize public health and safety by facilitating IDU,
184 increasing the circulation of contaminated needles, and increasing crime. The third
185 argument is that federal approval of needle and syringe exchange programs could cause
186 children to believe that drug use is acceptable.[15] However, studies have shown these
187 concerns to be largely unfounded.

188 The US government authorized several reports to evaluate outcomes of needle and
189 syringe exchange programs. Key report authors were: 1) the National Commission on
190 AIDS; 2) the U.S. General Accounting Office; 3) the Centers for Disease Control/University
191 of California; and 4) the National Academy of Sciences. The reports reinforced the
192 advantages of needle and syringe exchange programs and did not indicate any negative
193 outcomes. The studies affirmed that when barriers such as criminalization laws regarding
194 the purchase and possession of IDU equipment are eliminated, PWID are less likely to
195 share needles. The reports further concluded that needle and syringe exchange programs
196 do not increase drug use among program participants, nor do they lead to the recruitment
197 of new drug users.[17]

As a potential threat to public safety, the concern of improper disposal of needles has been widely studied. This perspective assumes that PWID will not return needles to distribution sites, and will, therefore, potentially endanger the health of the surrounding community by exposing residents to contaminated needles. However, successful rates of return of used needles have been documented. In her meta-analysis, study author Kate Ksobiech reviewed needle return data from 8 studies, comprised of 26 articles. Ksobiech calculated an overall worldwide return rate of 90%, though there was great variability at individual sites. Return rates for U.S. needle and syringe exchange programs were comparable to those of international programs. One limitation noted in the study, however, is that researchers could not confirm where the needles originated, nor could they ascertain if people returned their own needles or those of their social network.[18]

Additionally, the World Health Organization has concluded that there is no evidence that needle and syringe programs negatively impact PWID, their communities, or society at large. "Studies have searched for and found no convincing evidence of the following unintended complications associated with needle and syringe exchange programs: greater injection frequency, increased illicit drug use, a rise in syringe lending to other IDUs, recruitment of new IDUs, social network formation, greater numbers of discarded used needles, less motivation to change, i.e. reduce, drug use and increased transition from non-injecting drug use to IDU."[19]

Needle and syringe exchange sites are not always accessible to people when they need them. As a result, some PWID collect and exchange high volumes of used needles and then sell the clean ones to their peers. This black market has been identified as an unintended consequence of needle and syringe exchange programs in some rural and scarcely resourced areas and underscores the need for more substance abuse services and IDU resources in these communities.[20] Little if any research has been conducted on the effects of black market needles on injection drug use and HIV transmission.

Also of note, while needle and syringe exchange programs are found to be effective in reducing HIV transmission and injecting risk behaviors among PWID, evidence regarding their impact on reducing HCV infection has been inconclusive.[21]

BENEFITS OF NEEDLE- SYRINGE EXCHANGE PROGRAMS

The most notable benefit of needle and syringe exchange programs is that they lead to a reduction of morbidity and disease transmission, which translates to a reduction in associated health care costs. However, there are many other documented benefits. Needle and syringe exchange programs also promote public health and safety, connect PWID to substance abuse treatment programs, and provide an entry point into other health services, such as HIV and STD testing and care and treatment programs.[14]

- **Interruption of Disease transmission**

In their systematic review, Bramson, Des Jarlais et al found positive associations between publicly funded syringe exchange programs, low HIV incidence, low absolute numbers of new HIV diagnoses, and greater service provision. The study concluded that the distribution of large numbers of needles and syringes was causal, indicating that public funding of Syringe exchange programs leads to lower HIV incidence. When Syringe exchange programs and over the counter sales of syringes are consistently funded, they are impactful in reducing HIV transmission.[22]

ACCORDING TO THE CDC, "NEARLY 30 YEARS OF RESEARCH HAS SHOWN THAT COMPREHENSIVE SSPS ARE SAFE, EFFECTIVE, AND COST-SAVING, DO NOT INCREASE ILLEGAL DRUG USE OR CRIME, AND PLAY AN IMPORTANT ROLE IN REDUCING THE TRANSMISSION OF VIRAL HEPATITIS, HIV AND OTHER INFECTIONS."[13]

- **Linkage to Care and Services**

Many SSPs link PWID to key services and programs, such as HIV care and treatment, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) services; hepatitis C treatment, hepatitis A and B vaccinations; screening for STI's and TB; partner services; prevention of mother-to-child HIV transmission; and other medical, social, and mental health services.[3] Given the availability of new treatments that effectively cure HCV, linking PWID to HCV and HIV testing and referring those diagnosed to care and treatment may be the most significant services offered.[14]

~~However, access to substance abuse counseling and treatment is also an important component. Study results indicate that new SEP participants are five times more likely to enter a drug treatment program than nonparticipants. Findings also showed that PWID who participated in needle exchange were more likely than those who did not to reduce or stop injecting.~~

THE MAJORITY OF SSPS OFFER REFERRALS TO MEDICATION-ASSISTED TREATMENT. NEW SSPS USERS ARE FIVE TIMES MORE LIKELY TO ENTER DRUG TREATMENT AND THREE TIMES MORE LIKELY TO STOP USING DRUGS THAN THOSE WHO DON'T USE THE PROGRAMS.[14]

- **Reduction in Health Care Costs**

ACCORDING TO THE CDC, "SSPS REDUCE HEALTH CARE COSTS BY PREVENTING HIV, VIRAL HEPATITIS, AND OTHER INFECTIONS, INCLUDING ENDOCARDITIS, A LIFE-THREATENING HEART VALVE INFECTION. THE ESTIMATED LIFETIME COST OF TREATING ONE PERSON LIVING WITH HIV IS MORE THAN $450,000. HOSPITALIZATIONS IN THE U.S. FOR SUBSTANCE-USE-RELATED INFECTIONS COST OVER $700 MILLION EACH YEAR. SSPS REDUCE THESE COSTS AND HELP LINK PEOPLE TO TREATMENT TO STOP USING DRUGS."[23]

~~International studies have concluded that harm reduction programs reduce health-related expenses by decreasing the number of emergency room visits, as well as the number of infected persons needing treatment and care. From 2000 to 2009, the Australian Centre in HIV Epidemiology and Clinical Research spent approximately $27 million annually on its NSP. During the same period, net cost savings of $1.28 billion were realized as a result of preventing new HCV and HIV infections. Similarly, analyses of Vancouver's harm reduction and SIF revealed over $6 million in savings, due to prevention of overdose deaths and HIV infections in Vancouver. While these savings are due in part to the accessibility of sterile injecting equipment, a significant portion can be attributed to prevention of downstream emergency care costs.~~

~~When compared to non-drug users, chronic drug users, such as PWID, are more likely to seek inpatient and emergency care than non-drug users, and less likely to use outpatient/ primary care services. PWID are prone to soft-tissue infections and other preventable IDU-related complications that lead them to utilize the emergency room for care. Data analyses of consecutive admissions of PWID to emergency care for late stage treatment of these conditions indicate that harm reduction methods, including skin-cleaning practices, effectively diminish preventable incidents and acute care expenses.~~

- **Promotion of Public Health and Safety**

In communities where IDU is prevalent, residents are understandably concerned about unsafe disposal and circulation of potentially contaminated needles and syringes because inadvertent contact could lead to infection. Syringe exchange programs address this issue by removing used needles from circulation and educating their clients about safe disposal of used syringes.[13]

~~In fact, many Syringe exchange programs urge participants to return as many needles and syringes as possible. Consequently, most syringes issued by Syringe exchange programs are returned. In Baltimore, for example, evaluation of Syringe exchange programs confirmed that Syringe exchange programs contributed significantly in reducing the number of improperly discarded syringes by approximately 50 percent. Similarly, studies In Portland, Oregon, revealed a two-thirds reduction in the number of improperly discarded syringes after the implementation of a SEP, and in 2000, nearly 3.5 million syringes were returned in San Francisco.~~

EVIDENCE DEMONSTRATES THAT SSPS DO NOT INCREASE ILLEGAL DRUG USE OR CRIME. STUDIES IN BALTIMORE AND NEW YORK CITY HAVE FOUND NO DIFFERENCE IN CRIME RATES BETWEEN AREAS WITH AND AREAS WITHOUT SSPS. IN BALTIMORE, TRENDS IN ARRESTS WERE EXAMINED BEFORE AND AFTER A SSP WAS OPENED AND FOUND THAT THERE WAS NOT A SIGNIFICANT INCREASE IN CRIME RATES. THE STUDY IN NEW YORK CITY ASSESSED WHETHER PROXIMITY TO AN SSP WAS ASSOCIATED WITH EXPERIENCING VIOLENCE IN AN INNER CITY NEIGHBORHOOD AND FOUND NO ASSOCIATION.[13]

- **Protection of Law Enforcement Personnel from Needle Stick Injuries**

In the course of duty, police officers are in danger of needle stick injuries, placing them at risk of becoming infected with hepatitis B, hepatitis C and HIV. Risk factors include working evening shifts, performing pat-down searches, being on patrol duties, and being a less experienced officer.

STUDIES SHOW THAT SSPS PROVIDE SAFE NEEDLE DISPOSAL AND REDUCE THE NUMBER OF NEEDLES IN THE COMMUNITY WHICH PROTECTS FIRST RESPONDERS AND THE PUBLIC. DATA FROM CDC'S 2015 NATIONAL HIV BEHAVIORAL SURVEILLANCE SYSTEM SHOWED THAT THE MORE SYRINGES DISTRIBUTED AT SSPS PER PEOPLE WHO INJECT DRUGS IN A GEOGRAPHIC REGION, THE MORE LIKELY PEOPLE WHO INJECT DRUGS IN THAT REGION WERE TO REPORT SAFE DISPOSAL OF USED SYRINGES.[13]

~~Findings from a study of police officers in San Diego revealed that nearly 30 percent had experienced a needle stick at some point, and more than 27 percent of those injured been stuck at least 2 times. By contrast, only 1 in 50,000 officers in the United States are killed~~

~~by a firearm during the course of duty. Syringe exchange programs decrease the number of contaminated needles in circulation, which may in turn decrease law enforcement personnel's risk of exposure to contaminated needles. In a study of Connecticut police officers, needle stick injuries declined by nearly two-thirds after implementing Syringe exchange programs.~~

SAFE INJECTING FACILITIES

Safe injection facilities (SIF) are known by many names, including Safe(r) injection Sites (SIS), drug consumption facilities (DCF), Medically Supervised Injection Centers (MSIC), and Safer or Supervised Injection Facilities (SIF). They are part of a harm reduction approach to IDU. At these sites, users of illicit drugs have access to disinfecting agents and clean needles, as well as medical professionals. These legally sanctioned facilities provide a safe environment without the threat of arrest, and it provides them with access to professionals that can offer advice and refer them for rehabilitation services.[10] SIFs are not "shooting galleries", which are illegal injecting facilities run by drug dealers.[24] SIFs are managed by medical professionals, such as nurses and social workers, and drug sales are prohibited.[25]

Government sanctioned SIFs came into operation in Europe in the mid-1980s; the first of these facilities was established in Switzerland in 1984. Other SIFs existed in the Netherlands prior to this era, but they were not government sanctioned. In Germany, government sanctioned SIFs came into operation in the early 1990s, but government funding and approval was not obtained until later in 2000. Australia has attempted to open three non-government sanctioned SIFs in the late 1990s; one facility was legally approved in 2001.[24] ~~Currently, the only government approved SIF in North America is located in Vancouver, Canada, and it was implemented in 2003.~~

IN DECEMBER 2021, NEW YORK CITY OPENED THE NATION'S FIRST OVERDOSE PREVENTION CENTER PILOTS. THE DRUG POLICY ALLIANCE AND ITS ALLIES ADVOCATED FOR MANY YEARS TO REACH THIS MILESTONE.[25]

IN JULY 2021, RHODE ISLAND AUTHORIZED A TWO-YEAR PILOT PROGRAM TO ESTABLISH "HARM REDUCTION CENTERS" WHERE PEOPLE CAN CONSUME PRE-OBTAINED SUBSTANCES UNDER THE SUPERVISION OF TRAINED STAFF, BECOMING THE FIRST STATE TO DO SO.[25]

There are various models of SIFs, however, the core services are generally the same:

- Provision of sterile injecting equipment;
- Medical supervision of injections, including emergency response to drug overdoses;
- Injection-related first aid (such as wound and abscess care); and
- Assessment and referral to primary health care, drug treatment and social services.[23]

~~Despite demonstrated efficacy and the presence of these facilities in Europe, there is still apprehension in North America. *There are nearly 100 SIFs in operation outside of the United States, yet none have been established within the U.S. However, King County in*~~

~~*Seattle is attempting to open at least two public SIFs after a unanimous vote in January to endorse these sites by the county's Board of Health. In September of 2016, a task force of heroin and opioid* abuse experts recommended that the sites be opened in Seattle to reduce the surge of overdose deaths in recent years.~~

ADVANTAGES OF SAFE INJECTING FACILITIES

There are many benefits associated with this kind of intervention. These benefits include allowing PWID to inject in a clean environment without having to rush, allowing PWID to have access to medical staff that are able to respond to overdoses and prevent deaths, and easy access to clean IDU equipment. The success rate of reduction of overdose deaths in safe injecting facilities is very high. SIFs aid public health by controlling the spread of disease and improving the quality of life for PWID. [24]

~~Additionally, SIFs lower the costs of public health and emergency room visits by providing PWID with supervision by medical professionals who can help reduce the risk of overdose. On average, an emergency ambulance costs $1,000 per trip, with additional costs if medical supplies are used. This expense is absorbed by taxpayers for the uninsured.~~

A systematic literature review performed via PubMed, ScienceDirect, and Web of Science databases found seventy-five articles whose study results converged to find that SIFs were most effective in attracting marginalized PWID, providing access to primary health care, reducing the frequency of overdoses, and providing safer conditions for injection. There was no evidence indicating an increase in drug trafficking, drug use, nor crime in the areas surrounding the SIFs. There was a positive correlation between the presence of SIFs, reduced amounts of abandoned syringes, and reduced levels of public drug injections. The majority of referenced articles originated in Vancouver and Sydney.[26]

OPPOSITION TO SAFE INJECTING FACILITIES

Common objections to the establishment of facilities such as SIFs, SISs, DCRs, and other harm reduction programs include the fear that these facilities would attract more drug users to that area, encourage youths to use drugs, and increase drug use rates. Even though the evidence previously presented along with other evidence has not supported these beliefs, these views still have a large influence on the public's beliefs about the effects of these facilities on their communities.[23]

~~The large amount of evidence thwarting this view indicates that objections to these programs often originate from speculation rather than concrete evidence. SISs have also been accused of fostering drug use and drug trafficking, though no substantial evidence has been found to support this claim~~.

CONCLUSION

AS OF 2018, there are approximately ~~3,000~~ 3,864 new HIV infections among PWID per year in the US.[4] HIV, HCV, overdose, STIs, soft tissue infections, tuberculosis, and substance use disorders are among the many health problems facing PWID. Harm reduction interventions such as needle and syringe exchange programs, opioid substitution

therapy, and SIFs have demonstrated potential to reduce morbidity, mortality and disparities among vulnerable individuals, decrease costs associated with injection drug use, and diminish harm sustained by PWID and their communities. However, public funding is necessary to provide effective, comprehensive services for this population.

State and local funding is only possible in areas with favorable syringe exchange policies. Fully repealing the ban on the use of federal funds for harm reduction interventions would provide additional funding to programs and enhance overall impact. IDU has been an important factor of HIV transmission in the US. Public funding of NSP is strongly associated with both reducing HIV transmission among PWID in states that experienced high HIV incidence, and with maintaining low HIV in other states. Increased, consistent state and local public funding of syringe exchange and other harm reduction strategies, in addition to federal funding, would be a significant step forward. [22]

AOA POLICY

Given the research demonstrating the effectiveness of harm reduction strategies, such as syringe service programs and supervised injection facilities, in reducing HIV transmission, along with endorsements of the ~~American Medical Association (AMA) (H-95.958),~~ World Health Organization (WHO), U.S Centers for Disease Control and Prevention (CDC), and the Institute of Medicine (IOM), the AOA adopts the following policy statements as its official position on the use of harm reduction strategies to combat the consequences of injection drug use:

1. ~~The American Osteopathic Association (AOA) supports harm reduction strategies, such as syringe service programs and supervised injection facilities, particularly when they include comprehensive services, such as substance abuse and mental health counseling and treatment~~. **THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS THE DECRIMINALIZATION OF HARM REDUCTION STRATEGIES, SUCH AS SYRINGE SERVICE PROGRAMS AND SUPERVISED INJECTION FACILITIES. SUCH SERVICES SHOULD BE LEGALLY PROVDED AND PAIRED WITH MORE COMPREHENSIVE SERVICES, SUCH AS SUBSTANCE ABUSE AND MENTAL HEALTH COUNSELING AND TREATMENT**.

2. The American Osteopathic Association (AOA) shall advocate for the increased availability of harm reduction modalities including safe injecting facilities and supervised injection facilities at the local, state, and federal level.

3. The American Osteopathic Association (AOA) strongly encourages state medical associations to initiate state legislation that decriminalizes drug paraphernalia possession and procurement so that injection drug users can obtain needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

4. The American Osteopathic Association (AOA) is in favor of complete repeal of the ban on federal funding for syringe exchange programs.

5. The American Osteopathic Association (AOA) is in favor of syringe service programs and encourages physicians to provide patients with education on such programs.

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Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED____

DATE: __July 16, 2022_____

SUBJECT: MEDICATION FOR INDIGENT PATIENTS - SOURCE: H444-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health/Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health/Bureau on
3 Federal Health Programs has reviewed the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the donation of non-expired
7 medications for distribution to indigent patients on the basis of financial need.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED

DATE: July 16, 2022

SUBJECT: AOA POLICIES ON OPIOIDS AND SUBSTANCE USE – WHITE PAPER

SUBMITTED BY: Bureau on Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association has numerous policies addressing opioids and substance use; and

WHEREAS, the AOA House of Delegates in 2021 directed the Bureau on Osteopathic Research and Public Health to compile all policies on opioids and substance use into a comprehensive white paper; now, therefore be it

RESOLVED, that the white paper titled AOA Policies on Opioids and Substance Use be approved.

AOA Policies on Opioids and Substance Use

White Paper

Background on the issue

Opioid addiction and abuse continues to be an urgent public health crisis. Based on 2019 data, an average of 38 people died each day from overdoses involving prescription opioids, totaling more than 14,000 deaths. For the 12-month period ending in December 2020, provisional data from the Centers for Disease Control and Prevention (CDC) indicates that the number of overdose deaths rose to 93,331. This number is the highest ever recorded for overdose deaths in a 12-month period. Opioids were involved in approximately 75% of these deaths.[1]

Over the last few years, drug overdose deaths involving synthetic opioids and methamphetamine have shifted geographically.[2]

- From 2018 to 2019, the largest increase in death rates involving synthetic opioids occurred in the West (67.9%). Previously, the highest increases in deaths involving synthetic opioids occurred in the East.

- The largest increase in death rates involving psychostimulants occurred in the Northeast (43.8%) compared to the Midwest which had the highest increases in the past.

- No state had a significant decrease from 2018-2019.

In July 2021, the AOA House of Delegates directed the AOA Bureau of Osteopathic Research and Public Health to combine all AOA policies on opioids and substance use disorders into a comprehensive white paper. The following paper includes AOA policy statements on opioids and substance use disorders. Policies are divided into the following categories: Education on Substance Use Disorders, Education on Opioid Use and Abuse, Access to Treatment, and Diversion.

Education on Substance Use Disorders

1. The American Osteopathic Association (AOA) will advance knowledge and understanding of appropriate use of prescription drugs and TREATMENT OF substance use disorders through the education of the public and osteopathic medical education at all levels.
2. The AOA encourages its members to maintain current knowledge of addictive substances with a high potential for abuse and appropriate treatment techniques. The AOA urges all members of the osteopathic profession to participate in the prevention and rehabilitation of persons suffering from substance use disorder and the disease of addiction.
3. The AOA will work with other associations representing health care professionals to educate on the indicators of potential prescription drug abuse, misuse, and diversion.
4. The American Osteopathic Association (AOA) encourages communities to work collaboratively with law enforcement agencies to implement evidence-based referral resources and advocate for Medication Assisted Treatment (MAT) programs as the most clinically effective and cost-effective intervention for sustained recovery, and reduction of criminal activity and mortality.

Education on Opioid Use and Abuse

1. The AOA will advocate for medical education for all practitioners on proper opioid prescribing practices and any state mandated pain education requirements should include proper prescribing practices for opioids relating to pain treatment, opioid addiction, and identification of prescription drug abuse, misuse, and diversion.
2. The AOA encourages osteopathic physicians whose practice includes the prescribing of Extended Release-Long Acting (ER/LA) Opioids to complete ER/LA Opioid Risk Evaluation and Mitigation Strategy (REMS) training to ensure that ER/LA opioids are prescribed, when indicated, in a manner that enhances patient well-being and does not contribute to individual or public harm.

63 Access to Treatment

64 1. The AOA will not support any program which limits access to prescription drugs
65 for patients with legitimate need and will not support any program which reduces
66 the provider's ability to inform the patient's care. In addition, it is in the best
67 interest of all patients not to confine, or seek to regulate medications, including
68 opioid/opiate, by limiting their use to a small number of selected specialties of
69 medicine. This would also extend to modalities now developed, or yet to be
70 developed, such as long-acting opioid/opiate preparations. These exclusionary
71 strategies will limit access for patients with medical indications for therapy,
72 complicate delivery of care, and add to pain and suffering of patients.
73 2. The AOA supports policies that do not hinder patient access to and coverage of
74 appropriate pharmacologic and non-pharmacologic treatments. It is a right of all
75 patients to have access to medically appropriate intervention and/or treatment for
76 conditions, including acute and chronic pain. It is the right of all physicians, to
77 provide medically appropriate intervention and treatment modalities that will
78 achieve safe and effective treatment, including pain control, for all their patients.
79 3. The AOA opposes the imposition of administrative or financial deterrents that
80 decrease access to and coverage of prescription drugs with abuse-deterrent
81 properties.
82 4. The AOA will advocate to states to not lower opioid addiction treatment numbers
83 below the 275 maximum patient load allowed under the Comprehensive Addiction
84 Recovery Act.
85 5. The AOA will support the administration and/or prescribing of all FDA-approved
86 treatments for opioid use disorder (OUD) for all individuals with OUD who are
87 incarcerated or under other forms of governmental or private correctional control.
88
89 Diversion

90 1. The AOA will advocate for evidence-informed use of state prescription monitoring
91 programs, tamper resistant drug formulas and support efforts to assist state
92 osteopathic medical associations in developing physician drug abuse, misuse
93 and diversion awareness and prevention education programs.
94 2. The AOA supports an integrated national opioid database that allows prescribers,
95 dispensers, or their designated staff in any state to access a patient's prescription
96 history, regardless of their residing state at no cost to the prescriber or dispenser.
97 3. The AOA will continue to cooperate with the pharmaceutical industry, law
98 enforcement, and government agencies to stop prescription drug abuse, misuse
99 and diversion as a threat to the health and well-being of the American public.

100 4. The AOA will encourage the Institute of Medicine and other private and public
101 organizations/agencies to conduct further research into development of reliable
102 outcome indicators for assessing the effectiveness of measures proposed to
103 reduce prescription drug abuse, misuse, and diversion.
104

References:

1. FDA. "Online Opioid Summits." https://www.fda.gov/drugs/news-events-human-drugs/online-opioid-summits. (Accessed 2-9-2022)
2. CDC. "Drug Overdose Deaths." https://www.cdc.gov/drugoverdose/deaths/index.html. (Accessed 2-9-2022)

Background Information: Provided by AOA Staff

Current AOA Policy:

The white paper is based on the following current AOA policies. If this white paper is approved, it is recommended that these policies be deleted.

H203-A/18 Substance Use Disorders Education

H300-A/19 Training – Extended Release-Long Acting (Er/La) Opioid Risk Evaluation And Mitigation Strategy (Rems)

H300-A/21 Medication For Opioid Use Disorder (Moud) Availability For Incarcerated Individuals and/or Individuals Under Correctional Control Policy Statement

H322-A/20 Prescription Drug Diversion And Abuse – Education, Research, And Advocacy

H326-A/21 Pain Related Education Requirements Policy Statement

H330-A/17 Patient Load Restrictions To Increase Pharmacological Opioid Addiction Treatment Access – Abolishment Of

H331-A/17 Interstate Opioid Database

H414-A/18 Substance Use Disorder

H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs For

Prior HOD action on similar or same topic:
The AOA has two other policies/white papers generally related to substance use and opioids. It is recommended that these two policies continue as standalone policies.

H452-A/20 Breastfeeding While on Methadone Maintenance

H443-A/17 Harm Reduction Modalities for People Who Inject Drugs – Update to white paper submitted to the 2022 HOD to Reaffirm as Amended.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED_____

DATE: __July 16, 2022_____

SUBJECT: ADDRESSING DIVERSITY, EQUITY AND INCLUSION AS A PROFESSION

SUBMITTED BY: PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

REFERRED TO: Committee on Public Affairs

WHEREAS, Osteopathic physicians, residents and students are major participants in providing health care in the United States; and

WHEREAS, the Osteopathic profession recognizes the evolving diversity of the population and changing environment occurring within the boundaries of the country; and

WHEREAS, diversity, in its broadest sense, not only considers culture and ethnicity, but also includes and it not limited to, differences/disparities in age, gender, education, economic ability, physical ability, lifestyle, and geography; and

WHEREAS, the Osteopathic profession commits to maintain a climate of respect, civility and inclusion with our colleagues and our patients; now therefore be it; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) strongly affirms its commitment to be a diverse, inclusive and equitable organization in the provision of patient services, employment practices and engagement of volunteers; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) strongly affirm its nondiscrimination policy including, but not limited to, the basis of sex, color, creed, race, religion, ability, ethnic origin, national origin, sexual orientation, gender identity, age, locus of medical training and military service.

Background Information: Provided by POMA

According to the Office of Equal Employment Opportunity (OEEO), there are ten types of discrimination.[1]

- Age Discrimination
- Disability Discrimination
- Sexual Orientation
- Status as a Parent
- Religious Discrimination

[1] https://www.cdc.gov/eeo/faqs/discrimination.htm

- National Origin
- Pregnancy
- Sexual Harassment
- Race, Color and Sex (Gender)
- Reprisal/Retaliation

In general, organizational discrimination policies are focused inward addressing how an organization views discrimination with a focus to meet the legal requirements of existing legislation addressing discrimination. Associations/non-profit organizations have discrimination policies that focus inward (from an employer perspective) and outward (expected member behavior).

A review of existing policy of the POMA finds the association lacking in this area. To support the work group efforts, a review of the current policies within the American Osteopathic Association (AOA) has been done. There is existing policy in some of the areas as described by the OEEO above.

NOTE: This is not intended to be an exhaustive list of policies enacted by the AOA but those policies available to the public via the AOA website – www.osteopathic.org – and made available as reference material for the work group.

- Sexual Orientation
  - H439-A/16 Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws
  - S-17-06 Standing Against Sexual Orientation Change Efforts
  - S-16-04 Expanding Gender Identity Options on Physician Intake Forms to be more Inclusive of LGBTQ Patients
  - F-16-04 Inclusion of LGBTQ Health Topics in Medical School Curricula
- Status as a Parent
  - H402-A/19 Same Sex Relationships and Healthy Families
- Religious Discrimination
  - S-18-16 Religious Freedom and Ethical Medical Practice
- Race, Color and Sex (Gender)
  - S-19-08 Addressing the Gender Pay Gap in the Medical Profession
  - H207-A/17 Non-Gender Discrimination
  - H439-A/20 Gender Identity Non-Discrimination
  - H638-A/19 Addressing the Gender Pay Gap in the Medical Profession

There exist additional areas of discrimination specific to the osteopathic profession, which include but may not be limited to discrimination against osteopathic physicians in hiring, credentialing, granting privileges, and recognition of osteopathic board certification. Discrimination is against the osteopathic profession regarding reimbursement for services, serving as a residency/program director in the single post-graduate accreditation system and, specific to Pennsylvania, issues with licensure based on an osteopathic rotating internship.

There were no policies found in the areas of Age Discrimination; Disability Discrimination; National Origin; Pregnancy; and Reprisal/Retaliation. The AOA Code of Ethics does distinguish sexual harassment in the context of the physician/patient relationship (The AOA Code of Ethics, Sections 3 and 16). Further, the AOA has established anti-discrimination policies in the following areas:

- Discrimination in the Practice of Osteopathic Medicine – H608-A2017
- Discrimination against Osteopathic Physicians – H304-A2018
- Osteopathic Discrimination by Payors – H318-A2018
- Discrimination in Healthcare – H406-A19
- Genetic Testing – H412-A/17
- Discrimination of Medical Students – S-15-07

The AOA also addresses discrimination within the federal government as noted within the December 19, 2019, correspondence to the Secretary of the Department of Health and Human Services concerning Health and Human Services Grant Regulations.

Background Information: Provided by AOA Staff
Current AOA Policy: H328-A19 - Diversity in Leadership Positions

Prior HOD action on similar or same topic: None.

The 2021-2026 AOA Strategic Plan, approved by the AOA Board of Trustees in February 2021, addresses Diversity, Equity and Inclusion (DEI) through the Value Statements and Priority Objectives. The value statement notes: Diversity, Equity and Inclusion: The AOA commits to creating and sustaining a community that promotes and values diversity, equity and inclusion. The priority objective of Diversity, Equity and Inclusion ensure that the AOA's leadership and staff best reflects the diversity of its membership and patients under the care of osteopathic physicians with five strategies and supporting tactics. The AOA Strategic Plan can be viewed at: AOA-Strategic-Plan.pdf (osteopathic.org).

The AOA DEI Strategic Plan, approved by the AOA Board of Trustees in April 2021, expands on the efforts described in the 2021-2026 AOA Strategic Plan. The plan includes four priority objectives with supporting strategies and tactics.

1. Developing and maintaining an inclusive workplace environment that welcomes and incorporates diverse perspectives and backgrounds at all levels within the organization.
2. Creating processes and programs to ensure our physician leadership are reflective of the osteopathic community and that the profession more broadly reflects the patient populations it serves.
3. Demonstrating the organizational impact of diversity, equity, and inclusion on our professional community, membership, leadership, and workforce.
4. Communicating our progress with internal and external stakeholders.

FISCAL IMPACT: $0

ACTION TAKEN __REFERRED (*Bureau of Osteopathic Research and Public Health)**__

DATE ____July 16, 2022_____

*Action items taken to address referral noted below

All current AOA policies are noted below:

H433-A/25 Gender Identity Non-Discrimination
The American Osteopathic Association (AOA) opposes discrimination on the basis of gender identity.

Source: H433-A/25
Status: 2010; 2015 Adopted; 2020 Adopted; 2025 Adopted as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/H433-A-25-Gender-Idenity-Non-Discrimination.pdf

H336-A/24 Diversity in Leadership Positions
The American Osteopathic Association supports increased awareness of and encourages diversity in its leadership positions and encourages its divisional and specialty societies to do the same.

Source: H336-A/24
Status: 1999, 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H336-A-24-Diversity-in-Leadership-Positions-H328-A19.pdf

H339-A/24 Promoting Diversity in AOA Membership and Leadership
The American Osteopathic Association (AOA) reaffirms its commitment to promote diversity within the osteopathic profession.

The AOA endorses programs to encourage increased diversity in enrollment at colleges of osteopathic medicine.

The AOA will work to identify and encourage such qualified individuals for participation in those osteopathic affiliate and national activities which foster leadership opportunities.

Source: H339-A/24
Status: 1979 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H339-A-24-Promoting-Diversity-in-AOA-Membership-and-Leadership-H326-A19.pdf

H406-A/24 Discrimination in Healthcare
The American Osteopathic Association (AOA) adopts a zero-tolerance policy for all forms of patient discrimination.

The AOA in concert with other healthcare organizations, and the federal, state, and local governments will continue to monitor, correct, and prevent any future negative bias.

Source: H406-A/24
Status: 1999, 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H406-A-24-Discrimination-in-Healthcare-H406-A19.pdf

H423-A/24 LGBTQIA+ Relationships and Health Families
The American Osteopathic Association (AOA) recognizes the need of LGBTQIA+ households to have the same access to health insurance and health care as heterosexual/cisgender households and supports measures to eliminate discrimination against LGBTQIA+ households in health insurance and health care.

The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s).

The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for LGBTQIA+ marriages and civil unions and the children of those families.

Source: H423-A/24
Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H423-A-24-LGBTQIA-Relationships-and-Healthy-Families-H402-A19.pdf

H305-A/23 Equality in the Military

The American Osteopathic Association (AOA), as the main representative of the osteopathic profession, support that all uniformed service personnel, which includes military physicians, DO or MD, who are physically and operationally qualified are to be recognized as members of the military in the United States without regard to race, color, creed, national origin, medical degree, gender, gender identity or sexual preference; and that the AOA oppose any attempt, either by legislation, directive or hierarchal order, that seeks to infringe upon this status.

Source: H305-A/23
Status: 2018; 2023 Adopted as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H305-A-23_Equality_in_the_Military_(H354-A18).pdf

H622-A/23 Protection of the Patient-Physician Relationship and Opposition to Physician Penalties for the Provision of Gender Affirming Care
The American Osteopathic Association (AOA) supports policy that all patients, continue to have access to medically comprehensive evidence-based gender affirming care; and that the AOA opposes any policy that penalizes physicians for recommending and/or providing requested medically comprehensive evidence-based gender affirming care to their patients.

Source: H622-A/23
Status: 2023

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H622-A-23_Protection_of_the_Patient_Physician_Relationship_and_Opposition_to_Penalties_for_Gender_Affirming_Care.pdf

H628-A/23 In Support of Training and Advocacy for Diverse Patient Populations Including but Not Limited to LGBTQ2+ Within Residency

The American Osteopathic Association (AOA) encourages all graduate medical education programs to implement inclusive curricula promoting advocacy for patients of all sexual orientations and gender identities.

Source: H628-A/23
Status: 2023

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H628-A-23_In_Support_of_Training_and_Advocacy_for_Diverse_Populations_not_limited_to_LGBTQ2_within_Residency.pdf

H616-A22 Opposition to the Practice of LGBTQIA2S+ Conversion Therapy or Reparative Therapy

The American Osteopathic Association affirms that identifying as lesbian, gay, bisexual, transgender, questioning queer, or other than heterosexual (LGBTQIA2S+) is not a mental disorder. Sexual orientation and gender identity are not mental disorders.

The AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity as the preferred outcome.

The AOA supports potential legislation, regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity as the preferred outcome.

Source: H616-A22
Status: 2017; 2022 Reaffirmed as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H616-A-22_Opposition_to_the_Practice_of_LGBTQIA2SConversion_Therapy_or_Reparative_Therapy.pdf

H204-A/21 Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth

The American Osteopathic Association recognizes the importance and supports advocacy that acknowledge LGBTQ identities, and the implementation of anti-bullying policies that specifically protect children from harassment based on sexual orientation or gender identity in educational settings.

Source: H204-A/21
Status: 2021

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy-H204-A-21-Protective-Educ-Envir-for-LGBTQ.pdf

H206/A-21 Optional Correct Pronoun Demographic on General Medical Education Applications

The American Osteopathic Association (AOA) supports the inclusion of an optional pronoun demographic inquiry on medical school, residency, and fellowship application forms.

Source: H206-A/21
Status: 2021

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy-H206-A-21-Optional-Correct-Pronoun-Demographic-on-GME-Applications.pdf

H434-A/21 Lesbian, Gay, Bisexual, Transgender, Queer / Questioning, Intersex, Asexual Protection Laws

The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (LGBTQIA+) individuals from discriminating practices and harassment and reaffirms equal rights and protections for all patient populations as stated in the AOA Rules and Guidelines on Professional Conduct.

Source: H434-A/21
Status: 2016; 2021 Reaffirmed as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy-H434-A-21-Lesbian,-Gay,-Bisexual,-Transgender,-Queer-Questioning-Intersex,-Asexual-Protection-Laws-Updated-082021.pdf

H619-A/21 Expanding Gender Identity Options on Physician Intake Forms

The American Osteopathic Association (AOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their assigned sex at birth (male, female, intersex) and gender identity (male, female, transgender male, transgender female, nonbinary, additional category with blank for patient to complete).

Source: H619-A/21
Status: 2016; 2021 Reaffirmed as Amended

https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy-H619-A-21-Expanding-Gender-Itendity-Options-on-Physician-Intake-Forms-Updated-082021.pdf

SUBJECT: SUPPORT INTERPRETATION OF MEDICAL INFORMATION AMONG THE GENERAL PUBLIC

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, many patients and community members are seeking medical information from someone other than their physicians and licensed medical providers; and

WHEREAS, there is an abundance of medical information available to the public that is both legitimate and non-legitimate[1]; and

WHEREAS, the general public may be unaware how to interpret the information that is widely available via social media and other sources which may lead them to a false conclusion[2]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) encourage the education of the general public on how to interpret medical information to determine its legitimacy; and be it further

RESOLVED, that the American Osteopathic Association (AOA) encourage education of the general public and promote access to resources that help the public interpret medical information.

References

1. [1]Suarez-Lledo V, Alvarez-Galvez J. *Prevalence of Health Misinformation on Social Media: Systematic Review*. J Med Internet Res 2021; 23(1):e17187
2. [2]United States, Congress, Office of the Surgeon General, and Vivek H Murthy. *Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment.* 2021.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

The AOA Communications and Marketing department ensure well-researched, proven resources are updated on osteopathic.org and shared across all social media platforms to proactively education the general public.

FISCAL IMPACT: $0

ACTION TAKEN: _REFERRED (*Ohio Osteopathic Association*)____

DATE: __July 16, 2022_____

SUBJECT: RECOGNIZING THE DISPROPORTIONATE ~~PREVALENCE~~ **MORTALITY FROM** ~~OF~~ CARDIOVASCULAR DISEASE IN THE AFRICAN AMERICAN POPULATION AS A PUBLIC HEALTH ISSUE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, African Americans are more likely to die of cardiovascular disease, more likely to have hypertension, and less likely to have it controlled in comparison to Caucasians[1]; and

WHEREAS, even with continued national decline in mortality rates for heart disease, rates for African Americans were still 20% higher for heart disease and 40% higher for stroke as compared to the Caucasian population[2]; and

WHEREAS, African Americans are less likely to be tested and prescribed lipid-lowering drugs than Caucasian men[3]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognize the disproportionate ~~prevalence of~~ **MORTALITY FROM** cardiovascular disease in the African American population as a public health issue, **FOR WHICH GREATER AWARENESS AND RESEARCH IS NEEDED.**

References

1. Heart disease and African Americans. (2022). Minorityhealth.hhs.gov; U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19#:~:text=In%202018%2C%20African%20Americans%20were

2. Noonan, A.S., Velasco-Mondragon, H.E. & Wagner, F.A. Improving the health of African Americans in the USA: an overdue opportunity for social justice. Public Health Rev 37, 12 (2016). https://doi.org/10.1186/s40985-016-0025-4

3. Dorsch, M. P., Lester, C. A., Ding, Y., Joseph, M., & Brook, R. D. (2019). Effects of Race on Statin Prescribing for Primary Prevention With High Atherosclerotic Cardiovascular Disease Risk in a Large Healthcare System. Journal of the American Heart Association, 8(22). https://doi.org/10.1161/jaha.119.014709

Background Information: Provided by AOA Staff

Current AOA Policy:

H428-A/20 Minority Health Disparities

Cardiovascular and cerebrovascular disease is listed as one of the identified areas of disparity in policy H428-A/20.

Prior HOD action on similar or same topic:

H319-A/19 Cardiovascular Disease and Women

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE ___July 16, 2022_____

SUBJECT: STANDARDIZED SCREENING FOR INTIMATE PARTNER VIOLENCE FOR ALL INDIVIDUALS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the National Intimate Partner and Sexual Violence Survey defines intimate partner violence (IPV) as sexual violence, stalking, physical violence, and psychological aggression to include spouses, boyfriends, girlfriends, people with whom they dated, were seeing, or "hooked up"[1]; and

WHEREAS, IPV affects greater than 32 million Americans, and can occur among individuals with any sexual orientation or gender identity[2], which has been identified as a significant public health issue in the U.S. by the Centers for Disease Control (CDC) and the U.S. Preventive Services Task Force (USPSTF)[3]; and

WHEREAS, the lifetime economic cost associated with medical services for IPV-related injuries, lost productivity from paid work, criminal justice and other costs, was $103,767 for women and $23,414 for men over a victim's lifetime[1]; and

WHEREAS, IPV screening recommendations are conflicting between organizations on which populations should be screened and when[3,4]; and

WHEREAS, the AMA has policy recommending universal screening for all individuals for intimate partner violence[5]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) collaborate with appropriate stakeholders to identify and subsequently implement a standardized universal screening tool for intimate partner violence in all individuals in seeking intimate relationships regardless of race, ethnicity, sexual orientation, gender identity, ability, religious/spiritual identity, national identity, age, and socioeconomic status during each initial encounter and at least annually thereafter.

References:

1. Centers for Disease Control and Prevention. (2015). National Intimate Partner and Sexual Violence Survey: 2015 Data Brief - Updated Release. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf.
2. Weil, A. (2021) Intimate Partner Violence: Diagnosis and Screening. UpToDate. Retrieved from https://www.uptodate.com/contents/intimate-partner-violence-diagnosis-and-

screening?search=IPV%20diagnosis%20and%20screening&source=search_result&selectedTitle=1~96&usage_type=default&display_rank=1

3. US Preventive Services Task Force. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement. JAMA, 320(16), 1678–1687. https://doi.org/10.1001/jama.2018.14741
4. Health Resources & Services Administration. (2020) Women's Preventive Services Guidelines. Health Resources & Services Administration. Retrieved from https://www.hrsa.gov/womens-guidelines-2016/index.html
5. Family and Intimate Partner Violence, H-515.965 (2019). https://policysearch.ama-assn.org/policyfinder/detail/intimate%20partner%20violence?uri=%2FAMADoc%2FHOD.xml-0-4664.xml

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
H-441 - A/2017 Response to H-400-A/16 Violence and Abuse Prevention and Education
H-418 - A/2019 Domestic and Intimate Partner Violence – Development of Programs to Prevent
H-634 - A/2018 Recognizing Sexual Assault Survivors' Rights

FISCAL IMPACT: $0

ACTION TAKEN ___REFERRED (*Student Osteopathic Medical Association*)__

DATE __July 16, 2022_____

SUBJECT: SUPPORT FOR INCREASED CRISIS INTERVENTION TEAM TRAINING FOR LAW ENFORCEMENT

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, law enforcement officers often serve as first-line responders and primary gatekeepers that determine whether the mental health or criminal justice system can best meet the needs of the individual suffering from an acute psychiatric crisis[1]; and

~~WHEREAS, approximately 1 in 4 deaths by law enforcement involves a person with a mental health illness[2]; and~~

~~WHEREAS, relative to law enforcement; encounters with patients exhibiting signs of excited delirium are 70% less likely to end in fatality when paramedics are first to respond[3]; and~~

WHEREAS, Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction between persons with mental illness and police officers[2]; and

WHEREAS, officers' confidence in their abilities and preparedness to handle calls involving persons with mental illness is positively associated with implementation of CIT training[4]; and

WHEREAS, CIT-trained officers were more efficient in safely deescalating situations involving a subject with psychosis when compared to non CIT-trained officers[5]; and

WHEREAS, over 15,000 officers were assaulted while interacting with a person with a mental illness between 2007 and 2017[6]; and

WHEREAS, CIT-trained officers become better able to identify mental health crises and refer more often to mental health services with subsequent decreased arrest rates[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage increased resources and training initiatives, such as the crisis intervention team (CIT) and other continued best practices, for law enforcement to improve patient safety and reduce negative outcomes for patients.

References

1. Wood J, Beierschmitt L. (2014) Beyond police crisis intervention: Moving "upstream" to manage cases and places of behavioral health vulnerability. Int J Law Psychiatry. 2014;37(5):439-447. doi:10.1016/j.ijlp. https://doi.org/10.1016/j.ijlp.2014.02.016
2. Rogers MS, McNiel DE, Binder RL. (2019) Effectiveness of Police Crisis Intervention Training Programs. J Am Acad Psychiatry Law. 2019;47(4):414-421. doi:10.29158/JAAPL.003863-19
3. James, D.J., Glaze, L.E. (2006). Mental health problems of prison and jail inmates. Bureau of Justice Statistics.
4. Boren, E. A., Folk, J. B., Loya, J. M., Tangney, J. P., Barboza, S. E., & Wilson, J. S. (2018). The Suicidal Inmate: A Comparison of Inmates Who Attempt Versus Complete Suicide. Suicide & life-threatening behavior, 48(5), 570- 579. https://doi.org/10.1111/sltb.12374
5. Strömmer, E.M.F., Leith, W., Zeegers, M.P. et al. (2020) The role of restraint in fatal excited delirium: a research synthesis and pooled analysis. Forensic Sci Med Pathol 16, 680–692 https://doi.org/10.1007/s12024-020-00291-8
6. Agee, E. R., Zelle, H., Kelley, S., & Moore, S. J. (2019). Marshaling administrative data to study the prevalence of mental illness in assault on law enforcement cases. Behavioral Sciences & the Law, 37(6), 636–649. https://doi.org/10.1002/bsl.243
7. Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, B. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. Psychiatric services (Washington, D.C.), 65(4), 523–529. Retrieved September 21, 2020 from https://doi.org/10.1176/appi.ps.201300108

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic:

H435-A/21 Evidence Based Treatment Programs for Substance Use Disorders (SUD)
H410-A/21 Improving Outcomes in Behavioral Health Care in The Emergency Department
H449-A/20 Homeless Support
H-408 – A/2021 Increased Law Enforcement Resources and Training for Response in Mental Health Crises was submitted by SOMA in 2021 and referred back to SOMA for review.

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED__

DATE ___July 16, 2022_____

SUBJECT: INCREASED RESEARCH ON THE PUBLIC HEALTH IMPACTS OF DECRIMINALIZING POSSESSION OF ALL ILLICIT DRUGS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the term "illicit drug use" is defined as the use of substances (not including alcohol or tobacco products) that are illegally obtained or involve non-medical use of prescription medications[1]; and

WHEREAS, there is no statistically significant relationship between incarceration for drug offenses and lower rates of drug use, drug arrests, or overdose deaths[2]; and

WHEREAS, multiple studies have shown an increased risk of overdose in individuals following incarceration and suggest diverting individuals away from the criminal justice system[3,4]; and

WHEREAS, the recommendation to address substance use disorders as public health problems instead of criminal justice issues was unanimously adopted by all 193 member states at the 2016 United Nations General Assembly Special Session on drugs[5]; and

WHEREAS, the World Health Organization, the United Nations Office of the High Commissioner for Human Rights, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Organization of American States, the International Federation of the Red Cross and Red Crescent Societies, the Global Commission on Drug Policy, and the American Public Health Association have all urged for decriminalization[6]; and

WHEREAS, other interventions in lieu of incarceration, such as supervised consumption facilities (SCFs), have been demonstrated to consistently benefit people who use drugs, including the mitigation of overdose-related harms and unsafe drug use behaviors[7]; and

WHEREAS, a review of several European countries that have already implemented policies that decriminalize possession of illicit drugs, found public health benefits but noted the need for more research to provide more ground for policy consideration[8]; and

WHEREAS, in November 2020 Oregon became the first state in the U.S. to decriminalize possession of all illicit drugs, but there has been little data collected on the outcomes of the measure thus far[9]; now, therefore be it

31 RESOLVED, that the American Osteopathic Association (AOA) encourages
32 increased research and data collection on the public health outcomes
33 associated with decriminalizing the possession of all illicit drugs.

References

1. US Preventive Services Task Force. Primary Care–Based Interventions to Prevent Illicit Drug Use in Children, Adolescents, and Young Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2020;323(20):2060–2066. doi:10.1001/jama.2020.6774)

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3. Joudrey, P. J., Khan, M. R., Wang, E. A., Scheidell, J. D., Edelman, E. J., McInnes, D. K., & Fox, A. D. (2019). A conceptual model for understanding post-release opioid-related overdose risk. Addiction Science & Clinical Practice, 14(1). https://doi.org/10.1186/s13722-019-0145-5

4. Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Annals of internal medicine, 159(9), 592–600. https://doi.org/10.7326/0003-4819-159-9-201311050-00005)

5. Volkow, N. D., Poznyak, V., Saxena, S., Gerra, G., & UNODC-WHO Informal International Scientific Network (2017). Drug use disorders: impact of a public health rather than a criminal justice approach. World psychiatry : official journal of the World Psychiatric Association (WPA), 16(2), 213–214. https://doi.org/10.1002/wps.20428

6. Stauffer, B. (2019, June 28). Every 25 Seconds The Human Toll of Criminalizing Drug Use in the United States. Human Rights Watch. https://www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states.

7. Kennedy, M. C., Karamouzian, M., & Kerr, T. (2017). Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. Current HIV/AIDS reports, 14(5), 161–183. https://doi.org/10.1007/s11904-017-0363-y

8. Unlu, A., Tammi, T., & Hakkarainen, P. (2020). Drug decriminalization policy : Literature review: Models, implementation and outcomes. International Drug Policy Consortium. https://idpc.net/publications/2020/06/drug-decriminalization-policy-literature-review-models-implementation-and-outcomes

9. Drug Addiction Treatment and Recovery Act, Oregon Legislature (2020) (testimony of Michael Lantz & Brian Nieubuurt). https://www.oregonlegislature.gov/lpro/Publications/Background-Brief-Measure-110-(2020).pdf

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic:
H300-A/21 Medication for Opioid Use Disorder (MOUD) Availability for Incarcerated Individuals and/or Individuals Under Correctional Control Policy Statement

H322-A/20 Prescription Drug Diversion and Abuse – Education, Research, And Advocacy

H424-A/21 Research on Medical Cannabis

H443-A/17 Harm Reduction Modalities for People Who Inject Drugs – Update to white paper submitted to the 2022 HOD to Reaffirm as Amended.

H628-A/18 Cannabis Reclassification: Effect on Research

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED_____

DATE ____July 16, 2022_____

SUBJECT: IMPROVING RESIDENT MEMBER INCLUSION AND RETENTION IN HOUSE OF DELEGATES PROCEEDINGS

SUBMITTED BY: New Jersey Association of Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA House of Delegates provides opportunities for member delegates to participate in AOA business; and

WHEREAS, osteopathic resident physicians are very likely to practice in the same state in which they complete their residency training; and

WHEREAS, state associations offer opportunities to young physicians to fellowship and join in advocacy for our profession and our patients; and

WHEREAS, the AOA is strengthened by improved and sustained participation by new physician members, and recognizing that increasing resident opportunities to participate with the AOA will likely contribute to engaging our profession's future leaders; and

WHEREAS, the Resident American Academy of Osteopathy (RAAO) delegates have a national rather than regional reach and interest; and

WHEREAS resident membership in state societies provide a seamless transition to maintain engagement with the AOA after completing residency training; now, therefore be it

RESOLVED, that those resident members of AOA state societies be eligible to serve as official state delegates, limited to no more than 1/3 of total of that state's delegates in attendance.

References:

1. Balthazar, P., Sekhar, A. & Magudia, K. New blood: trainee and early career engagement augmenting the society of abdominal radiology experience. Abdom Radiol 46, 5475–5479 (2021). https://doi.org/10.1007/s00261-021-03144-2
2. 40 Specific Member Engagement Tactics Any Organization Can Use. https://blog.accessdevelopment.com/40-specific-member-engagement-tactics-any-organization-can-use

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN DISAPPROVED

DATE July 16, 2022

SUBJECT: AMERICAN OSTEOPATHIC SOCIETY FOR RHEUMATIC DISEASE CHARTER OF AFFILIATION REVOCATION

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the American Osteopathic Society for Rheumatic Diseases (AOSRD) was originally chartered by the American Osteopathic Association (AOA) as an affiliated organization with a particular focus for osteopathic physicians whose practices involved rheumatology and rheumatologic diseases; and

WHEREAS, the AOSRD has undergone significant organizational change and its promotional information describes itself as – "the integrative medicine subspecialty within the American Osteopathic Association" and states further that "physicians, students, nurse practitioners, nurses, pharmacists, physical and occupational therapists, and physicians assistants interested in autoimmune and rheumatic disease issues, integrative, holistic, and osteopathic medicine and those interested in the latest research in lipidology and new concepts in the diagnosis of and treatment of traumatic brain injury"[1]; and

WHEREAS, charters of affiliation are, under the AOA's Bylaws (Article I, Section 3) are issued by the House of Delegates based on recommendation of the Board of Trustees; and

WHEREAS, based on information provided by the AOSRD to the Committee on Governance and Organizational Structure (CAGOS), the AOA Board of Trustees believes that the AOSRD has significantly changed its organizational purpose and mission from its original purpose (advancing osteopathic treatment of rheumatology and rheumatologic disease) to integrative medicine and the AOA Board of Trustees are recommending that the AOSRD's charter of affiliation be revoked; now, therefore be it

RESOLVED, that the House of Delegates revoke AOSRD's charter of affiliation.

Explanatory Statement:
The AOSRD would be allowed to seek a new charter of affiliation from the AOA consistent with its current activities and membership by utilizing the procedure set out in Article I, Section 3 of the Bylaws.

Reference
1. See www.emedevents.com/organizer-profile/american-osteopathic-society-of-rheumatic-diseases

Background Information: Provided by AOA Staff
Current AOA Policy: If an affiliate's charter is revoked, they are not eligible to be an AOA CME Sponsor until a new charter is granted.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $19,000 Annually
As a chartered affiliate, AOSRD remits the fees to be a CME sponsor. If AOSRD is not chartered, the organization would not be eligible to be a CME sponsor and therefore these fees would no longer be remitted. This would result in a revenue loss of $1,000.

Additionally, the AOA participates in a revenue share with AOSRD for the sale of their OMED online enduring program. To date, the AOA has received an average of $4,500 from two quarterly distributions. For a full year, this would equate to $18,000.

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION-NEW PHYSICIAN IN PRACTICE DEFINITION ***(Second Read)***

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Constitution and Bylaws currently describes a "new physician in practice" in the AOA Constitution, Article VIII, Section 1-C. as, "…an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College of Accreditation within the last 10 years"; and

WHEREAS, the AOA Department of Professional Affairs/Membership categorizes "new physicians in practice" as osteopathic physicians in the first three years following completion of their postdoctoral training program[1]; and

WHEREAS, that the AOA policy H349-A17 defines a new physician in practice as a "physician no more than five years past the completion of postdoctoral training"; and

WHEREAS, the proposed amendment was presented for first reading at the July 2021 House of Delegates annual meeting; now, therefore, be it,

RESOLVED, that the AOA House of Delegates clarifies the "new physician in practice" definition by approving the following amendments to the American Osteopathic Association Constitution:

AOA Constitution

Article VIII – Board of Trustees and Executive Committee, Section 1-C
One new physician in practice member elected by the House of Delegates to serv~~EICE~~ for one year. Candidates for the NEW physician in practice position ~~shall be~~ (osteopathic physicians who have completed their postdoctoral training within the past five years) ~~or received the DO degree within the previous ten years~~ shall be nominated by the ~~council of new physicians in practice;~~ **BUREAU OF EMERGING LEADERS. CANDIDATES MUST BE MEMBERS IN GOOD STANDING OF THE AOA.**

Reference

1. Membership Dues Rates. The American Osteopathic Association.https:/osteopathic.org/about/aoa-membership/membership-dues-rates. Accessed March 11, 2021.

Background Information: Provided by AOA Staff

Current AOA Policy: H349-A/2017 The American Osteopathic Association defines a new physician in practice as a "physician is not more than five years past the completion of postdoctoral training".

Prior HOD action on similar or same topic:

H349-A/2017 Defining New Physicians in Practice – Reaffirmed 2017

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED_

DATE _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION- NAME OF THE AOA JOURNAL
(Second Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the current procedure for amending the AOA's Constitution described in Article IX of the AOA Constitution calls for providing notice to members through publication in the on-line edition of *The Journal of the American Osteopathic Association*; and

WHEREAS, in January 2021, the AOA announced that it was changing the name of *The Journal of the American Osteopathic Association* to *the Journal of Osteopathic Medicine*; and

WHEREAS, the proposed amendment to the AOA Constitution was presented for first reading at the July 2021 House of Delegates annual meeting; now, therefore, be it,

RESOLVED, that the AOA House of Delegates approved the following amendments to the American Osteopathic Association Constitution:

AOA Constitution

Article IX – Amendments
This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by US mail or electronic mail to each divisional and specialty society entitled to and voting representatives to the House of Delegates, posted on the AOA's website, and published in the on-line edition of *the Journal of* ***OSTEOPATHIC MEDICINE*** ~~*the American Osteopathic Association*~~ not less than two months nor more than four months prior to the meeting at which they are to acted upon.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO ARTICLE VI, SEC 1 B OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(First Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VI – House of Delegates - Section 1 - Composition, Part B Student Council Representation – of the Constitution at the 2023 House of Delegates annual meeting: now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VI – House of Delegates, Section 1 - Composition, Part B (Student Council Representation)

B. Student Council Representation in Divisional Societies

Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by ~~the association~~ THE COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION (COCA) and located in the state represented by that divisional society, such student delegate IS to be elected according to the Bylaws of the American Osteopathic Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____FIRST READ_____

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO ARTICLE VI SEC 1 D OF AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(First Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VI – House of Delegates – Section 1 – Composition – Part D - of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VI - House of Delegates, Section 1 - Composition

D. REPRESENTATION OF OSTEOPATHIC POSTDOCTORAL TRAINEES AND NEW PHYSICIANS IN PRACTICE. OSTEOPATHIC PHYSICIANS IN POSTDOCTORAL TRAINING AND NEW PHYSICIANS IN PRACTICE SHALL BE REPRESENTED BY THREE DELEGATES TO BE SELECTED BY THE BUREAU OF EMERGING LEADERS AS PROVIDED IN THE BYLAWS OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___FIRST READ_____

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO ARTICLE VII SEC 2 OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(First Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article VII – Officers – Section 2 – Administrative Officers – of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article VII - Officers, Section 2- Administrative Officers
The administrative officers shall be Chief Executive Officer, a ~~controller~~ CHIEF FINANCIAL OFFICER, a General Counsel, and an Editor-IN-CHIEF who shall all be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __FIRST READ_____

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO ARTICLE X OF THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION
(First Read)

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the procedure for amending the Constitution of the American Osteopathic Association (AOA), as described in Article IX of the Constitution requires that all proposed amendments be presented to the House of Delegates and filed with the Chief Executive Officer at the annual meeting in the year prior to its presentation to the House of Delegates for action; and

WHEREAS, the Board of Trustees Committee on AOA Governance and Organizational Structure has undertaken a review of the AOA's Constitution and Bylaws and intends to present proposed changes to Article X – Gender Disclaimer – of the Constitution at the 2023 House of Delegates annual meeting; now, therefore be it

RESOLVED, that the official meeting record reflect that a first reading of the following amendment has been presented at the July 2022 annual meeting of the AOA House of Delegates and filed with the Chief Executive Officer of the AOA so that it can be presented for action at the 2023 House of Delegates:

AOA Constitution

Article X - Gender Disclaimer
The American Osteopathic Association is open to **ALL** persons ~~of both sexes~~ and does not discriminate against any persons because of ~~sex~~ **THEIR GENDER IDENTITY**; therefore, the wording herein importing the masculine or feminine gender ~~includes the~~ **IS INCLUSIVE OF ALL** ~~other~~ gender **IDENTITIES** and imports no such discrimination.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___FIRST READ_____

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS - ARTICLE II SECTION 2F

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the American Osteopathic Association (AOA) Bylaws (Article II–Membership, Section 1 F and Section 2, Paragraph F) defines membership classification for Honorary Members; and

WHEREAS, the AOA has other avenues, such as awards and presidential citations, to recognize significant contributors to the osteopathic profession; and

WHEREAS, there have been no members in this category in the past five (5) years; now, therefore be it

RESOLVED, that the AOA remove the Honorary Member classification; and be it further

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article II – Membership, Section 1 - Classification
The members of this Association shall be classified as follows:

a. Regular Members
b. Honorary Life Members
c. Life Members
d. Associate Members
e. Student Members
~~f. Honorary Members~~
~~g~~. F. International Physician Members
~~h.~~ G.Allied Members

~~f. Honorary Member~~

~~By specific action of the Board of Trustees, honorary membership may be granted to individuals, not eligible for any other category of membership, who support the goals and objectives of this Association. Such honorary members shall not be required to pay dues or assessments. They shall receive complimentary copies of the Association's publications and such other services as authorized by the Board of Trustees. Honorary members shall not be eligible for membership in the House of~~

~~Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the AOA Yearbook and Directory shall be provided. Such membership, when conferred, shall remain in full force and effect unless revoked by action of the Board of Trustees of the American Osteopathic Association~~

Background Information: Provided by AOA Staff

Current AOA Policy:

The AOA has eight (8) membership classifications defined in its Bylaws. A total of three (3) Honorary Members have been recognized by the AOA House of Delegates. Each year, the AOA recognizes individuals who have contributed to the advancement of the osteopathic profession through its awards program. Honoring such individuals through an award or presidential citation in lieu of Honorary membership provides AOA a way to highlight achievements and celebrate accomplishments of our greatest champions.

Honorary Members**:** Anne Wittner; Norman Gevitz, PhD; Mario Lanni.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – DELETE REFERENCES TO AOA YEARBOOK & DIRECTORY

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA no longer publishes nor distributes the AOA Yearbook and Directory; and

WHEREAS, the Yearbook and Directory are referenced at various places in the AOA's Bylaws; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article II - Membership, Section 2 - Membership Requirements, part d (Associate Member)
~~Special listing in the *AOA Yearbook and Directory of the Osteopathic Profession* shall be provided.~~

Article II – Membership , Section 2 - Membership Requirements, part e (Student Member)
Each student member shall receive such publications and other literature~~, except the *AOA Yearbook and Directory*,~~ as may be directed by the Board of Trustees or House of Delegates.

Article II - Membership, Section 2 - Membership Requirements, part f (Honorary Member)
~~Special listing in the *AOA Yearbook and Directory* shall be provided.~~

Article II - Membership, Section 2 - Membership Requirements, part g (International Physician Members)
~~Special listing in the *AOA Yearbook and Directory* shall be provided.~~

Article II - Membership, Section 2 - Membership Requirements, part h (Allied Member)
~~Special listing in the *AOA Yearbook and Directory* shall be provided.~~

Article VIII - Duties of Officers, Section 9 (Editor)
The Editor shall:

a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of The Journal of Osteopathic Medicine, **AND** other periodical publications of the Association ~~and of the AOA Yearbook and Directory,~~ under the general supervision of the Chief Executive Officer, and shall cooperate with all departments of the central office.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE II-SECTION 2H

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the Bureau of Professional Education previously served as the recognized accrediting agency within the American Osteopathic Association for accreditation of colleges of osteopathic medicine; and

WHEREAS, due to a restructuring of the operations in the AOA's Department of Educational Affairs in 2004, the Bureau of Professional Education was eliminated and its functions were divided between two entities – (1) a Bureau of Osteopathic Education; and (2) a Commission on Osteopathic College Accreditation (COCA); and

WHEREAS, accreditation issues for colleges of osteopathic medicine are now handled by the COCA; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws to update the name of the accreditation agency for colleges of osteopathic medicine:

AOA Bylaws

Article II - Membership, Section 2 - Membership Requirements, Part h (Allied Member)
Individuals who have received their training and/or degree in osteopathic medicine from a school that is not accredited by the ~~AOA Bureau of Professional Education~~ **COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION (COCA**) are not eligible for membership in the AOA.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VI – SECTION 1

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the language used in the current AOA Bylaws to describe the qualifications for service as an elected officer also includes additional language that describes criteria for service on an AOA Bureau, Committee, or Committee; and

WHEREAS, the criteria for service on an AOA Bureau, Committee, or Council is better addressed in Article IX of the Bylaws, where Bureaus, Committees and Councils are described; and

WHEREAS, it is necessary to amend the AOA's Bylaws to provide for a clear definition of qualifications for service as an elected officer; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article VI - Elections, Section 1—Qualifications **FOR ELECTED POSITIONS** ~~Except where positions are designated as public members, m~~Membership in both the AOA and a divisional society shall be a requisite for qualification for any officer. ~~or for any member of any department, division, bureau or committee of the Association, however selected, if the incumbent shall be an osteopathic or allopathic physician.~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS - ARTICLE VI-SECTION 4

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the installation of the AOA President and President-elect often takes place prior to the installation of other officers and trustees in their positions; and

WHEREAS, it is necessary to amend the AOA's Constitution and Bylaws to reflect the clarification of the installation process for elected officers and trustees; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article VI – Elections, Section 4 - Installation
THE AOA PRESIDENT AND PRESIDENT-ELECT SHALL BE INSTALLED IN THEIR POSITIONS DURING THE ANNUAL MEETING AT A TIME TO BE DESIGNATED IN THE OFFICIAL MEETING AGENDA. ALL OTHER ~~The officers who have served throughout that meeting shall complete all business of the annual meeting so far as is practicable. The~~ officers-elect **AND TRUSTEES-ELECT** shall be installed as the final order of business and shall assume the authority of their respective offices upon adjournment of the meeting.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII-SECTION 1B, ARTICLE VIII-SECTION 7, ARTICLE VIII-SECTION 9

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, two of the AOA's identified staff officer positions are "Controller" and "Editor"; and

WHEREAS, the duties of the position are better described as "Chief Financial Officer" to reflect the title of the position and "Editor-in-Chief" to reflect that the position is different than the other editors employed by AOA; and

WHEREAS, it is necessary to amend the AOA's Bylaws to change all references to the position title from Controller to Chief Financial Officer and Editor to Editor-in-Chief; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article VII - Board of Trustees, Section 1 – Duties, Part b
b. Appoint a Chief Executive Officer, a ~~Controller~~, **CHIEF FINANCIAL OFFICER**, a General Counsel, and an Editor-**IN-CHIEF**, and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, ~~Controller~~, **CHIEF FINANCIAL OFFICER**, General Counsel, Editor-**IN-CHIEF** and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the Association and not fixed by these Bylaws.

Article VIII – Duties of Officers, Section ~~6~~ 7 – ~~Controller~~ **CHIEF FINANCIAL OFFICER**
The ~~Controller~~ **CHIEF FINANCIAL OFFICER** shall:

Article VIII – Duties of Officers, Section ~~8~~ 9– Editor-**IN-CHIEF**
The Editor-**IN-CHIEF** shall:

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII-SECTION 1C

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Board of Trustees would like to clarify the respective roles of the Board of Trustees and House of Delegates with respect to the AOA's budgeting process; and

WHEREAS, the House of Delegates does not approve the AOA's expenditures as described in the AOA's Bylaws (Article VII, Section 1, part c), but does review the budget prepared by the Board of Trustees; and

WHEREAS, it is necessary to amend the AOA's Bylaws to better reflect the duties of the Board of Trustees and the House of Delegates with respect to the annual budget; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article VII - Board of Trustees - Section 1-Duties, Part c
Have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, **THE ANNUAL BUDGET** ~~all expenditures thereof~~. It shall appoint a certified public accountant to audit the financial records of the Association and certify to the accuracy of the statement of financial condition of the Association to be reported at the annual meetings.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED__

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII-SECTION 1E

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Bylaws currently does not specify the mechanism through which the AOA should distribute the Administrative Guide to its divisional societies and specialty affiliates; and

WHEREAS, the most cost-effective mechanism for allowing access to the Administrative Guide is through publication on the AOA's website and distribution by electronic mail; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article VII - Board of Trustees, Section 1-Duties, Part e

e. Maintain and revise the Administrative Guide annually. The general purpose of this manual shall be to provide a handy reference book of concise statements of the duties of all officials, committees, departments, bureaus and employees of the Association, to the end that there shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be ~~furnished~~ **PUBLISHED ON THE ASSOCIATION'S WEBSITE AND THEREBY MADE AVAILABLE** to each divisional society and affiliated organization as well as officers of the American Osteopathic Association and other groups or individuals as directed by the Board of Trustees of the Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED___

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE IX

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the current language used to identify the criteria for service as a member of an AOA Bureau, Committee, or Council is currently included in Article VI (Elections), Section 1 (Qualifications) of the AOA Bylaws; and

WHEREAS, A separate resolution H-513 – A/2022, if approved, will delete the language from Article VI, Section 1 that describes the criteria for service on an AOA Bureau, Council, or Committee; and

WHEREAS, the criteria for service as a member of an AOA Bureau, Committee or Council should be included in the section of the Bylaws that describes the bureaus, councils, and committees; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article IX - Departments, Bureaus, and Committees
The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association's departments shall include the Departments of Affiliate Relations, Finance, Education, Governmental Affairs, Membership, and Research and Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

EXCEPT WHERE POSITIONS ARE DESIGNATED FOR PUBLIC MEMBERS (I.E., NON-PHYSICIANS SERVING ON A BUREAU OR COMMITTEE WHO ARE INTENDED TO REPRESENT AND SPEAK FOR THE INTERESTS OF THE PUBLIC AND CONSUMERS OF OSTEOPATHIC MEDICAL SERVICES), MEMBERSHIP IN BOTH THE AOA AND A DIVISIONAL SOCIETY SHALL BE A REQUISITE FOR QUALIFICATION FOR SERVICE ON A BUREAU, COUNCIL,

OR COMMITTEE OF THE ASSOCIATION, HOWEVER SELECTED, IF THE INCUMBENT SHALL BE AN OSTEOPATHIC OR ALLOPATHIC PHYSICIAN.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE XI-SECTION 2

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Bylaws (Article XI) currently require that members receive a minimum of five days prior notice of proposed amendments to the AOA's Articles of Incorporation Board of Trustees; and

WHEREAS, five days may not provide members with sufficient opportunity to review and consider the proposed amendments to the Articles of Incorporation before the House of Delegates can change the Articles of Incorporation;

WHEREAS, it is necessary to amend the AOA's Bylaws to change the current procedure for amending the Articles of Incorporation; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

AOA Bylaws

Article XI – Amendments, Section 2 - Articles of Incorporation
The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes to be effected thereby shall be posted on the AOA's website and delivered not less than ~~five~~ **TWO WEEKS** nor more than 40 days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each delegate entitled to vote at such meeting.

Written or printed notice shall include the printing of the amendment in the electronic and/or printed issue of *The Journal of Osteopathic Medicine* published not less than ~~five days~~ **TWO WEEKS** or more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE XII

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Board of Trustees, on recommendation of the Committee on AOA Governance & Organizational Structure (CAGOS), approved a resolution that calls for changing language for the gender disclaimer applicable to interpreting the AOA's Bylaws; and

WHEREAS, it is necessary to amend the current disclaimer language in the AOA's Bylaws; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws

AOA Bylaws

Article XII - Gender Disclaimer
The American Osteopathic Association is open to **ALL** persons ~~of both sexes~~ and does not discriminate against any persons because of ~~sex~~ **THEIR GENDER IDENTITY**; therefore, the wording herein importing the masculine or feminine gender ~~includes the~~ **IS INCLUSIVE OF ALL** ~~other~~ gender **IDENTITIES** and imports no such discrimination.

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED_

DATE: _____July 16, 2022_____

SUBJECT: OSTEOPATHIC NEUROLOGIC AND PSYCHIATRIC STANDARD OF CARE - SOURCE: H604-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health/Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health/Council
5 on State Health Affairs recommends that the following policy be
6 REAFFIRMED.

7 The American Osteopathic Association acknowledges the role osteopathic
8 manipulative treatment (OMT) has in the specialty of Osteopathic Neurology
9 and Psychiatry and agrees that when OMT is chosen to be utilized with
10 appropriately selected patients, therapeutic boundaries will be maintained
11 and respected.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2010; 2017 Reaffirmed)

Prior HOD action on similar or same topic:
H349-A/19 OMT Privileges – Support For; and as noted above

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: PHYSICIAN / PATIENT EDUCATIONAL MATERIALS RECEIVED FROM PHARMACEUTICAL COMPANIES THAT PRODUCE AND/OR MARKET GENERIC MEDICATIONS - SOURCE: H615-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic encourages pharmaceutical companies that produce
7 and/or market generic medications to provide educational materials about
8 their products to both physicians and patients.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed; 2017 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: OSTEOPATHIC MUSCULOSKELETAL EVALUATION – SOURCE: H623-A/17

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association urges ~~the~~ osteopathic physicianS to integrate the musculoskeletal evaluation, along with the concepts of body unity, self-regulation, and structure-function interrelationships, into their clinical evaluation of each patient and include the findings in a plan for treatment.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1982; 1987 Reaffirmed; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed)

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED AS AMENDED

DATE: _____July 16, 2022_____

SUBJECT: ADJUSTMENT TO PRIMARY CARE INCENTIVE PROGRAM
SOURCE: H602-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be ~~SUNSET.~~ **REAFFIRMED AS AMENDED.**

The American Osteopathic Association is supportive of ~~a~~ **AT LEAST** 10% incentive payment to primary care physicians and non-physician providers (NPPs), supervised by primary care physicians, who perform the Primary Care Services. ~~specified in The Affordable Care Act, Section 5501(a); and, after the demonstration period is completed, the AOA will work to have the US Congress instruct the Centers for Medicare & Medicaid Services (CMS) to continue to modify the existing qualifications in the Affordable Care Act for the 10% incentive payment by eliminating the Physician's Primary Care Incentive threshold, thereby including many more or all primary care physicians who perform the specified primary care services.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed as Amended).
Note: The relevant provision in the Affordable Care Act has expired.

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED___

DATE: ____July 16, 2022_____

SUBJECT: PHYSICIAN DEPOSITIONS - SOURCE: H605-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association believes that physicians being deposed
7 should have the right to review and amend the deposition prior to submission
8 and be provided a complete, final copy of the deposition.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2012; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: THE PRACTICE OF OSTEOPATHIC MEDICINE DISCRIMINATION –SOURCE: H608-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association supports the inclusion of osteopathic physicians in all healthcare delivery systems; opposes restraint of trade and supports the ability of all osteopathic physicians to practice freely in all institutions, as qualified by training and experience as defined and specified by the AOA; and opposes discrimination against osteopathic physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1987; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed as Amended; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: DRUG PRESCRIBING, INCLUDING ELDERLY PATIENTS – SOURCE: H609-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports measures to significantly reduce
7 the problems of over-medication, under-medication and / or harmful drug
8 interactions in all patients, including the elderly population. ~~and supports having only~~
9 ~~osteopathic and allopathic physicians prescribe or supervise prescriptions written by~~
10 ~~non-physician clinicians.~~

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2002, 2007 Reaffirmed as Amended; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV) – POSITIVE STATUS AS A DISABILITY FOR PHYSICIANS - SOURCE: H610-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports efforts to require all disability
7 insurance contracts to recognize HIV positive status as a disability for all physicians,
8 regardless of specialty, provided that the physician can demonstrate that this status
9 has caused a significant loss of patients, income or privileges.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992; 1997 Reaffirmed as Amended; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: HEALTH CARE FRAUD AND ABUSE - SOURCE: H611-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association continues to pledge its full cooperation and
7 support of all reasonable and appropriate efforts by the federal government
8 and the states to stop all fraud and abuse in health care.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1992;1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: _____ADOPTED___

DATE: ____July 16, 2022_____

SUBJECT: MILITARY MEDICAL READINESS - SOURCE: H613-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports efforts by the Department of
7 Defense which encourage the voluntary participation of osteopathic
8 physicians in the military and improves the military medical readiness of
9 America.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1987; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __ADPOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: PAYMENT FOR PSYCHIATRIC DIAGNOSES AND TREATMENT BY PRIMARY CARE PHYSICIANS - SOURCE: H618-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association strongly objects to any insurance plan
7 refusal to pay primary care physicians for treating patients with psychiatric
8 diagnoses without a referral from the behavioral medicine agency or
9 provider; will make every effort to influence these insurers to reverse this
10 policy and allow primary care physicians to provide care for these patients
11 and be paid for these services; and will communicate with the regulators and
12 respective third-party payers to eliminate the mandatory referral in order to
13 be paid when proper documentation is provided.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: PHYSICIAN FINES IMPOSED BY THIRD PARTY PAYORS – SOURCE: H621-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association opposes all punitive fees, hold backs or
7 other financial penalties levied on physicians for acts committed by patients that are
8 not under the absolute control of the physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED____

DATE: ____July 16, 2022_____

SUBJECT: HEALTH CARE INSURANCE OPTIONS - SOURCE: H622-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on State Health Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports legislation that requires employers
7 who are obligated by law to provide insurance to offer more than one option
8 for health insurance.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (1986; 1991 Reaffirmed as Amended, 1992, 1997; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: PHYSICIAN PAYMENT IN FEDERAL PROGRAMS – SOURCE: H624-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes there is on-going need for the policy and has provided amendments to provide clarity on the policy; now, therefore be it ~~now, therefore be it~~

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association recommends that educational programs for osteopathic medical students, interns, residents and practicing physicians should include utilization management and cost-effectiveness to support their understanding of working in alternate payment models; recommends that the osteopathic staff members of health care institutions should continue to improve utilization review programs for all patients, consistent with quality assurance and sound osteopathic medical practice; and if states adopt alternate payment systems for Medicaid, that they contain a provision to ensure the fullest participation of all physicians, ensuring best patient care and adequate compensation to all parties concerned~~, while preserving referral patterns~~ **INCLUDING REFERRALS**.

Background Information: Provided by AOA Staff

Current AOA Policy: As noted above (1986; 1991 Reaffirmed as Amended; 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: __ADOPTED AS AMENDED___

DATE: ___July 16, 2022_____

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV) CONSENT FORM ELIMINATION - SOURCE: H625-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the elimination of the requirement
7 of physicians and healthcare settings to have consent forms completed
8 before an HIV test.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: ____July 16, 2022_____

SUBJECT: DIRECT PRIMARY CARE - SOURCE: H628-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the direct primary care model of
7 practice and specifies that it is not insurance. **ADDITIONALLY, THE AOA**
8 ~~and~~ supports patients' payments to direct primary care practices as qualified
9 medical expenses eligible for Health Savings Accounts through federal
10 changes to Internal Revenue Code 213(d) and 223(c) and a physician's
11 ability to dispense prescription medications from their office in accordance
12 with applicable federal and state laws. The AOA supports mechanisms
13 allowing Medicaid and Medicare patients access to direct primary care
14 services while preserving physician autonomy.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED___

DATE: ___July 16, 2022_____

SUBJECT: OPPOSITION TO THE PRACTICE OF LGBTQIA**2S**+ CONVERSION THERAPY OR REPARATIVE THERAPY – SOURCE: H629-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, LGBTQIA**2S**+ is an inclusive term that includes people of all genders and sexualities, and is the preferred terminology; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association affirms that ~~individuals who~~ **identify<u>ING</u> as lesbian, gay, bisexual, transgender, questioning~~, identifying as~~ queer, or other than heterosexual (LGBTQ<u>IA2S</u>+) <u>IS</u> ~~are~~ not ~~inherently suffering from~~ a mental disorder. SEXUAL ORIENTATION AND GENDER IDENTITY ARE NOT MENTAL DISORDERS.**

The AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity **AS THE PREFERRED OUTCOME**.

The AOA supports potential legislation, regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity **AS THE PREFERRED OUTCOME.**

~~**The AOA opposes the use of Sexual Orientation Change Efforts (SOCE), which is based on the assumption that homosexuality is a mental disorder that should be changed and states that any effort by an osteopathic physician to participate in any SOCE activity is considered unethical.**~~

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

<u>FISCAL IMPACT</u>: $0

ACTION TAKEN: ___ADOPTED AS AMENDED___

DATE: ___July 16, 2022_____

SUBJECT: STANDING AGAINST SEXUAL ORIENTATION CHANGE EFFORTS (SOCE)- SOURCE: H635-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be SUNSET.

6 The American Osteopathic Association opposes the use of Sexual Orientation
7 Change Efforts (SOCE), which is based on the assumption that
8 homosexuality is a mental disorder that should be changed.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017)

Prior HOD action on similar or same topic: Policy included in H629-A/17; and as noted above.

FISCAL IMPACT: $0

ACTION TAKEN: _ADOPTED (***for Sunset***)

DATE: ___July 16, 2022_____

SUBJECT: PATIENT INTERPRETETERS - SOURCE: H636-A/17

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is scheduled for sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports efforts to remove from Section
7 1557 of the Affordable Care Act the unfunded mandate on physicians to
8 provide interpreters for those patients with Limited English Proficiency (LEP)
9 by revising the current federal policy to include adequate reimbursement for
10 physicians for patient interpreters.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: AOA OPPOSITION TO MERGING OF STATE OSTEOPATHIC LICENSING BOARDS WITH STATE MEDICAL LICENSING BOARDS
SOURCE: H637-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, there are currently thirteen states with separate DO and MD boards; and

WHEREAS, the AOA only engages on state issues upon request by – or with the assent of – relevant state associations; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association stands in opposition to the consolidation of any state osteopathic and medical licensure boards. The AOA will actively monitor for activities that threaten separate state osteopathic licensing boards in the ~~fourteen~~ states where they exist~~s~~ and will prioritize its resources to **OPPOSE** ~~aggressively combat any and all~~ ~~threats~~ **EFFORTS** to consolidate state osteopathic and medical licensing boards.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: July 16, 2022

SUBJECT: PRESCRIPTION DRUG PRICING - SOURCE: H638-A/17

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is scheduled for sunset review; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association will advocate for policies that encourage pharmaceutical manufacturers, prescription drug benefit managers, pharmacies, and payers to price drugs and insurance products ~~on~~ THAT COVER prescription drugs in order to promote access, affordability, and continued advancement of healthcare quality and innovation.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2017).

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ___ADOPTED AS AMENDED__

DATE: ____July 16, 2022_____

SUBJECT: Addressing Insurance Denials

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Ad Hoc Committee

WHEREAS, 91% of physicians perceived a somewhat or significant negative impact of prior authorization process on clinical outcomes, 93% of physicians felt there was a delay in necessary care due to the prior authorization process, and 34% of physicians report that prior authorization has led to a serious adverse event for a patient in their care[1], and

WHEREAS, the average denials rate is up 20% since 2016, with 10.8% of claims being initially denied in 2020[2], and

WHEREAS, data shows that 86% of denials are potentially avoidable, with reasons ranging form lack of denials resources, staff attrition and training, a growing denials backlog, and legacy technology[2], and so be it

RESOLVED, the American Osteopathic Association (AOA) will develop resources to share with affiliates that educate physicians on guidelines to avoid claims denials and successfully appeal claims denials, and further be it

RESOLVED, the American Osteopathic Association supports requirements that all insurance company medical directors and physicians participating in reviewing requests, engaging in peer-to-peer reviews, and/or issuing denials should be licensed to practice medicine in the state for which the patient resides, and further be it

RESOLVED, the American Osteopathic Association supports requirements that all insurance company medical directors and physicians engaging in peer-to-peer reviews be board certified in the specialty of the physician requesting the peer-to-peer review, and further be it

RESOLVED, the American Osteopathic Association supports a time limit on insurers responding to appeals of denials so that patient care is not delayed beyond a reasonable amount of time for the condition in question and if the time limit is not met, approval is deemed granted, and further be it

RESOLVED, the American Osteopathic Association supports simplification of healthcare plans so that patients, healthcare providers, and hospitals easily understand coverage and the patient's out-of-pocket expenses, and finally be it

RESOLVED, the American Osteopathic Association initiate federal legislation to achieve the above goals.

References:
1. [1]https://cdn.ymaws.com/www.maops.org/resource/resmgr/2022_committees/insurance_denials_fat/prior-authorization-survey.pdf
2. [2]https://cdn.ymaws.com/www.maops.org/resource/resmgr/2022_committees/insurance_denials_fat/The_Change_Healthcare_2020_R.pdf

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

The Physician Services Department (PS) team provided numerous presentations at Affiliate conferences as well as "Lunch and Learns" on coding, billing, denials, and audits. Several of these programs are available on-demand at https://www.thecmecenter.org/.

The PS team established elevated contacts with the 5 major payers and meets with them monthly, as needed or at least annually to express AOA member concerns as well as learn about new policies. Information gained through these relationships and through PS staff research are available on the Private Payer Advocacy and News - American Osteopathic Association website.

Educational webinars developed by the PS team regarding topics impacting physicians are also available on the AOA Online Learning platform for CME.

The PS team also provides individual support to members and their staff regarding reimbursement, denials, audits, and other practice related issues. These services are also available to Affiliates to allow them to assist their members. The AOIA Physician Services team can be reached by email physicianservices@osteopathic.org or phone: 312/202-8194.

FISCAL IMPACT: $0

ACTION TAKEN: _REFERRED (*MAOPS*)_

DATE: ____July 16, 2022_____

SUBJECT: REDUCING THE WAITING PERIOD FOR CREDENTIALING, RECREDENTIALING AND ENROLLMENT OF HEALTH CARE PROFESSIONALS BY HEALTH PLANS

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, credentialing and privileging are essential for healthcare quality, safety, and risk management; and

WHEREAS, credentialing is required for all licensed individual health care professionals to participate with health insurance companies; and

WHEREAS, physician credentialing, the process of evaluating the qualifications and practice history of a physician, can sometimes take as long as 120 days, subsequently sidelining physicians and creating barriers to patient care; and

WHEREAS, delays in the credentialing process add administrative costs that are especially damaging to physicians in rural communities and those who have recently completed graduate medical education programs; and

WHEREAS, the credentialing process is prone to human error, which in turn results in missing data and delayed delivery of information, which then ultimately leads to delays in patient care; and

WHEREAS, the credentialing process is time-consuming, costly, dangerous, and often inaccurate with 85 percent of applications missing critical information that is required for processing; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate for transparent, unburdensome, timely, and cost effective credentialing processes; and, be it further

RESOLVED, that the AOA advocate for legislation, and provide sample language, recommending the reduction of the length of time required for credentialing, ~~re-credentialing~~ **RECREDENTIALING** and enrollment by any health plan to 60 days **OR LESS** when a clean provider application is submitted to the health plan.

References

1. "Pennsylvania Health Care Workforce Needs." Joint State Government Commission, General Assembly of the Commonwealth of Pennsylvania. Staff Study. Published 4/2019.
2. 155 Rural Hospital Closures: January 2005–Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina.
   September 2019 analysis of data from the Kaiser Family Foundation and CAQH.
3. Wikler E, Bausch P, Cutler DM. Reducing Administrative Costs and Improving the Health Care System." New England Journal of Medicine 367, no. 20. 11/15/2012.
4. MedPage Today's KevinMD.com

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE ___July 16, 2022_____

SUBJECT: **INCLUSION OF** DIVERSE ~~EXPANDING SEVEN CORE COMPETENCIES TO INCLUDE~~ PATIENT POPULATIONS INCLUDING BUT NOT LIMITED TO LGBTQ+ WITHIN STANDARDIZED PATIENT EDUCATION

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Ad Hoc Committee

WHEREAS, the population of individuals identifying as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) is rapidly growing within the United States, underscoring the importance of physician competency when working with these patients[6]; and

WHEREAS, the American Osteopathic Association (AOA) supports the inclusion of the evolving understanding of sex and gender based medicine in the medical education programs and curricula across the continuum as stated in H214-A/18 SEX AND GENDER BASED MEDICINE[2]; and

WHEREAS, lack of provider competency and fear of provider discrimination have been cited as some of the greatest barriers to LGBTQ+ healthcare access since data has been collected in these populations[1, 4], especially within transgender/gender non-conforming populations, who disproportionally experience health inequities, in part, due to the exclusion of transgender-specific health needs from medical school and residency curricula[1]; and

WHEREAS, involvement of LGBTQ+ individuals in standardized patient panels have been shown to improve attitudes regarding the LGBTQ+ community and provide anecdotal evidence suggesting increased awareness of implicit bias among students, and suggests that discomfort when working with this community may come from a lack of exposure to this patient population[6,3]; and

WHEREAS, there is evidence that suggests that students who participate in trainings that include such standardized patient panels feel more confidence using personal pronouns and taking history, regardless of prior exposure to the LGBTQ+ community[8,5]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA), ~~in accordance with the AOA Seven (7) Core Competencies~~, supports osteopathic medical training by promoting inclusion of diverse standardized patient panels, **INCLUDING PATIENTS OF ~~WITH~~ ~~BUT NOT~~ ~~LIMITED TO~~ ~~LGBTQIA2S+~~ ~~VARIOUS~~ ALL SEXUAL ORIENTATIONS AND GENDER IDENTITIES ~~PATIENTS~~**.

References:

1. Dubin, S. N., Nolan, I. T., Streed, C. G., Jr, Greene, R. E., Radix, A. E., & Morrison, S. D. (2018). Transgender health care: improving medical students' and residents' training and awareness. *Advances in medical education and practice*, *9*, 377–391. https://doi.org/10.2147/AMEP.S147183
2. *H214-A/18 SEX AND GENDER BASED MEDICINE [PDF]. (2018). The American Osteopathic Association (AOA).*
3. Kelley, Leah; Chou, Calvin L.; Dibble, Suzanne L.; Robertson, Patricia A. 2008. *A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students. Teaching and Learning in Medicine, 20(3): 248–253.*
4. Lambda Legal. When healthcare isn't caring: Lambda Legal's survey on discrimination against LGBT people and people living with HIV. New York: Lambda Legal 2010.
5. Minturn MS, Martinez EI, Le T, et al. 2021. Early Intervention for LGBTQ Health: A 10-Hour Curriculum for Preclinical Health Professions Students. *MedEdPORTAL*, 17:11072.
6. Morris, M., Cooper, R.L., Ramesh, A. *et al.* 2019.Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC Med Educ* 19: 325.
7. National Board of Osteopathic Examiners. 2016.Fundamental Osteopathic Medical Competency Domains 2016. Guidelines for Assessment for Osteopathic Medical Licensure and the Practice of Osteopathic Medicine.
8. Silverberg R, Averkiou P, Servoss J, Eyez M, Martinez LC. 2021. Training Preclerkship Medical Students on History Taking in Transgender and Gender Nonconforming Patients. Transgend Health. Dec 2;6(6):374-379

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___REFERRED (*OPSC*)___

DATE ____July 16, 2022_____

SUBJECT: EXPANDING SCHEDULED DIALYSIS SERVICES TO ALL PATIENTS WITH END STAGE KIDNEY DISEASE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, immigration status is an important limiting factor in determining the provision of dialysis and kidney-related care, and nephrologists report an increasing prevalence of providing care to undocumented immigrants[1]; and

WHEREAS, undocumented immigrants nationwide are ineligible for Medicare or financial assistance through the Affordable Care Act and most cannot afford private insurance, making emergency hemodialysis the only option for treatment[2]; and

WHEREAS, one study finds that switching from emergency-only dialysis to outpatient dialysis in undocumented immigrants was associated with a cost reduction of $5,768 per person per month[3]; and

WHEREAS, the national cost of providing undocumented immigrants with routine dialysis is approximately $260 million, compared to the significant financial benefit undocumented persons have contributed to the social safety net they are disallowed from utilizing—approximately $15 billion in Social Security payroll taxes annually[4]; and

WHEREAS, the inability to provide needed services for patients based on citizenship alone creates a significant emotional and physical burden for physicians, including the emotional toll of witnessing patient suffering, the depersonalization of patients to avoid distress at the inability to care for them properly, and physical exhaustion from overworking in order to bridge care[5]; and

WHEREAS, 12 states have already enacted policies expanding access to outpatient dialysis services to undocumented immigrants with ESRD[6]; and

WHEREAS, in states where undocumented immigrants qualify only for emergency dialysis there is an association with increased length of hospital stay, cost, and emotional burden on the patient, in addition to a 14-fold higher mortality rate in comparison to those receiving the standard of care[2]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage expansion of outpatient scheduled dialysis services for all patients with end stage kidney disease regardless of their citizenship status to reduce the overall cost and burden to the healthcare system.

References

1. Ornelas IJ, Yamanis TJ, Ruiz RA. The Health of Undocumented Latinx Immigrants: What We Know and Future Directions. Annu Rev Public Health. 2020 Apr 2;41:289-308.doi:10.1146/annurev-publhealth-040119-094211. PMID: 32237989
2. Rizzolo K, Cervantes L. Immigration status and end-stage kidney disease: Role of policy and access to care. Seminars in dialysis. 2020;33(6):513-522. doi:10.1111/sdi.12919
3. Nguyen OK, Vazquez MA, Charles L, et al. Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease. JAMA Intern Med.2019;179(2):175–183. doi:10.1001/jamainternmed.2018.5866
4. Rodriguez RA. Dialysis for undocumented immigrants in the United States. Adv Chronic Kidney Dis. 2015 Jan;22(1):60-5. doi: 10.1053/j.ackd.2014.07.003. PMID: 25573514
5. Cervantes, L., Richardson, S., Raghavan, R., Hou, N., Hasnain-Wynia, R., Wynia, M. K., Kleiner, C., Chonchol, M., & Tong, A. (2018). Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants: A Qualitative Study. Annals of Internal Medicine, 169(2), 78–86. https://doi.org/10.7326/M18-0400
6. Rizzolo K, Novick TK, Cervantes L. Dialysis Care for Undocumented Immigrants With Kidney Failure in the COVID-19 Era: Public Health Implications and Policy Recommendations. Am J Kidney Dis. 2020;76(2):255-257. doi:10.1053/j.ajkd.2020.05.001

Background Information: Provided by AOA Staff

Current AOA Policy:

H338-A/18 Uninsured – Access to Health Care

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___DISAPPROVED____

DATE _____July 16, 2022_____

SUBJECT: Approval to Concur with the AOA FY2023 Expenditures

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board of Trustees "have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, all expenditures thereof."; and

WHEREAS, the Joint Board/House Budget Review Committee convened on July 15, 2022 to review and accept the AOA FY2023 Operating Budget, the AOA FY2023 Capital Expenditures Budget and the AOA FY2023 142 E. Ontario Building budget reports as submitted; and be it

RESOLVED, the American Osteopathic Association House of Delegates concur with the FY2023 expenditures as provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

ACTION TAKEN: ____ADOPTED_____

DATE: _____July 16, 2022_____

SUBJECT: BUDGET ADJUSTMENT PARAMETERS

SUBMITTED BY: Joint Board House Budget Review Committee

REFERRED TO: AOA House of Delegates

WHEREAS, the Finance Committee reviewed the Budget Adjustment Parameters Policy and believes it remains relevant and appropriate; now, therefore, be it

WHEREAS, the House of Delegates met in July, 2022 and approved the following Budget Adjustment Parameters Policy:

"RESOLVED, that without explicit approval of the Joint Board/House Budget Review Committee the AOA Board of Trustees may take no financial actions between meetings of the AOA House of Delegates which when taken together either decrease AOA's cash or increase its long term or recurring short term debt (to include operating leases and other contractual obligations) to an aggregated amount greater than 10% of the AOA's total equity as audited in the prior year; and, be it ~~further~~

RESOLVED, that this policy will be reviewed by the Joint Board/House Budget Review Committee every three years.", ~~and~~ **AND BE IT FURTHER**

RESOLVED, THAT THE JOINT BOARD/HOUSE BUDGET REVIEW COMMITTEE RE-AFFIRMS ITS SUPPORT OF THE BUDGET ADJUSTMENT PARAMETERS POLICY.

~~RESOLVED, that this resolution be forwarded to the Joint Board/House Budget Review Committee for consideration.~~

Explanatory Statement:
The above budget adjustment parameters were initially approved by the Joint Board/House Budget Review Committee in July 1995. These parameters were re-affirmed by the Joint Board/House Budget Review Committee in July 1998, July 2001, July 2004, July 2007, July 2010, July 2013, July 2016, July 2019 and July 2022. These budget adjustment parameters were reviewed and approved by the Joint Board/House Budget Review Committee in July 2022 as part of the three-year review process as required by the initial resolution.

Continuation of this policy is in accord with the specific subset of the budget adjustment provision contained in the Reserve Requirement Policy.

ACTION TAKEN: __ADOPTED AS AMENDED_____

DATE: __July 16, 2022_____

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
EDUCATIONAL AFFAIRS (200 SERIES)

House Of Delegates' Reference Committee Description:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Maintenance of Primary Board Certification for Subspecialty Certification	AOAAM	Educational Affairs	NOT ADOPTED
H-201	Vital Nature of Board-Certified Physicians in Aerospace Medicine	AOCOPM	Educational Affairs	ADOPTED as AMENDED
H-202	~~Training High Quality Physicians in a Healthy and Safe Environment~~ - WITHDRAWN BY AUTHOR	MAOP	Educational Affairs	WITHDRAWN
H-203	Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post-Graduate Medical Training	NYSOMS	Educational Affairs	ADOPTED as AMENDED
H-204	Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth	OOA	Educational Affairs	ADOPTED as AMENDED
H-205	Resolution Withdrawn			
H-206	Optional Correct Pronoun Demographic on General Medical Education Applications	BEL	Educational Affairs	ADOPTED
H-207	Referred Res. No. H-219 – A/2019 Osteopathic Manipulative Treatment Boot Camp	BOS	Educational Affairs	ADOPTED as AMENDED
H-208	~~Osteopathic Board Payment Reform~~ WITHDRAWN BY UNANIMOUS CONSENT	MOA	Educational Affairs	WITHDRAWN
H-209	Restoring An Equitable and Positive Learning Environment in Medical Training	MOA	Educational Affairs	REFERRED TO AUTHOR
H-210	Access To Healthcare-Developing a New Model of Administering Osteopathic Primary Care in the U.S. (SR-Source: H201-A-16)	BOE	Educational Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
EDUCATIONAL AFFAIRS (200 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-211	~~Depression~~ ACCESS TO MENTAL HEALTH SERVICES AND Awareness in U.S. OSTEOPATHIC Medical Students (SR-Source: H203-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-212	Disaster Response ~~Courses and~~ Training ~~Within Colleges of Osteopathic Medicine~~ (SR-Source: H204-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-213	Academic Osteopathic Educators, Researchers or Administrators Educational Program Development (SR-Source: H205-A/16)	BOE	Educational Affairs	ADOPTED (SUNSET)
H-214	Uniform Title for Osteopathic Medical Students (SR-Source: H208-A/16)	BOE	Educational Affairs	ADOPTED
H-215	Tobacco Free AND VAPING FREE Colleges / Schools of Osteopathic Medicine (SR-Source: H209-A/16)	BORPH	Educational Affairs	ADOPTED as AMENDED
H-216	Rural Healthcare Provided by Current ~~AOA~~ GME Programs – Preservation of (SR-Source: H211-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-217	Drug Stimulant Abuse in the Academic Setting – Education and Resources for (SR-Source: H213-A/16)	BOE	Educational Affairs	ADOPTED
H-218	Graduate Medical Education Funding and Incentives (SR-Source: H329-A/16)	CERA/BFH/ CSHA	Educational Affairs	ADOPTED
H-219	Promotion Of Osteopathic Medicine to Disadvantaged High School Students (SR-Source: H402-A/16)	BORPH	Educational Affairs	ADOPTED
H-220	Residency Training in Canada – Equality Between COCA- Accredited and LCME-Accredited Medical School Graduates Seeking (SR-Source: H641-A/16)	BOE	Educational Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PROFESSIONAL AFFAIRS (300 SERIES)

House of Delegates' Reference Committee Description:
Committee on Professional Affairs (300 series)
This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Medication For Opioid Use Disorder (MOUD) Availability for Incarcerated Individuals and/or Individuals Under Correctional Control	AOAAM	Professional Affairs	ADOPTED as AMENDED
H-301	Availability of Modalities of Prescribing	OOA	Professional Affairs	ADOPTED as AMENDED
H-302	Improving Insulin Affordability	SOMA	Professional Affairs	ADOPTED as AMENDED
H-303	Direct Acting Therapy for Hepatitis C Limitations	OOA	Professional Affairs	ADOPTED as AMENDED
H-304	Extension of the Shelf-Life Extension Program (SLEP) by the FDA	OOA	Professional Affairs	ADOPTED as AMENDED
H-305	Increasing Voter Access ~~Amongst~~ FOR Hospitalized Patients	SOMA	Professional Affairs	ADOPTED as AMENDED
H-306	Support of Continued Funding for ~~Americorps National Service Programs~~ CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)	SOMA	Professional Affairs	ADOPTED as AMENDED
H-307	Appropriate PPE Usage PROVISIONS	BEL	Professional Affairs	ADOPTED as AMENDED
H-308	Referred Sunset Res. No. H300-A/20; H327-A/15 intractable and / or Chronic Pain (Not Associated with End of Life Care)	CSHA	Professional Affairs	ADOPTED as AMENDED

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2021 RESOLUTION ROSTER WITH ACTION
PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-309	Conflicts of Interest	MAOP	Professional Affairs	ADOPTED as AMENDED
H-310	Resolution Withdrawn			
H-311	Revision of the Invocation to Support Inclusive and Interfaith Language	MOA	Professional Affairs	ADOPTED as AMENDED
H-312	Support of State Societies (SR-Source: H207-A/16)	BOM	Professional Affairs	ADOPTED *for Sunset*
H-313	Center of Excellence for Stroke (SR-Source: H306-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-314	Voting Day – AOA Supports Voting Day Policy (SR-Source: H307-A/16)	BFHP	Professional Affairs	ADOPTED
H-315	Patient Care at Extended Long Term Care Facilities (SR-Source: H308-A/16)	BFHP	Professional Affairs	ADOPTED
H-316	Osteopathic Term Protection (SR-Source: H310-A/16)	CSHA	Professional Affairs	ADOPTED
H-317	Cyberbullying through Social Media (SR-Source: H316-A/16)	BORPH	Professional Affairs	ADOPTED
H-318	Firearms – Commission of A Crime While Using a Firearm (SR-Source: H318-A/16)	CSHA/BFHP	Professional Affairs	ADOPTED
H-319	Good Samaritan Acts (Hold Harmless Agreement) Performed on Commercial Aircraft (SR-Source: H319-A/16)	CSHA/BFHP	Professional Affairs	ADOPTED
H-320	Medicaid Pharmaceutical Benefits (SR-Source: H320-A/16)	CSHA	Professional Affairs	ADOPTED as AMENDED
H-321	MedicaL~~tion~~ Shortages (SR-Source: H330-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-322	Health Insurance Availability to Osteopathic Medical Students (SR-Source: H337-A/16)	BFHP	Professional Affairs	ADOPTED
H-323	Behavioral Health Services – Funding and Access ~~Patients in Emergency Departments Topic~~ (SR-Source: H338-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-324	Physician Gag Rules – Opposition to (SR-Source: H340-A/16)	BFHP	Professional Affairs	ADOPTED

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PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-325	Congressional Budget Office Fiscal Scoring (SR-Source: H343-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-326	Pain Related Education Requirements (SR-Source: H344-A/16)	CSHA	Professional Affairs	ADOPTED as AMENDED
H-327	Non-Physician Health Care Clinician (SR-Source: H346-A/16)	BFHP	Professional Affairs	ADOPTED
H-328	Eugenic Selection with Preimplantation Genetic Diagnosis (SR-Source: H349-A/16)	BFHP	Professional Affairs	REFERRED
H-329	Tricare Health Insurance for our Military (SR-Source: H350-A/16)	BFHP	Professional Affairs	ADOPTED
H-330	Osteopathic Manipulative Treatment (OMT) in the CDC Chronic Pain Management Guidelines – Inclusion of (SR-Source: H351-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-331	~~Baby Friendly~~ SUPPORT OF BREASTFEEDING ~~Hospital Initiative (BFHI)~~ (SR-Source: H403-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-332	Organ And Tissue Donation and Transplantation Initiatives – Commitment to (SR-Source: H411-A/16)	BORPH	Professional Affairs	ADOPTED
H-333	Vaccine Supply and Distribution (SR-Source: H416-A/16)	BORPH	Professional Affairs	ADOPTED
H-334	Health Literacy (SR-Source: H426-A/16)	BORPH	Professional Affairs	ADOPTED
H-335	Onsite Lab Work No. 1 (SR-Source: H600-A/16)	CERA	Professional Affairs	ADOPTED
H-336	Managed Care Referrals (SR-Source: H602-A/16)	CERA	Professional Affairs	ADOPTED
H-337	Medicare Physician Payment for Osteopathic Manipulative Treatment (SR-Source: H621-A/16)	CERA	Professional Affairs	ADOPTED
H-338	Drug Plan Coverage Denials (SR-Source: H628-A/16)	CERA	Professional Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-339	Payor Adherence to Current Procedural Terminology (CPT) And International Classification of Diseases (ICD) Coding Definitions (SR-Source: H630-A/16)	CERA	Professional Affairs	ADOPTED
H-340	Interference – Lawful Off-Label Treatment of Patients (SR-Source: H634-A/16)	BFHP/CSHA	Professional Affairs	ADOPTED
H-341	Appropriate Payment Mechanisms for Physician-Led Team-Based Health Care (SR-Source: H636-A/16)	CERA/CSHA	Professional Affairs	ADOPTED as AMENDED
H-342	Human Immunodeficiency Virus (HIV) (SR-Source: H408-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-343	Improving Access to Physician-Led Care	BOT	Professional Affairs	ADOPTED
H-344	Reforming the Health IT Landscape to Improve the Patient and Clinician Experience	BOT	Professional Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

House of Delegates' Reference Committee Description:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research, and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Endorse Nutritionally Balanced, Low Cost or Free Meals for Children in Schools	ACOFP	Public Affairs	ADOPTED as AMENDED
H-401	Supporting Public Policy to Encourage Wholesome Food Donations to Those in Need in America	MOA	Public Affairs	ADOPTED
H-402	Collection of Public Health Data Concerning Firearm Fatalities	MOA	Public Affairs	ADOPTED as AMENDED
H-403	Patient Centered Treatment for Pain Management and Appropriate use of Opioids	MOA	Public Affairs	ADOPTED
H-404	Physician Communication to Patients Regarding ~~COVID-19 Prevention~~ PUBLIC HEALTH CRISES	NYSOMS	Public Affairs	ADOPTED as AMENDED
H-405	Addressing Dermatologic Health Disparities in People of Color	SOMA	Public Affairs	NOT ADOPTED
H-406	Addressing Law Enforcement Disproportionate use of Force During Interactions with Marginalized Groups as a Public Health Issue	SOMA	Public Affairs	NOT ADOPTED
H-407	Addressing The Change in Climate Effects on National Health	SOMA	Public Affairs	ADOPTED as AMENDED
H-408	Increased Law Enforcement Resources and Training for Response in Mental Health Crises	SOMA	Public Affairs	REFERRED
H-409	Referred Resolution H437-A/19 – AOA Firearm Policy	BFHP	Public Affairs	ADOPTED
H-410	Improving Outcomes in Behavioral Health Care in the Emergency Department	BFHP	Public Affairs	ADOPTED as AMENDED
H-411	COVID-19 Anti-Asian Discrimination and Abuse	MOA	Public Affairs	NOT ADOPTED
H-412	Drug Samples (SR-Source: H327-A/16)	BFHP	Public Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-413	Concussion, Return-to-Play and Return-to-Learn (SR-Source: H352-A/16)	CSHA	Public Affairs	ADOPTED
H-414	Osteopathic Medicine -- Autonomy of (SR-Source: H401-A/16)	BOT	Public Affairs	ADOPTED
H-415	Chelation Therapy (SR-Source: H406-A/16)	BORPH	Public Affairs	ADOPTED
H-416	Minority Health and Osteopathic Medical Education (SR-Source: H409-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-417	Obesity in Children (SR-Source: H410-A/16)	BORPH	Public Affairs	ADOPTED
H-418	~~Fitness~~, Sports, FITNESS and Nutrition (SR-Source: H412-A/16)	BORPH	Public Affairs	ADOPTED
H-419	Plastic Beverage and Food Container Recycling Act (SR-Source: H413-A/16)	BORPH	Public Affairs	ADOPTED
H-420	Childhood And Teenage Sexual Exposure (SR-Source: H414-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-421	Tobacco Control – The Framework Convention on (SR-Source: H415-A/16)	BIOM	Public Affairs	ADOPTED
H-422	Damage to Hearing from use of Headphones (SR-Source: H417-A/16)	BORPH	Public Affairs	ADOPTED
H-423	Dangers of the "Choking Game" (SR-Source: H418-A/16)	BORPH	Public Affairs	ADOPTED
H-424	Medical USE OF Cannabis – Research On (SR-Source: H419-A/16)	BORPH	Public Affairs	ADOPTED
H-425	Sports And Prevention of Traumatic Brain Injury (SR-Source: H420-A/16)	CSHA	Public Affairs	ADOPTED *for sunset*

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2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-426	Blood Donors, Protection from Depletion of Iron (SR-Source: H423-A/16)	BORPH	Public Affairs	ADOPTED
H-427	5-2-1-0**+10** Campaign for America's Children (SR-Source: H424-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-428	Healthy, Hunger-Free Kids Act (SR-Source: H425-A/16)	BORPH	Public Affairs	ADOPTED *for sunset*
H-429	Obesity Epidemic – Addressing the American (SR-Source: H427-A/16)	BORPH	Public Affairs	ADOPTED
H-430	Mandatory Influenza Vaccine of Healthcare Personnel (SR-Source: H429-A/16)	BORPH	Public Affairs	ADOPTED
H-431	Title X Funded Family Planning Services – Support for (SR-Source: H433-A/16)	BORPH	Public Affairs	ADOPTED
H-432	Shackling Of Pregnant Inmates (SR-Source: H435-A/16)	BORPH	Public Affairs	ADOPTED
H-433	Cancer Clinical Trials – Explore Incentives to Increase Patient Involvement In (SR-Source: H438-A/16)	BORPH	Public Affairs	REFERRED
H-434	Lesbian, Gay, Bisexual, Transgender, Queer / Questioning **INTERSEX, ASEXUAL** Protection Laws (SR-Source: H439-A/16)	BFHP/CSHA	Public Affairs	ADOPTED as AMENDED
H-435	Substance Use Disorders (SUD) – Evidence Based Treatment Programs for (SR-Source: H440-A/16)	BORPH	Public Affairs	REFERRED
H-436	Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) – Affirming the Scientific and Medical Foundation of (SR-Source: H605-A/16)	BORPH	Public Affairs	ADOPTED
H-437	Third Party Payors Changing Classes of Medications (SR-Source: H607-A/16)	CERA	Public Affairs	ADOPTED
H-438	Physician Comparative Utilization & Profiling (SR-Source: H610-A/16)	CERA	Public Affairs	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-439	Physician Supply in Rural, Underserved United States – Recommendations for Improving (SR-Source: H613-A/16)	BFHP/CSHA	Public Affairs	ADOPTED
H-440	Alternative Payment Models – Ensuring DO Opportunities and Patient Access in (SR-Source: H616-A/16)	CSHA/CERA	Public Affairs	ADOPTED
H-441	Health Insurance Coverage for Medical and Surgical Treatments for Good Oral Health (SR-Source: H619-A/16)	CERA	Public Affairs	ADOPTED
H-442	Physician Profiles (SR-Source: H623-A/16)	CSHA	Public Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
CONSTIUTION AND BYLAWS (500 SERIES)

House of Delegates' Reference Committee Description:
Committee on Constitution and Bylaws (500 series)
This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-500	Clarifying Student Representation at the American Osteopathic Association House of Delegates Constitution Amendment *First Read Only in July 2021*	SOMA	Constitution & Bylaws	FIRST READ
H-501	~~Clarifying Student Representation at the American Osteopathic Association House of Delegates Bylaws Amendment~~ WITHDRAWN	SOMA	Constitution & Bylaws	WITH DRAWN BY AUTHOR
H-502	Amendment to the American Osteopathic Association Constitution– New Physician in Practice Definition *First Read Only in July 2021*	BEL	Constitution & Bylaws	FIRST READ
H-503	Amendments to the American Osteopathic Association Bylaws – Definition of Student Member	CAGOS	Constitution & Bylaws	ADOPTED as AMENDED
H-504	Amendments to the American Osteopathic Association Bylaws – Administration of Membership Dues	CAGOS	Constitution & Bylaws	ADOPTED as AMENDED
H-505	Amendments to the American Osteopathic Association Constitution – Name of AOA Journal *First Read Only in July 2021*	CAGOS	Constitution & Bylaws	FIRST READ
H-506	Amendments to the American Osteopathic Association Constitution – Procedure for Notice of Proposed Changes to Constitution	CAGOS	Constitution & Bylaws	ADOPTED as AMENDED
H-507	Amendments to the American Osteopathic Association Constitution – Names of AOA Departments	CAGOS	Constitution & Bylaws	ADOPTED as AMENDED
H-508	Amendments to the American Osteopathic Association Bylaws – Name of AOA Journal	CAGOS	Constitution & Bylaws	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
AD HOC (600 SERIES)

House of Delegates' Reference Committee Description:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Decreasing the Limitations on Prescribing Calcitonin Gene-Related Peptide (CGRP) Inhibitors in Primary Care	OOA	Ad Hoc	REFERRED
H-601	ADVOCATING FOR ~~Requiring the~~ Coverage of Elemental Formula in State, Federal, And Private Insurance Programs	BFHP	Ad Hoc	ADOPTED as AMENDED
H-602	Prior Authorization	CERA	Ad Hoc	ADOPTED
H-603	AOA Policy on Telehealth - H601-A/17	CERA	Ad Hoc	ADOPTED as AMENDED
H-604	Patient Access to Home Health Services	CERA	Ad Hoc	ADOPTED as AMENDED
H-605	Disaster Relief Volunteers (SR-Source: H313-A/16)	CSHA/BFHP	Ad Hoc	ADOPTED as AMENDED
H-606	Electronic Medical/Health Record Exemption Without Penalty (SR-Source: H326-A/16)	CERA	Ad Hoc	ADOPTED
H-607	Physician Administered OMT (SR-Source: H601-A/16)	CERA	Ad Hoc	ADOPTED
H-608	Mandatory Participation in Insurance Plans (SR-Source: H617-A/16)	CERA	Ad Hoc	ADOPTED
H-609	Medicare Claims Coding – Centers for Medicare and Medicaid Services Communications with Physicians (SR-Source: H620-A/16)	CERA	Ad Hoc	ADOPTED
H-610	Physician Negotiation Rights (SR-Source: H622-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
AD HOC (600 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-611	Readmission Rates by the Centers for Medicare and Medicaid Services as a Criterion for Ranking – Opposition to use of (SR-Source: H626-A/16)	CERA	Ad Hoc	ADOPTED
H-612	Current Procedural Terminology (CPT) Codes –Blending Rates (SR-Source: H629-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED
H-613	Health Insurance Exchanges (SR-Source: H633-A/16)	CERA	Ad Hoc	ADOPTED
H-614	Access To Care – Network Adequacy and Coverage (SR-Source: H635-A/16)	CERA/CSHA	Ad Hoc	ADOPTED
H-615	Third Party ~~Payor~~ INSURER Coverage Process Reform (SR-Source: H637-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED
H-616	Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMS) (SR-Source: H638-A/16)	BFHP	Ad Hoc	ADOPTED
H-617	Health Insurer Consolidation (SR-Source: H643-A/16)	CERA/CSHA /BFHP	Ad Hoc	ADOPTED as AMENDED
H-618	Medicare Medical Necessity Certification Requirements (SR-Source: H645-A/16)	BFHP	Ad Hoc	ADOPTED as AMENDED
H-619	Expanding Gender Identity Options on Physician Intake Forms (SR-Source: H647-A/16)	BORPH	Ad Hoc	ADOPTED as AMENDED

SUBJECT: MAINTENANCE OF PRIMARY BOARD CERTIFICATION FOR SUBSPECIALTY CERTIFICATION

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, in 2020 the Subspecialty and Conjoint Certification Task Force was formed, and
2 their charge included determining if the requirement for maintaining primary
3 certification could be dropped upon successfully passing the Osteopathic Continuous
4 Certification (OCC) Component 3 cognitive assessment of any subspecialty, CAQ, or
5 conjoint. Their recommendations were sent to the Bureau of Osteopathic Specialist
6 (BOS) for consideration.; and

7 WHEREAS, the BOS approved Resolution #2 which states "…conjoint certifications be
8 maintained as they are currently and continue to require maintenance of primary
9 certification as a requirement to maintain an active conjoint certification..."; and

10 WHEREAS, the AOA discussed the topic at their 2021 Midyear meeting and accepted the BOS
11 resolution; and

12 WHEREAS, the American Board of Preventive Medicine (ABPM) does not require diplomates
13 certified by the ABPM in a subspecialty to maintain their primary board in order to
14 maintain their ABPM subspecialty board certification; and

15 WHEREAS, maintaining a primary board certification as a condition of obtaining and
16 maintaining subspecialty certification puts DOs at an unfair disadvantage from their
17 ABPM diplomates certified in addiction medicine; and

18 WHEREAS, the maintenance of two board certifications after becoming certified in a
19 subspecialty creates a financial hardship for DOs who may not otherwise practice in
20 their primary board; now, therefore be it

21 RESOLVED, that the requirement for maintaining primary certification is dropped upon
22 successfully becoming recertified in any subspecialty, CAQ, or conjoint.

Background Information: Provided by AOA Staff

Current AOA Policy:

The BOS has the authority to take final action on specialty certifying board recommendations for certification, subspecialty certification and Osteopathic Continuous Certification (OCC) completion, subject to appeal, and report these actions to the Board of Trustees for information only. (B-02/94)

In 2020, at the direction of the BOS, the Subspecialty and Conjoint Certification Task Force was formed, and their charge included determining if the requirement for maintaining primary certification could be dropped upon successfully passing the Osteopathic Continuous Certification (OCC)

Component 3 cognitive assessment of any subspecialty, CAQ, or conjoint. The task force solicited input from each AOA specialty certifying board and submitted their recommendations to the BOS for consideration.

At its Midyear meeting in April 2021, the BOS approved Resolution #2 that states "…conjoint certifications be maintained as they are currently and continue to require maintenance of primary certification as a requirement to maintain an active conjoint certification..." The resolution includes an opportunity for the boards to submit a request to the BOS to drop the requirement for its diplomates to maintain primary certification while still maintaining their subspecialty/CAQ (non-conjoint) certification if they meet certain requirements.

The AOA Addiction Medicine subspecialty certification is a conjoint certification. The American Osteopathic Conjoint Examination Committee on Addiction Medicine (Conjoint Committee) administers the Addiction Medicine subspecialty certification and Osteopathic Continuous Certification (OCC) examinations. The Conjoint Committee is made up of representatives from each specialty certifying board that participates in the creation and administration of the Addiction Medicine subspecialty certification exam.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $646,400
Should the requirement for primary board certification be removed, it is estimated that 3,232 diplomates would no longer be required to seek primary board certification resulting in an estimated annual revenue reduction of $646,400.

ACTION TAKEN ____NOT ADOPTED___

DATE _____JULY 17, 2021_____

SUBJECT: VITAL NATURE OF BOARD-CERTIFIED PHYSICIANS IN AEROSPACE MEDICINE

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Committee on Educational Affairs

WHEREAS, Aerospace Medicine is an internationally recognized, unique specialty of medicine with advanced education requirements supporting all domains of aviation and space flight; and

WHEREAS, in over a century of support, the Aerospace Medicine Team, led by Aerospace Medicine physicians, has advanced the art and science of every human flight endeavor, resulting in improved safety, reduced mishaps, and enhanced mission accomplishment;

WHEREAS, Aerospace Medicine physicians are required to maintain their professional knowledge and standing with state medical licensure, current specialty board certifications, continuing medical education activities, and ongoing privileging; and have extensive knowledge, skills, and professional self-regulation in the full and total range of the practice of Aerospace Medicine; and

WHEREAS, in an effort to reduce costs, outsource work, and pass-on legal liability, there has been a trend in managed medical care, U.S. commercial airlines and in the U.S. governmental departments to replace Aerospace Medicine physicians with non-aerospace medicine mid-level providers (protocol driven, lack of specialty training/experience), resulting in significantly increased risk and reduced safety margins; and

WHEREAS, 193 state parties are signatories to the Convention on International Civil Aviation ("Chicago Convention"), which obliges the governments to reciprocally implement certain international regulatory standards, including physician responsibility pertaining to medical fitness of license holders, prevention of ill health and management of public health events in aviation, now, therefore be it

RESOLVED, that world legislative, regulatory and rule-making bodies codify the Aerospace Medicine specialty, practitioners and the unique leadership roles of Aerospace Medicine physicians; and be it further

RESOLVED, that the AOA recognizes the unique contributions and advanced qualifications of Aerospace Medicine professionals; and specifically opposes any and all efforts to remove, reduce or replace Aerospace Medicine physician leadership in civilian, corporate or government Aerospace Medicine programs and aircrew healthcare support teams; and be it further

RESOLVED, that the AOA advocates against ~~other~~ FURTHER Aerospace medicine mid-level provider scope of practice expansions that threaten the safety, health, and wellbeing of aircrew, patients, support personnel and the flying public.

Background Information: Provided by AOA Staff

Current AOA Policy:

H-623 A/18 Non-Physician Clinicians is similar in that it addresses the appropriate scope of practice for non-physician clinicians. It opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

Prior HOD action on similar or same topic:

H-623 A/18 Non-Physician Clinicians policy approved in 2018

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: PHYSICIAN DESIGNATION, TRUTH IN ADVERTISING AND RESIDENCY/FELLOWSHIP TRAINING NON-PHYSICIAN POST-GRADUATE MEDICAL TRAINING

SUBMITTED BY: New York State Osteopathic Medical Society (NYSOMS)

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Medical Association (AMA) recently compiled data regarding public perceptions and understanding of the terms "physician" and "doctor"; and

WHEREAS, data collected by the AMA's Scope of Practice Partnership (the American Osteopathic Association [AOA] is a partner member) Truth in Advertising campaign report that nearly 90% of patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician."[i]; and

WHEREAS, in the same campaign, nearly 80% of patients "support legislation to require all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promising their services"[ii]; and

WHEREAS, the Center for Medicare and Medicaid Services defines 'resident' as "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board"[iii]; and

WHEREAS, the term 'medical students' should apply exclusively to students who are enrolled in educational programs provided by a college of osteopathic medicine or allopathic medicine accredited by the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education which lead to the DO or MD degree; and

WHEREAS, there has been an increase in the number of physician assistant (PA) and nurse practitioner (NP) postgraduate programs, many of which are inappropriately referred to as "residencies" or "fellowships"; and

WHEREAS, on September 3, 2020, every major academic emergency medicine association issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship' in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs"[iv]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) amend policy such that wherever the term, "physician" appears, it is to mean, "DO or MD or a recognized international equivalent terminal degree in medicine," and be used exclusively by graduates from educational programs provided by a college of osteopathic medicine or allopathic medicine accredited by the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education leading to the DO or

MD degree, or recognized international equivalent terminal degree in medicine; and, be it further

RESOLVED, THAT THE AOA WORK WITH THE AMA, AND OTHER RELEVANT STAKEHOLDERS TO ~~ASSURE TO~~ **CONTINUE TO ADVOCATE** THAT THE TITLE OF PHYSICIAN ASSISTANT (PA) BE PRESERVED, AND THAT THE PROPOSED TITLE CHANGE TO "PHYSICIAN ASSOCIATE" BE REJECTED, BECAUSE THE PROPOSED USE OF "ASSOCIATE" IS MISLEADING AND SHOULD BE ABANDONED OUT OF CONCERN FOR THE POTENTIAL IMPACT ON PATIENT CARE AND SAFETY.

~~RESOLVED that the AOA work with the AMA and other stakeholders to protect the titles "doctor," "resident" and "residency" by adopting that the AOA:~~

~~(1) recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe the physician role;~~

~~(2) advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation;~~

~~(3) support state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (DO/MD or recognized international equivalent terminal degree in medicine); and~~

~~(4) support state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," or "attending" in a healthcare setting; and be it further~~

~~RESOLVED, that the AOA work with the AMA and other relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME; and be it further~~

~~RESOLVED, that the AOA partner with the AMA and the ACGME to create standards requiring program directors and designated institutional officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further~~

~~RESOLVED, that the AOA oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals.~~

Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies are similar but do not specifically address of post-graduate clinical training for non-physicians:

H346-A/16 Non-Physician Health Care Clinician
H640-A/20 Non-Physician Clinicians
H336-A/20 Use of The Term "Physician" Doctor" and "Provider"

Prior HOD action on similar or same topic:

H346-A/16 Non-Physician Health Care Clinician - Reaffirmed 2016
H640-A/20 Non-Physician Clinicians - Adopted as Amended 2020
H336-A/20 Use of The Term "Physician" Doctor" and "Provider" - Adopted 2020

FISCAL IMPACT: $0

References:

[i] https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
[ii] https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
[iii] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf
[iv] https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/, accessed 9/12/2020

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: PROTECTIVE EDUCATIONAL ENVIRONMENTS FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER/QUESTIONING YOUTH

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) individuals from discriminatory practices and harassment, and reaffirms the equal rights provisions and protections for all patient populations as stated in *H439-A/16 Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws*; and

WHEREAS, the AOA acknowledges that LGBTQ youth experience higher rates of anxiety, depression, emotional distress, and suicidality[1, 2]; and

WHEREAS, scientific literature indicates that the implementation of policies that specifically protect LGBTQ youth from bullying and discrimination based on sexual orientation and gender identity lowers the risk of suicide in this population[1,3]; and

WHEREAS, evidence shows that inclusive and non-discriminatory educational institutions can serve as protective environments for LGBTQ students and help improve their sense of belonging and mental health outcomes[1, 4, 5]; now, therefore be it

RESOLVED, that the American Osteopathic Association recognizes the importance and supports ~~the development of curricula~~ ADVOCACY that acknowledge LGBTQ identities, ~~inclusive policies that allow LGBTQ youth to participate in extracurricular activities free from discrimination,~~ and the implementation of anti-bullying policies that specifically protect children from harassment based on sexual orientation or gender identity in educational settings.

[1] Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annu Rev Clin Psychol*. 2016;12:465–487. doi:10.1146/annurev-clinpsy-021815-093153

[2] Johns MM, Poteat VP, Horn SS, Kosciw J. Strengthening Our Schools to Promote Resilience and Health Among LGBTQ Youth: Emerging Evidence and Research Priorities from *The State of LGBTQ Youth Health and Wellbeing* Symposium. *LGBT Health*. 2019;6(4):146–155. doi:10.1089/lgbt.2018.0109

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[4] Kosciw, J. G., Greytak, E. A., Zongrone, A. D., Clark, C. M., & Truong, N. L. (2018). The 2017 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools. New York: GLSEN.

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Background Information: Provided by AOA Staff

Current AOA Policy:

H439-A/16 Lesbian, Gay, Bisexual, Transgender, Queer / Questioning Protection Laws

Prior HOD action on similar or same topic:

H439-A/16 Lesbian, Gay, Bisexual, Transgender, Queer / Questioning Protection Laws – Reaffirmed 2016

FISCAL IMPACT: $55,000-$100,000

If the AOA were to create a curriculum in service of this resolution, this would include staff time, platform development and educational content development. Depending on the scope of the program the estimated cost would range from $55,000 to $100,000.

ACTION TAKEN __ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: OPTIONAL CORRECT PRONOUN DEMOGRAPHIC ON GENERAL MEDICAL EDUCATION APPLICATIONS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, the use of chosen names and pronouns affirms gender identity and reduces mental
2 health risks in transgender people and people of sexual and gender minorities[1]; and

3 WHEREAS, the World Health Organization's policy on Gender, Equity, and Human Rights
4 states, "It is important to recognize identities that do not fit into the binary male or
5 female sex categories"[2]; and

6 WHEREAS, people of sexual and gender minorities in medical education indicate higher levels
7 of depression, lower levels of social support, and rate their campus climates as non-
8 inclusive[3]; and

9 WHEREAS, the Association of American Medical Colleges (AAMC) recommends that all
10 medical education institutions "ensure a safe learning environment for all students,
11 regardless of their sexual orientation or gender identity"[4]; and

12 WHEREAS, the Harvard School of Medicine uses their school-specific application as a
13 minority recruitment tool, allowing applicants to optionally identify as lesbian, gay,
14 bisexual, transgender or queer (LGTBQ), confirming that since fall of 2019, the
15 institution has a significant increase in underrepresented LGTBQ medical school
16 applicants[5]; and

17 WHEREAS, both the American Medical College Application Service's (AMCAS)[6] and the
18 American Association of Colleges of Osteopathic Medicine's (AACOM)[7] general
19 medical school applications, as of the 2020 cycle, include two optional questions: one
20 regarding applicants' gender identity and another regarding applicants' preferred
21 pronoun; and

22 WHEREAS, general graduate medical education (i.e, residency and fellowship) platforms do
23 not include optional pronoun demographic inquiries[8]; and

24 WHEREAS, people of sexual and gender minorities bring a unique and underrepresented
25 perspective to medicine; in particular, these individuals may be much more likely to
26 pursue careers that encompass caring for sexual and gender minority patients, who face
27 significant health and health care access disparities[9]; and

28 WHEREAS, the American Osteopathic Association's current Position on Health Disparities
29 states, "Healthcare disparities may also be alleviated through effective recruitment of
30 underrepresented minorities"[10]; now therefore be it

31 RESOLVED, that the American Osteopathic Association (AOA) supports the inclusion of an
32 optional pronoun demographic inquiry on medical school, residency, and fellowship
33 application forms.

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: REFERRED RES. NO. H-219 – A/2019 OSTEOPATHIC MANIPULATIVE TREATMENT BOOT CAMP

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, resolution H-219– A/2019 titled "OSTEOPATHIC MANIPULATIVE
2 TREATMENT BOOT CAMP" was referred to the Bureau of Osteopathic Specialists
3 (BOS); and

4 WHEREAS, the BOS has jurisdiction over Osteopathic Continuous Certification (OCC) and all
5 its components; and

6 WHEREAS, the BOS in conjunction with American Osteopathic Association (AOA)
7 leadership, Certifying Board Services (CBS) staff, and key osteopathic stakeholders
8 review each component of OCC; and

9 WHEREAS, policy currently exists in the Handbook of the BOS regarding specialty certifying
10 boards and requests relating to OCC (Handbook of the BOS, Page 13, Line 31); and

11 WHEREAS; the BOS has considered the request of the American College of Osteopathic
12 Family Physicians' OMT Boot Camp as per the policy in the Handbook of the BOS;
13 now, therefore be it

14 RESOLVED, that the Bureau of Osteopathic Specialists (BOS) recommends the AOA House
15 of Delegates not adopt H219-A/2019 OSTEOPATHIC MANIPULATIVE
16 TREATMENT BOOT CAMP AS IT HAS BEEN IMPLEMENTED INTO THE
17 AOBFP OCC PROCESS AFTER GOING THROUGH THE APPROPRIATE BOS
18 PROCESS.

Background Information: Provided by AOA Staff

Current AOA Policy:

The Standards Review Committee (SRC) oversees the policies of the BOS and its specialty certifying boards related to OCC (Handbook of the BOS, Page 13, Line 31).

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: RESTORING AN EQUITABLE AND POSITIVE LEARNING ENVIRONMENT IN MEDICAL TRAINING

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, anti-harassment and anti-discrimination policies address abusive and disruptive
2 behavior towards protected classes (i.e. race, color, sex, sexual orientation, national
3 origin, or age), however, mistreated employees who do not fall into these categories do
4 not have legal protections against such mistreatment with more than 75% of legal cases
5 regarding abusive behavior not being within the scope of antidiscrimination laws[8]; and

6 WHEREAS, many hospital and professional organization policies address overt mistreatment
7 such as discrimination, criminal activity, sexual assault, or physical abuse but do not
8 formally address other forms of abuse such as bullying and intimidation[3,4], which
9 includes behaviors such as humiliation, insults, threats, coercion, isolation, and
10 overwork[9]; and

11 WHEREAS, the Institute for Safe Medical Practices found that 88% of medical practitioners
12 encountered condescending language or voice intonation, 87% encountered impatience
13 with questions, 79% dealt with reluctance or refusal to answer questions, 48% were
14 subjected to strong verbal abuse, 43% experienced threatening body language, and 4%
15 reported physical abuse, while only 39% felt their organization dealt effectively with
16 intimidating behavior[1]; and

17 WHEREAS, the hierarchical system of residency training establishes an atmosphere of
18 dominance, resulting in a fear of consequences, including the negative influence on
19 career, an impaired learning experience, being labeled, concern for greater mistreatment
20 after reporting, and a subsequent culture of silence, rationalization, intimidation, and
21 harassment as a part of training[4,8]; and

22 WHEREAS, the Joint Commission reports intimidating and disruptive behaviors are often
23 manifested by health care professionals in positions of power[5, 10], which makes it
24 difficult to confront aggressors and leads to underreporting of abusive behavior in up to
25 79% of physicians[2, 12] and 88% of residents[6]; and

26 WHEREAS, the breakdown in effective communication secondary to abuse and intimidation
27 can lead to medical errors impairing patient safety[4, 5, 8, 13]; and

28 WHEREAS, targets of abuse have reported manifestations including insomnia, depression,
29 anxiety, gastrointestinal complaints, hypertension, chest pain, palpitations, weight loss,
30 headaches, loss of libido, worsening of chronic illness, post-traumatic stress disorder
31 and suicide[4, 5, 8]; and

32 WHEREAS, the American Osteopathic Association (AOA) existing policy (H343-A/17)
33 recognizes the need to "address stressful issues during all stages of career development

34 because failure to do so can have lasting ramifications for a physician mentally,
35 emotionally, socially, and physically," however, no policy exists to address abuse and
36 disruptive behavior which clearly contributes to this stress; and

37 WHEREAS, organizations within the medical community, including the Joint Commission and
38 the American College of Surgeons and the American College of Obstetricians and
39 Gynecologists, issued a "zero tolerance" policy against disruptive behavior in the
40 workplace[7, 9,10], and/or have addressed the need to address such behaviors within
41 institutions through clear communication of definitions and impacts of disruptive
42 behaviors, establishing confidential reporting systems and assistance programs, and
43 adopting hospital-wide policy and procedure that is enforced[7]; now, therefore, be it

44 RESOLVED, that the American Osteopathic Association (AOA) adopt a position of zero-
45 tolerance to abuse and disruptive behavior in residency training and consider such
46 violations as a violation of the code of ethics; and be it further

47 RESOLVED, that the AOA develop a mechanism for addressing abuse in medical training with
48 the goals to restore an equitable and positive learning environment that eliminates
49 abusive behavior and provides a resource to victims outside of their institution.

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3. Kaplan K, Mestel P, Feldman D. Creating a culture of mutual respect. AORN J. 2010;91(4):495–510.
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13. Institute for Safe Medication Practices. (March 11, 2004). Intimidation: practitioners speak up about this unresolved problem (part I). https://www.ismp.org/newsletters/acutecare/articles/20040311_2.asp.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___REFERRED (*Michigan Osteopathic Association*)____

DATE _____JULY 17, 2021_____

SUBJECT: ACCESS TO HEALTHCARE – DEVELOPING A NEW MODEL OF ADMINISTERING OSTEOPATHIC PRIMARY CARE RESIDENCIES IN THE UNITED STATES - SOURCE: H201-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, as this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy, now, therefore be it

3 RESOLVED, that the following changes are made to the policy statement.

4 The American Osteopathic Association will (1) PARTNER IN ADVOCACY EFFORTS TO
5 increase access to primary care through expanding innovative programs which incentivize
6 osteopathic medical students to enter primary care residencies with osteopathic recognition by
7 facilitating the development of high quality, outcome based, health information technology
8 infused programs with a patient-centered academic system of practice and education which
9 utilizes an integrated curriculum of a reproducible business model and standardized educational
10 model; and (2) leverage partnerships between graduate medical education, colleges of
11 osteopathic medicine, and government and private industry to promote initiatives to increase
12 the number of osteopathic medical students entering primary care residencies.

Background Information: Provided by AOA Staff
Current AOA Policy: 2001; 2006 Reaffirmed as amended; 2011 Reaffirmed; 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: ~~DEPRESSION~~ **ACCESS TO MENTAL HEALTH SERVICES AND** AWARENESS IN U.S. **OSTEOPATHIC** MEDICAL STUDENTS – SOURCE: H203-A/16

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Education has reviewed this policy; now, therefore be it

3 RESOLVED, that the Bureau of Education recommends that this following policy be
4 REAFFIRMED

5 The American Osteopathic Association recommends that there be increased MENTAL
6 HEALTH awareness ~~of depression~~ amongst US OSTEOPATHIC medical students and that
7 treatment options BE AVAILABLE THAT ARE ACCESSIBLE, PRIVATE, AND
8 CONFIDENTIAL for those affected ~~be provided~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011, 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: DISASTER RESPONSE ~~COURSES AND~~ TRAINING ~~WITHIN COLLEGES OF OSTEOPATHIC MEDICINE~~ - SOURCE: H204-A/16

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the following changes are made to the policy statement.

4 The American Osteopathic Association ~~supports~~ ENCOURAGES disaster response ~~didactic~~
5 ~~courses and~~ training FOR OSTEOPATHIC PHYSICIANS AND STUDENTS ~~within the~~
6 ~~curriculum for the colleges of osteopathic medicine~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011, 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: ACADEMIC OSTEOPATHIC EDUCATORS, RESEARCHERS OR ADMINISTRATORS EDUCATIONAL PROGRAM DEVELOPMENT - SOURCE: H205-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
4 be SUNSET.

5 The American Osteopathic Association encourages colleges of osteopathic medicine to
6 collaborate and develop with other institutions a master's level medical education program that
7 is available during or after the completion of an osteopathic medical training program that will
8 prepare osteopathic physicians for future academic careers as educators, researchers and
9 administrators.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011, 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED (***for sunset***)

DATE JULY 17, 2021

SUBJECT: UNIFORM TITLE FOR OSTEOPATHIC MEDICAL STUDENTS - SOURCE: H208-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
4 be REAFFIRMED.

5 The American Osteopathic Association recommends that students enrolled in accredited
6 osteopathic medical schools be referred to as Osteopathic Medical Students (OMS); after the
7 letters OMS, the level of study be identified by Roman numerals I, II, III, IV, and V, etc., such
8 as OMS I, OMS II, OMS III, OMS IV, and OMS V, etc.; unless prohibited by the institution in
9 which they are doing a clinical rotation, students shall be identified by use of the OMS and
10 appropriate Roman numeral designation after their name (e.g., Jane Doe, OMS II, John Doe,
11 OMS IV, etc.).

Background Information: Provided by AOA Staff
Current AOA Policy: 2006, 2011 Reaffirmed, 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: TOBACCO FREE **AND VAPING FREE** COLLEGES / SCHOOLS OF OSTEOPATHIC MEDICINE - SOURCE: H209-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association commits to the goal of establishing and supporting
7 tobacco-free and ~~electronic nicotine delivery system~~VAPING-free colleges of osteopathic
8 medicine at every Commission on Osteopathic College Accreditation (COCA)-accredited
9 college of osteopathic medicine

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: RURAL HEALTHCARE PROVIDED BY CURRENT ~~AOA~~ GME PROGRAMS – PRESERVATION OF - SOURCE: H211-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
4 be ~~SUNSET~~ REAFFIRMED AS AMENDED.

5 It is a priority of the American Osteopathic Association (AOA) to ~~ensure~~ ADVOCATE FOR
6 THE DEVELOPMENT AND ~~the~~ preservation of residencies in rural and underserved
7 communities~~; such that the absolute number of Graduate Medical Education (GME) positions~~
8 ~~does not decrease under the Single Accreditation System~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: ~~DRUG~~ STIMULANT ABUSE IN THE ACADEMIC SETTING – EDUCATION AND RESOURCES FOR - SOURCE H213-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the following changes are made to the policy statement.

4 The American Osteopathic Association (AOA) will encourage the development of continuing
5 medical education (CME) for physicians to RECOGNIZE RISK FACTORS, ensure
6 appropriate diagnosis, ~~dosing,~~ and SUBSEQUENT treatment of conditions which utilize ~~drugs~~
7 ~~abused~~ STIMULANTS for academic performance WHICH MAY BE ABUSED.
8

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES - SOURCE: H329-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs/Bureau on Federal Health Programs/Council on State Health Affairs

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs/Bureau on Federal Health
3 Programs/Council on State Health Affairs has reviewed the policy; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs/Bureau on Federal Health
5 Programs/Council on State Health Affairs recommends that the following policy be
6 REAFFIRMED.

7 The American Osteopathic Association (AOA) opposes cuts to graduate medical education
8 (GME) funding FOR PHYSICIAN TRAINING (DO AND MD) ~~of DO and MD programs~~
9 ~~while there are increases to GME funding for other professions' GME programs~~; supports the
10 distribution of federal funds for GME, prioritizing areas most in need for PHYSICIAN
11 TRAINING (DO AND MD) ~~DO and MD~~ programs based upon geography and specialty;
12 ~~strongly~~ advocates for continued and expanded contribution by all payers for health care
13 (including the federal government, the states, and local and private sources) to fund both the
14 direct and indirect costs of GME; supports allowing health insurers who provide financial
15 support for expansion or continuation of existing GME programs to include such sums as
16 direct medical expenditures as part of the calculation of the Medical Loss Ratio of their health
17 plans. ~~The AOA will evaluate and support promising model policies that promote GME, such~~
18 ~~as the Physician Education Advancing Community Health (PEACH) model legislation.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: PROMOTION OF OSTEOPATHIC MEDICINE TO DISADVANTAGED HIGH SCHOOL STUDENTS - SOURCE: H402-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages colleges of osteopathic medicine to identify
7 and support outreach programs for disadvantaged high school students in their communities
8 for successful health careers in osteopathic medicine.

Background Information: Provided by AOA Staff
Current AOA Policy: 2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: RESIDENCY TRAINING IN CANADA – EQUALITY BETWEEN COCA-ACCREDITED AND LCME-ACCREDITED MEDICAL SCHOOL GRADUATES SEEKING - SOURCE: H641-A/16

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; now, therefore be it

3 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
4 be REAFFIRMED.

5 The American Osteopathic Association (AOA) supports efforts to restore the equal eligibility
6 standards and criteria for Canadian residency training positions that existed prior to June 2014
7 for both United States Liaison Committee on Medical Education (LCME) and Commission on
8 Osteopathic College Accreditation (COCA) accredited medical schools.

9 The AOA encourages relevant Canadian authorities to restore the post-graduate medical
10 education eligibility rules in place prior to June 2014 and advocates Canadian authorities restore
11 equal LCME and COCA eligibility that existed prior to June 2014.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: MEDICATION FOR OPIOID USE DISORDER (MOUD) AVAILABILITY FOR INCARCERATED INDIVIDUALS AND/OR INDIVIDUALS UNDER CORRECTIONAL CONTROL

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Professional Affairs

WHEREAS, the American Osteopathic Association (AOA) has in place a broad policy supporting treatment and harm reduction for people who use drugs (PWUD) and/or patients with substance use disorder (SUD); and

WHEREAS, the United States of America has the highest number of incarcerated individuals in the world--both per capita and total number; and

WHEREAS, more than 50% of individuals with an opioid use disorder (OUD) report involvement with the criminal legal system; and

WHEREAS, as of 2019, only 30 out of 5100 jails or prisons provided methadone or buprenorphine for OUD; and

WHEREAS, incarcerated individuals with OUD have post-incarceration mortality rates up to 50 times the post-incarceration average, due to untreated OUD leading to drug poisoning/overdose; now, therefore, be it

~~RESOLVED, that the American Osteopathic Academy of Addiction Medicine (AOAAM) supports the administration and/or prescription of all FDA-approved treatments for OUD for all incarcerated individuals and all individuals under other forms of governmental correctional control; and, be it further~~

RESOLVED, that the American Osteopathic Association will ~~explicitly~~ support the administration and/or ~~prescription~~ **PRESCRIBING** of all FDA-approved treatments for **OPIOID USE DISORDER (OUD)** for all ~~incarcerated individuals and all~~ individuals WITH OUD WHO ARE INCARCERATED OR under other forms of governmental OR PRIVATE correctional control.~~; and, be it further~~

~~RESOLVED, that the American Osteopathic Association is supportive and maintains the above AOAAM position in the treatment and care of incarcerated individuals.~~

Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies are similar:

H414-A/18 Substance Use Disorder: States that the American Osteopathic Association encourages its members, to maintain current knowledge of addictive substances with a high potential for abuse, and of appropriate treatment techniques, and supports health care and community support agencies in their efforts to eliminate substance use disorder, and urges all

members of the osteopathic profession to participate in the prevention and rehabilitation of persons suffering from substance use disorder and the disease of addiction.

H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs For: States that the American Osteopathic Association supports evidence-based treatment protocols SUCH as developed by the American Osteopathic Academy of Addiction Medicine (AOAAM) and the American Society for Addiction Medicine (ASAM) and will help educate the public about substance use disorder (SUD) and effective treatment options and encourage communities to work collaboratively with law enforcement agencies to implement evidence-based referral resources and advocate for Medication assisted Treatment (MAT) programs as the most clinically effective and cost effective intervention for sustained recovery, and reduction of criminal activity and mortality.

H444-A/20: This policy addresses stigmatizing language relating to SUD patients and addresses a different aspect of SUD treatment.

H203-A/18: This policy relates to SUD. Its focus is on education and does not overlap with this resolution.

Prior HOD action on similar or same topic:
H414-A/18 Substance Use Disorder: policy reaffirmed as amended in 2018.
H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs For: 2016
H444-A/20: Traumatic Brain Injury Awareness: policy reaffirmed in 2020.
H203-A/18 Substance Use Disorders Education: policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: AVAILABILITY OF MODALITIES OF PRESCRIBING

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Wal-Mart Company believes that e-Prescriptions (also known as EPCS and also known as Electronic Prescriptions for Controlled Substances) cannot be altered or copied, are less prone to errors, and can be tracked to ensure proper steps are taken throughout the prescription process; and

WHEREAS, the Wal-Mart Company pharmacies will no longer accept written or faxed prescriptions for controlled substance prescriptions after December 31, 2019; and

WHEREAS, the OPTUMRx™ company will no longer be accepting via fax, telephone, print, or hand-written format prescriptions for controlled substances as of March 1, 2020; and

WHEREAS, EPCS (Electronic Prescriptions for Controlled Substances) systems on occasion may not be immediately available to a prescriber on a scheduled or unscheduled basis (such as scheduled downtime, power outages, or critical infrastructure interruption) or for physicians not utilizing electronic means of documentation; and

WHEREAS, the Drug Enforcement Administration (DEA) requires that a prescription for a controlled substance must be dated and signed on the date when issued, and must include the patient's full name and address, and the practitioner's full name, address, and DEA registration number. In addition, a valid prescription must also include: drug name, strength, dosage form, quantity prescribed, directions for use, and number of refills authorized (if any). Additionally, a valid controlled substance prescription must also be written in ink or indelible pencil or typewritten and must be manually signed by the practitioner on the date when issued; and

WHEREAS, a registered pharmacy may process electronic prescriptions for controlled substances only if the following conditions are met, first, the pharmacy uses a pharmacy application that meets all of the applicable requirements of 21 C.F.R. §1311, and second the prescription is otherwise in conformity with the requirements of the Controlled Substance Act (CSA) and 21 C.F.R.; and

WHEREAS, the United States Drug Enforcement Administration states that a "pharmacist may dispense directly a controlled substance listed in Schedule III, IV, or V only pursuant to either a paper prescription signed by a practitioner, a facsimile of a signed paper prescription transmitted by the practitioner or the practitioner's agent to the pharmacy, an electronic prescription that meets DEAs requirements for such prescriptions"; now, therefore be it

RESOLVED, that the American Osteopathic Association advocate for all methods of prescribing by physicians for schedule II through schedule V controlled substances including fax, telephone, print, EPCS (Electronic Prescriptions for Controlled Substances) and hand-

35 written prescriptions that meet the United States Drug Enforcement Administration
36 guidelines AND APPLICABLE **FEDERAL AND** STATE LAWS AND REGULATIONS
37 for a valid controlled substance prescription. ~~without limitation or preference for any one~~
38 ~~specific method or limitation on prescribing.~~

Background Information: Provided by AOA Staff

Current AOA Policy:

Policy H318-A/19 Electronic Prescribing is similar in that it states that the AOA supports e-prescribing for all scheduled pharmaceuticals on a voluntary basis without CMS monetary penalty and without state sanctioned civil or criminal penalties.

Prior HOD action on similar or same topic:

H318-A/19 Electronic Prescribing - Reaffirmed as Amended 2019

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED__

DATE __JULY 17, 2021_____

SUBJECT: IMPROVING INSULIN AFFORDABILITY

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, Type 1 Diabetes is one of the most common chronic diseases starting in early childhood in the United States that is fatal without lifelong insulin treatment[1]; and

WHEREAS, the cost of insulin has tripled over a mere decade from 2002-2013, despite only incremental added benefits of new insulin products on the market[2]; and

WHEREAS, it costs uninsured patients ten times more for insulin treatment at $7,000 annually versus $700 annually with insurance[3]; and

WHEREAS, one in four insulin dependent diabetics with associated poor glycemic control reported insulin underuse or rationing due to cost[3]; and

WHEREAS, an increasing number of patients are dying due to inability to afford insulin, with diabetes being the 7th leading cause of death in 2017[4]; and

WHEREAS, Colorado, Illinois, and Virginia have all enacted laws that cap insulin co-payments[5,6,7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supportS ALL

EFFORTS TO PROVIDE AFFORDABLE, AND WHERE NECESSARY, FREE INSULIN PRODUCTS IN ALL STATES ~~legislation capping insulin copays within every state legislature~~ by working with and encouraging action by their respective state OSTEOPATHIC medical societies.

References:

1. Imperatore G., Mayer-Davis E.J., Orchard T.J., & Zhong V.W. (2017). Prevalence and Incidence of Type I Diabetes Among Children and Adults in the United States and Comparison with Non-U.S. Countries. In Cowie C.C., Casagrande S.S., Menke A., Cissell M.A., Eberhardt M.S., Meigs J.B., Gregg E.W., Knowler W.C., Barrett-Connor E., Becker D.J., Brancati F.L., Boyko E.J., Herman W.H., Howard B.V., Narayan K.M.V., Rewers M., Fradkin J.E. (Eds.), *Diabetes in America.* (3rd ed., pp. 2.1-2.17) Bethesda, MD: National Institutes of Health. Retrieved on February 2, 2019, from: https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition.
2. Hua, X., Carvalho, N., Tew, M., Huang, E. S., Herman, W. H., & Clarke, P. (2016). Expenditures and prices of antihyperglycemic medications in the united states: 2002-2013. *Journal of the American Medical Association, 315*(13), 1400-1402. doi:https://doi:10.1001/jama.2016.0126
3. Johnson, C., Y. (2016, October 31). Why treating diabetes keeps getting more expensive. *Washington Post.* Retrieved on February 2, 2019, from

https://www.washingtonpost.com/news/wonk/wp/2016/10/31/why-insulin-prices-have-kept-rising-for-95-years/?utm_term=.17cda82418ca

4. Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2020*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020. Retrieved on February 28, 2020, from https://www.cdc.gov/diabetes/data/statistics/statistics-report.html
5. Reduced insulin prices, HB19-1216, 2019 Regular Session Colorado General Assembly. (2019). Retrieved on February 28, 2020, from https://leg.colorado.gov/bills/hb19-1216
6. Pricing-prescription insulin, SB0667, 101st Session Illinois General Assembly. (2010). Retrieved on February 28, 2020, from http://www.ilga.gov/legislation/BillStatus.asp?GA=101&DocTypeID=SB&DocNum=667&GAID=15&SessionID=108&LegID=116604#actions
7. Health insurance; cost-sharing payments for prescription insulin drugs, HB66, 2020 Virginia General Assembly. (2020). Retrieved on March 8, 2020, from https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+HB66

Background Information: Provided by AOA Staff

Current AOA Policy:

This is similar to H638-A/17 Prescription Drug Pricing. The resolved clause in this resolution creates a broad obligation for the AOA that is contingent on external considerations.

Prior HOD action on similar or same topic

H638-A/17 Prescription Drug Pricing – Reaffirmed 2017

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: DIRECT ACTING THERAPY FOR HEPATITIS C LIMITATIONS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are an estimated 2.4 million people in the US living with hepatitis C infection with 3216 new cases reported to the CDC in 2017; and

WHEREAS, hepatitis C transmission via bloodborne exposure and vertical transmission has become a public health concern; and

WHEREAS, 75-85% of acute hepatitis C becomes chronic and 10-20% of patients infected with hepatitis C progress to hepatic cirrhosis. Those patients with cirrhosis have increased risk of development of hepatocellular carcinoma and hepatic decompensation. 17,253 U.S. death certificates listed hepatitis C as an underlying or contributing cause of death, and the CDC estimates this is underreported; and

WHEREAS, there are no available immunizations to prevent hepatitis C infection; and

WHEREAS, there has been robust pharmaceutical research and development in the treatment of hepatitis C with resultant numerous oral agents available; and

WHEREAS, treatment has simplified with direct acting antiviral therapies leading to cure in over 90% of hepatitis C infections within 8-12 weeks of oral treatment regardless of genotype with a favorable adverse effect profile; and

WHEREAS, **SOME** payors have limited prescribing of direct acting antiviral treatments for hepatitis C to infectious disease and gastroenterology specialists; and

WHEREAS, limitations in prescribing lead to decreased access to treatment. This results in a continued high prevalence of hepatitis C with progression risks to the patients, elevated long-term cost of care for complications, as well as public health concern for increased incidents.; now, therefore be it

RESOLVED, that the American Osteopathic Association support elimination of **PHYSICIAN** prescribing limitations of direct acting antiviral treatments for hepatitis C based on specialty.

References:

1. www.cdc.gov/hepatitis/hcv
2. www.Hcvguidelines.org

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED AS AMENDED_____

DATE _____JULY 17, 2021_____

SUBJECT: EXTENSION OF THE SHELF-LIFE EXTENSION PROGRAM (SLEP) BY THE FDA

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, the healthcare system faces a multitude of medication shortages and high
2 medication prices; and

3 WHEREAS, the FDA's Shelf Life Extension Program (SLEP) has 34 years of data
4 supporting the extension of shelf life for over 122 medications by an average of 5.5 years;
5 and

6 WHEREAS, the FDA's program cost $3.1 million annually to save the federal government
7 $2.1 billion annually in medications that do not need to be discarded; and

8 WHEREAS, all hospital and retail pharmacies are held to the same environmental control
9 standards for the storage of medications that the federal government is subjected to; and

10 WHEREAS, a significant increase in the availability of medications would occur if FDA
11 expanded the SLEP program to all civilian hospital and retail pharmacies; and

12 WHEREAS, the safe extension of expiration dating on medications would result in a
13 significant annual cost savings to the US healthcare system; now, therefore be it

14 RESOLVED, that the American Osteopathic Association ~~to~~ petition the US Food and Drug
15 Administration (FDA) and the Congress of the United States for the expansion of the Shelf
16 Life Extension Program to all civilian hospital and retail pharmacies.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: INCREASING VOTER ACCESS ~~AMONGST~~ **FOR** HOSPITALIZED PATIENTS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, previous studies have demonstrated that an individual's state of health can significantly affect their decision and ability to go to voting polls[1]; and

WHEREAS, the causal relationship between voting and health is bidirectional; voting affects health, in that it shapes who is in power and what policy is made, and an individual's health affects voting, in that it decreases the amount of access to polls[1]; and

WHEREAS, nonpartisan voter registration initiatives in the primary care setting have demonstrated notable efficacy with previously unregistered patients successfully registering to vote via such efforts[2,3]; and

WHEREAS, medical institutions offer the unique opportunity to engage diverse and underrepresented populations in the voting process, as registration efforts within these settings have been shown to increase participation in the electoral process[4]; and

WHEREAS, the American Osteopathic Association (AOA) encourages osteopathic physicians to adopt workplace policies that facilitate environments that increase voting capabilities on election day for their employees[5]; and

WHEREAS, the AOA has previously enacted "Get Out the Vote" campaigns aimed at increasing voter turnout[6]; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) **SUPPORT** ~~encourage initiatives aimed at increasing voting~~ access **TO VOTING FOR** ~~amongst~~ hospitalized patients ~~with the capacity to vote for all local, state, and federal government elections~~.

References:

1. Brown, C. L., Raza, D., & Pinto, A. D. (2020). Voting, health and interventions in healthcare settings: a scoping review. *Public health reviews*, *41*, 16. https://doi.org/10.1186/s40985-020-00133-6
2. Liggett, A., Sharma, M., Nakamura, Y., Villar, R., & Selwyn, P. (2014). Results of a Voter Registration Project at 2 Family Medicine Residency Clinics in the Bronx, New York. The Annals of Family Medicine, 12(5), 466. doi:10.1370/afm.1686
3. Lickiss, S., Lowery, L., & Triemstra, J. D. (2020). Voter Registration and Engagement in an Adolescent and Young Adult Primary Care Clinic. Journal of Adolescent Health, 66(6), 747-749. doi:https://doi.org/10.1016/j.jadohealth.2019.11.316
4. Kathryn Linder Alisha Maity, M. B., MD, Gregory Kane, MD,. (2019). Implementation of a Medical Student-Led Emergency Absentee Ballot Voting Initiative at an Urban Tertiary Care University Hospital. American College of Physicians. Retrieved from

https://www.acponline.org/membership/medical-students/acp-impact/archive/july-2019/implementation-of-a-medical-student-led-emergency-absentee-ballot-voting-initiative-at-an-urban

5. American Osteopathic Association. (2016) *Voting day – AOA supports voting day policy* (H307-A/16). Retrieved from https://osteopathic.org/wp-content/uploads/2020-HOD-Compendium.pdf
6. Staff, AOA (2020, September 1). *Check your voter registration using the AOA's Advocacy Action Center*. American Osteopathic Association. https://osteopathic.org/2020/09/01/check-your-voter-registration-using-the-aoas-advocacy-action-center/.

Background Information: Provided by AOA Staff

Current AOA Policy:

H307-A/16 Voting Day – AOA Supports Voting Day Policy

Prior HOD action on similar or same topic:

H307-A/16 Voting Day - Reaffirmed 2016

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: SUPPORT OF CONTINUED FUNDING FOR ~~AMERICORPS NATIONAL SERVICE PROGRAMS~~ **CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)**

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, the Corporation for National and Community Service (CNCS) is a government-
2 mandated national service organization that is committed to improving individual and
3 community health as well as diversity in higher education and the workforce[1]; and

4 WHEREAS, the CNCS includes the subsidiary programs AmeriCorps and Senior Corps, whose
5 interventions have been shown to have significant benefits addressing social
6 determinants of health in communities they serve[2]; and

7 WHEREAS, AmeriCorps has several programs aimed at addressing health disparities and
8 improving health outcomes in vulnerable communities through various paid volunteer
9 opportunities, including the Rural Health Service Corps, National Health Corps,
10 Community HealthCorps, and AmeriCorps health fellowship programs[3-6]; and

11 WHEREAS, the mission of the Community HealthCorps program is specifically to develop and
12 strengthen health care programs, in order to assure the provision of culturally
13 appropriate preventive and primary health care to medically underserved populations
14 and communities[6]; and

15 WHEREAS, CNCS funding is frequently in danger of being limited or discontinued by
16 withdrawal of congressionally appropriated funds despite the positive benefits these
17 programs provide[7]; and

18 WHEREAS, the CNCS and its subsidiary program's missions align with the American
19 Osteopathic Association's (AOA) policies regarding minority health disparities as well as
20 their recommendations for improving physician supply in rural, underserved areas in the
21 United States[8]; and

22 WHEREAS, the AOA has previously supported policy for continued funding of other
23 government-mandated programs affecting health and health outcomes, such as
24 Medicare, the Title V Maternal and Child Healthcare Block Grants Program, federal
25 funding for chaplain, social work and home health aide provider services for palliative
26 care patients[8]; now, therefore be it

27 RESOLVED, that the American Osteopathic Association (AOA) support continued
28 **FEDERAL** funding for Corporation for National and Community Service (CNCS)
29 programs.

References:

1. Perry JL, Thomson AM, Tschirhart M, Mesch D, Lee G. *Inside a Swiss Army Knife: An Assessment of AmeriCorps. J Public Adm Res Theory. 1999.* doi:10.1093/oxfordjournals.jpart.a024409
2. Richman, S., Maxwell, N., Streke, A., Needels, K., & Eddins, K. (2018). *Evidence of Effectiveness in CNCS-Funded Interventions: Benchmark Findings.* Prepared for the Corporation for National and Community Service, Office of Research and Evaluation. Chicago, IL: Mathematica Policy Research
3. *About National Health Corps*. NHC. (n.d.). https://www.nationalhealthcorps.org/about-national-health-corps.
4. Administrator. (n.d.). *AmeriCorps Health Fellows Program*. AmeriCorps. https://www.lifelongmedical.org/services/americorps.html.
5. *About: National Service Program*. Rural Health Service Corps. (2019, January 14). https://ruralhealthservicecorps.org/about/.
6. *My AmeriCorps*. My AmeriCorps - Community HealthCorps VISTA. (n.d.). https://my.americorps.gov/mp/listing/viewListing.do?id=3995.
7. United States, White House, "Budget of the U.S. Government, FY 2021." U.S. Government Publishing Office, February 10, 2020. https://www.whitehouse.gov/wp-content/uploads/2020/02/budget_fy21.pdf
8. AOA Policy Search. (n.d.). Retrieved from https://osteopathic.org/about/leadership/policy-search/.

Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies are similar, however do not address this specific resolution:

H613-A/16 Physician Supply in Rural, Underserved United States – Recommendations for Improving
H428-A/20 Minority Health Disparities
H413-A/19 Maternal and Child Healthcare Block Grants
H322-A/18 Medicare
H601-A/19 Palliative Care – Federal Funding for Support Services
H600-A/19 Hospice – Federal Payment for Required Face-to-Face Visits

Prior HOD action on similar or same topic:

H613-A/16 Physician Supply in Rural, Underserved United States – Recommendations for Improving - Reaffirmed 2017
H428-A/20 Minority Health Disparities- 2005; Reaffirmed 2010; 2015) Adopted as Amended 2020
H413-A/19 Maternal and Child Healthcare Block Grants - Reaffirmed 2019
H322-A/18 Medicare - Reaffirmed 2018
H601-A/19 Palliative Care – Federal Funding for Support Services – Reaffirmed 2019
H600-A/19 Hospice – Federal Payment for Required Face-to-Face Visits – Reaffirmed as Amended 2019

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: APPROPRIATE PPE USAGE **PROVISIONS**

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, personal protective equipment (PPE) is an essential means to protect frontline
2 healthcare workers in the context of both contact and droplet transmitted pathogens[1];
3 and

4 WHEREAS, employers are required by OSHA standard 29 CFR Part 1910.132 to provide and
5 maintain sanitation of protective equipment, including PPE for the eyes, face, head, and
6 extremities, protective clothing, respiratory devices, and protective shields and barriers
7 wherever it is necessary by reason of hazards of processes or environment, chemical
8 hazards, radiological hazards, or mechanical irritants encountered in a manner capable
9 of causing injury or impairment in the function of any part of the body through
10 absorption, inhalation or physical contact[2]; and

11 WHEREAS, according to the World Health Organization, during the Ebola epidemic (2013-
12 2015), healthcare workers were between 21 and 32 times more likely to be infected with
13 Ebola than people in the general adult population due to several factors including
14 inappropriate use or lack of personal protective equipment (PPE) and substandard
15 employment conditions[3]; and

16 WHEREAS, PPE supply and demand are frequently mismatched, with issues in the supply
17 chain intersecting with controversy regarding best practices at the local institutional
18 level, leaving essential healthcare personnel unnecessarily exposed[4,5]; and

19 WHEREAS, the COVID-19 pandemic, as of March 2021, has infected 421,932 and claimed the
20 lives of 1,397 healthcare personnel[6]; and

21 WHEREAS, quickly evolving PPE guidelines[7-10] in the wake of the COVID-19 pandemic have
22 confused the matter of best practices and rational use; and

23 WHEREAS, according to the latest December 2020 COVID-19 Rational Use of PPE
24 Guidelines, PPE reuse beyond a single patient encounter is not recommended[10];
25 however, due to shortages, single-use PPE items are having to be worn all day and in
26 some cases for multiple days; now, therefore be it

27 RESOLVED, that the American Osteopathic Association (AOA) supports evidence-based
28 standards and national guidelines regarding the use, reuse, and proper decontamination
29 of personal protective equipment (PPE), especially in circumstances of increased
30 demand; and, be it further

31 RESOLVED, that the American Osteopathic Association (AOA) advocate for the utmost
32 protection of all healthcare personnel, emphasizing the responsibility of the healthcare

33 institution to provide sufficient **PPE WITHIN REASONABLE MEASURES.** ~~for~~
34 ~~all employees, staff, and medical trainees at all times; and, be it further~~

35 ~~RESOLVED, that the American Osteopathic Association (AOA) support healthcare~~
36 ~~professionals in being permitted to use additional appropriately decontaminated PPE to~~
37 ~~optimize institution-provided PPE~~.

References:

1. National Center for Immunization and Respiratory Diseases (NCIRD). COVID-19: Strategies for Optimizing the Supply of PPE. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html. Published July 16, 2020. Accessed March 2021.
2. Occupational Safety and Health Administration. UNITED STATES DEPARTMENT OF LABOR. 1910.132 - General requirements. | Occupational Safety and Health Administration. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132. Published November 2016. Accessed March 2021.
3. World Health Organization. Health worker Ebola infections in Guinea, Liberia and Sierra Leone. World Health Organization. https://www.who.int/csr/resources/publications/ebola/health-worker-infections/en/. Published January 22, 2016. Accessed March 11, 2021.
4. Cohen J, Rodgers YVM. Contributing factors to personal protective equipment shortages during the COVID-19 pandemic. *Prev Med.* 2020;141:106263. doi:10.1016/j.ypmed.2020.106263
5. Park SH. Personal Protective Equipment for Healthcare Workers during the COVID-19 Pandemic. Infect Chemother. 2020;52(2):165-182. doi:10.3947/ic.2020.52.2.165
6. Centers for Disease Control and Prevention. CDC COVID Data Tracker. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker/#health-care-personnel. Published March 10, 2021. Accessed March 10, 2021.
7. World Health Organization. Rational use of personal protective equipment for coronavirus disease (COVID-19): interim guidance, 27 February 2020. World Health Organization. https://apps.who.int/iris/handle/10665/331215. Published February 27, 2020. Accessed February 2021.
8. World Health Organization. Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19): interim guidance, 19 March 2020. World Health Organization. https://apps.who.int/iris/handle/10665/331498. Published March 19, 2020. Accessed February 2021.
9. World Health Organization. Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages: interim guidance, 6 April 2020. World Health Organization. https://apps.who.int/iris/handle/10665/331695. Published April 6, 2020. Accessed February 2021.
10. World Health Organization. Rational use of personal protective equipment for COVID-19 and considerations during severe shortages: interim guidance, 23 December 2020. World Health Organization. https://apps.who.int/iris/handle/10665/338033. Published December 23, 2020. Accessed February 2021.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: REFERRED SUNSET RES. NO. H300-A/20; H327-A/15 INTRACTABLE AND / OR CHRONIC PAIN (NOT ASSOCIATED WITH END-OF-LIFE CARE)

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, Resolution H300-A/20 INTRACTABLE AND/OR CHRONIC PAIN (NOT ASSOCIATED WITH END-OF-LIFE CARE) was referred to the Council on State Health Affairs by the 2020 House of Delegates and the Council revised the resolution to account for Reference Committee feedback; and

WHEREAS, the Council on State Health Affairs reviewed the resolution for accuracy and deleted language that referred to information no longer included in H438-A/17 END-OF-LIFE CARE – POLICY STATEMENT ON; and

WHEREAS, the Council on State Health Affairs also removed inaccurate and/or outdated references to states "[criminalizing] civil malpractice litigation," of which "only about 15 appellate cases…occurred between 1809 and 1981, and there have only been a handful of criminal cases since;"[1] and

WHEREAS, the Council on State Health Affairs further revised the resolution in accordance with the Reference Committee's recommendation to align the structure of the Definitions to match the structure of the Provisions section and model legislation; now, therefore, be it

RESOLVED, that the Council on State Health Affairs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H327-A/15 INTRACTABLE AND/OR CHRONIC PAIN (NOT ASSOCIATED WITH END-OF-LIFE CARE)

The American Osteopathic Association supports the enactment of legislation concerning the administration of controlled substances to persons experiencing intractable and/or chronic non-malignant pain THAT INCLUDES DEFINITIONS AND PROVISIONS substantially conforming to the FOLLOWING ~~attached definitions and requirements~~; and will advocate and promote to students, residents, fellows and practicing physicians educational resources regarding ~~addictive~~ SUBSTANCE USE disorders, diversion awareness and monitoring and appropriate referral resources, as well as the prevention and treatment of pain disorders.

Definitions:

A. Intractable ~~and/or chronic~~ pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none

[1] Bae, Kelly. "When Should Medical Malpractice Be Criminally Culpable?" *Journal of Health & Biomedical Law*, Suffolk University, Feb. 2, 2019.

has been found after reasonable efforts including, but not limited to, a face-to-face evaluation by the attending physician and/**OR** ~~one or more~~ **OTHER** physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.[2]

~~THE CENTERS FOR DISEASE CONTROL AND PREVENTION DEFINES~~ CHRONIC PAIN ~~AS~~ MEANS "PAIN THAT TYPICALLY LASTS >3 MONTHS OR PAST THE TIME OF NORMAL TISSUE HEALING. CHRONIC PAIN CAN BE THE RESULT OF AN UNDERLYING MEDICAL DISEASE OR CONDITION, INJURY, MEDICAL TREATMENT, INFLAMMATION, OR AN UNKNOWN CAUSE."[3]

~~Requirement~~~~GUIDELINES~~PROVISIONS:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's treatment of the person for a diagnosed condition causing intractable and/or chronic pain. This includes patients with chemical dependency and/or substance abuse history if chronic pain exists and controlled substance management is indicated. Physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

B. No physician shall be subject to ~~disciplinary~~ ADVERSE action (by the state medical board, EMPLOYERS, INSURERS, ETC.) for appropriately prescribing or administering controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

C. No physician shall be subject to criminal prosecution (by state or federal agencies) for appropriately prescribing or administering medically necessary controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

D. This section shall not authorize a physician to prescribe or administer controlled substances to a person the physician knows to be using drugs or substances for non-therapeutic purposes.

E. This section ~~does not affect~~ IS NOT INTENDED TO INTERFERE WITH the power (of the state medical board) to deny, revoke, or suspend the license of any physician who fails to keep accurate records of purchases and disposal of controlled substances, writes false or fictitious prescriptions for controlled substances, or prescribes, administers, or dispenses in violation of state controlled substances actS.

~~Recent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medically necessary pain management needs to be revisited. Furthermore, the term intractable pain is ambiguous as to the source. A policy on hospice related pain exists and is supportive of palliative care, including~~

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[2] See MN 152.125 Intractable Pain; TX Sec. 107.001 Intractable Pain Treatment Act; FL 458.326 Intractable Pain – Authorized Treatment.

[3] Dowell, Deborah; Haegerich, Tamara; Chou, Roger. "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016." *Recommendations and Reports*, March 18, 2016 / 65(1);1–49. *See* https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.

71 ~~opiate and/or controlled substance management for terminally ill patients. This defines~~
72 ~~intractable pain in the terminally ill, but further clarification is necessary for chronic pain.~~
73 ~~Chronic pain might also necessitate opiate and/or controlled substance management for~~
74 ~~patients when other interventions have been inadequate. Opiate and/or controlled substance~~
75 ~~management in treating chronic pain patients in those with substance abuse disease issues is~~
76 ~~now supported as a standard of care by the medical literature. Such patients require physician~~
77 ~~hypervigilance as part of this standard of care.~~ (2005, revised 2010)

Background Information: Provided by AOA Staff
Previous comments from reference committee: It is unclear if this is to be a guideline as suggested by the change from "Requirement" to "Guidelines" in page 2, line 43, or if it is to be model legislation as suggested by the language in section B or C of the "Guidelines". We recommend the language be clarified to be consistent with model legislation since there is a lack of evidence-based literature referenced. We also recommend that the title of the resolution be updated to match the language change proposed on page 1, line 29.

The council on state health affairs did not adopt the reference committee's suggestion to amend the title of the resolution to be consistent with the definition that now appears on page 1, line 29 ("intractable ~~and/or chronic~~ pain") because the resolution still covers chronic pain, but that definition was separated out and now appears on page 2, line 38.

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ADOPTED AS AMENDED

DATE: JULY 17, 2021

SUBJECT: CONFLICTS OF INTEREST

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Professional Affairs

WHEREAS, in the interest of promoting professionalism in the osteopathic profession, and maintaining the trust of our fellow physicians and protecting the public from those whose interests may diverge from the best interest of the profession; and

WHEREAS, it is in the best interest of associations to establish and maintain practices that provide confidence in the processes of the association; and

WHEREAS, duality of interests or conflicts of interest can arise in carrying out the work of the association; now, therefore be it

~~RESOLVED, that American Osteopathic Association (AOA) and organizations working with the AOA welcome ideas and discussion from members and stakeholders even if those statements may appear to differ from those found in positions voiced by others; and, be it further~~

RESOLVED, that the AMERICAN OSTEOPATHIC ASSOCIATION **(**AOA**)** work to identify competing interests prior to people assuming leadership roles and ~~publicly share~~ **DISCLOSE** the interests and responsibilities people in leadership have to other organizations; and, be it further

~~RESOLVED, that the AOA work to identify duality of interest or conflict of interest and work to remove people with conflicting responsibilities from discussion and voting on issues with direct financial impact; and, be it further~~

~~RESOLVED, that the AOA when leaders with duality of responsibilities and interests to separate boards are involved in decision making, that the association look to involve a disinterested person or committee to investigate alternatives to proposed arrangements and provide independent oversight.~~

RESOLVED, THAT THE AOA WILL IMPLEMENT A COMPREHENSIVE AND TRANSPARENT CONFLICT OF INTEREST PROGRAM FOR ALL EMPLOYEES, AND PERSONS IN LEADERSHIP ROLES WITHIN THE AOA AND ALL AFFILIATED ENTITIES; AND BE IT FURTHER

RESOLVED, THAT THE AOA BOARD OF TRUSTEES WILL REPORT THE POLICY BACK TO THE 2022 HOUSE OF DELEGATES.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: REVISION OF THE INVOCATION TO SUPPORT INCLUSIVE AND INTERFAITH LANGUAGE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the American Osteopathic Association (AOA) "supports increased awareness of and encourages diversity in its leadership positions and encourages its divisional and specialty societies to do the same," as stated in policy H328-A/19 Diversity in Leadership Positions, and

WHEREAS, the AOA "reaffirms its commitment to promote diversity into the osteopathic profession; endorses programs to encourage increased diversity in enrollment at colleges of osteopathic medicine; and will work to identify and encourage such qualified individuals for participation in those osteopathic affiliate and national activities which foster leadership opportunities," as stated in policy H326-A/19 Promoting Diversity in AOA Membership and Leadership, and

WHEREAS, in the AOA Rules and Guidelines on Physicians' Professional Conduct in policy H506-A/14, it is quoted that physicians should conduct themselves with appropriate respect for their patients' social and cultural needs and provide necessary care without regard to gender, race, color, religion, creed, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, gender identity or sexual orientation," be it further

RESOLVED, that in the spirit of promoting diversity and inclusion, the American Osteopathic Association (AOA) ~~develop a process to work towards the inclusion of all spiritual beliefs in the invocations of official AOA events~~ **SUPPORTS THE USE OF NON-DENOMINATIONAL LANGUAGE IN ALL INVOCATIONS TO BE RESPECTFUL TO PEOPLE OF ALL BELIEFS.**

Background Information: Provided by AOA Staff
Current AOA Policy: None.
The current invocation process includes a meeting between the AOA Chief Engagement and Diversity Officer and the speaker to discuss drafted language and ensure religious inclusivity and sensitivity.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED_____

DATE _____JULY 17, 2021_____

SUBJECT: SUPPORT OF STATE SOCIETIES - SOURCE: H207-A/16

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Membership has reviewed the policy; now, therefore be it

3 RESOLVED, that the Bureau of Membership recommends that the following policy be
4 ~~REAFFIRMED~~ SUNSET.

5 The American Osteopathic Association recommends that membership in an individual's state
6 or divisional society, if available and where permitted by law, be given strong consideration
7 when determining qualification for all osteopathic Directors of Medical Education (DMEs) and
8 residency directors.

Background Information: Provided by AOA Staff
Current AOA Policy:
2006, 2011 Reaffirmed, 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED *(for sunset)*_____

DATE _____JULY 17, 2021_____

SUBJECT: CENTER OF EXCELLENCE FOR STROKE - SOURCE: H306-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the following changes are made to the policy statement.

The American Osteopathic Association encourages practitioners and healthcare institutions, through certification and streamlined coordinated quality patient centered care, to develop stroke centers of excellence to improve the healthcare quality for US citizens. ~~; and will utilize its political and legislative contacts to educate regulatory policy and licensing bodies that the Healthcare Facility Accreditation Program (HFAP), a nationally recognized accrediting and certifying body with deeming authority from the Centers for Medicare and Medicaid Services, must be recognized and included in the process for Stroke Center designation and certification in all US states.~~

Background Information: Provided by AOA Staff

Current AOA Policy:
2011, 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_AS AMENDED_

DATE ____JULY 17, 2021_____

SUBJECT: VOTING DAY – AOA SUPPORTS VOTING DAY POLICY – SOURCE: H307-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association encourages all osteopathic physicians to adopt voting
7 policies in their workplaces that would allow their employees time off during working hours, if
8 necessary, to participate in voting for local, state, and national elections

Background Information: Provided by AOA Staff

Current AOA Policy:
1991; 1996, 2001; 2006; 2011 Reaffirmed as amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: PATIENT CARE AT EXTENDED LONG TERM CARE FACILITIES-SOURCE: H308-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset review; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association encourages the Centers for Medicare and Medicaid
7 Services (CMS) and any other regulatory and non-regulatory entity to: (1) re-evaluate their
8 payment policy to encourage appropriate and adequate care to occur at extended long term care
9 facilities; (2) improve payment to physicians for patient care in extended long term care facilities
10 and to reimburse time spent on phone calls and care plan oversight from extended long term
11 care facilities to physicians; (3) encourage physicians to participate in treatment of their patients
12 at their respective extended long term care facilities; and (4) encourage appropriate tort reform
13 to eliminate less than meritorious claims of elder abuse and malpractice in extended long term
14 care facilities.

Background Information: Provided by AOA Staff

Current AOA Policy:

2006; 2011 Reaffirmed as amended; 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: OSTEOPATHIC TERM PROTECTION - SOURCE: H310-A/16

SUBMITTED BY: Council on Student Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Student Health Affairs has reviewed the policy; now, therefore be
3 it

4 RESOLVED, that the Council on Student Health Affairs recommends that the following policy
5 be REAFFIRMED.

6 The American Osteopathic Association's policy regarding the preferential terms to be used in
7 reference to the osteopathic profession has been updated over the years. However, we are
8 mindful that there are osteopathic physicians practicing medicine who were granted degrees in
9 "osteopathy." Therefore, the AOA will continue to advocate for the protection of the terms
10 "osteopathic", "osteopathy" and "osteopath" as referenced in state and federal laws and rules.

Background Information: Provided by AOA Staff
Current AOA Policy:
2006; 2011 Reaffirmed as amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CYBERBULLYING THROUGH SOCIAL MEDIA - SOURCE: H316-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports increasing awareness among
7 parents/guardians, caregivers, educators, counselors and physicians about the danger of
8 cyberbullying through media advocacy efforts and encourages osteopathic physicians to talk to
9 their patients and the parents/guardians of their patients about cyberbullying and the lasting
10 emotional damage that it can cause.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM - SOURCE: H318-A/16

SUBMITTED BY: Council on State Health Affairs/Bureau of Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs/Bureau of Federal Health Programs has
3 reviewed the policy; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs/Bureau of Federal Health Programs
5 recommend that the following policy be REAFFIRMED.

6 The American Osteopathic Association supports the position that persons accused of a crime
7 involving a firearm be prosecuted to the full extent of the law.

Background Information: Provided by AOA Staff

Current AOA Policy:
1994; Revised 1996, 2001; 2006 Reaffirmed; 2011 Reaffirmed as amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: GOOD SAMARITAN ACTS (HOLD HARMLESS AGREEMENT) PERFORMED ON COMMERCIAL AIRCRAFT - SOURCE: H319-A/16

SUBMITTED BY: Council on State Health Affairs/Bureau of Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs/Bureau of Federal Health Programs has
3 reviewed the policy; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs/Bureau of Federal Health Programs
5 recommend that the following policy be REAFFIRMED.

6 The American Osteopathic Association strongly recommends that all counties and states
7 recognize Good Samaritan (Hold Harmless) laws for medical care rendered on commercial
8 aircraft and urges all airlines to provide liability coverage for such medical care; and will petition
9 the Federal Aviation Administration and appropriate international aviation entities to adopt
10 such standards for all commercial airlines.

Background Information: Provided by AOA Staff

Current AOA Policy:
2001; 2006 Reaffirmed; 2011 Reaffirmed as amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: MEDICAID PHARMACEUTICAL BENEFITS - SOURCE: H320-A/16

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

3 RESOLVED, that the Council on State Health Affairs recommends that the following policy
4 be REAFFIRMED.

5 The American Osteopathic Association should ~~advance~~ **SUPPORT** federal and state policies
6 that ensure Medicaid beneficiaries have access to high-quality health care at the same level of
7 non-Medicaid beneficiaries, to include all healthcare services and products including relevant
8 pharmaceuticals, medical devices, and therapies.

Background Information: Provided by AOA Staff
Current AOA Policy:
1996; 2001 Amended; 2006 Reaffirmed; 2016 Reaffirmed as amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: MEDICA~~LTION~~ SHORTAGES - SOURCE: H330-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the following changes are made to the policy statement **AND**
5 **REFFIRMED WITH THE FOLLOWING AMENDMENTS:**~~.~~

6 The American Osteopathic Association will ~~enjoin~~ **WORK** with the Federal Government,
7 pharmaceutical **AND MEDICAL SUPPLY** manufacturers, and hospital ~~associations~~
8 **ORGANIZATIONS** to ensure that any interruptions of the ~~hospital~~ **MEDICAL** supply
9 **chainS** are as limited in depth and breadth as possible

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: HEALTH INSURANCE AVAILABILITY TO OSTEOPATHIC MEDICAL STUDENTS - SOURCE: H337-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association will advocate for subsidized and more affordable
7 healthcare for Osteopathic Medical Students for the duration of their education

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: BEHAVIORAL HEALTH SERVICES – FUNDING AND ACCESS ~~PATIENTS IN EMERGENCY DEPARTMENTS TOPIC~~ - SOURCE: H338-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association (AOA) supports legislative and other efforts to ensure
6 adequate funding of behavioral health services ~~in the state~~ and will support actions, including
7 federal, state or local legislation or regulation, that improve access to and continuity of
8 behavioral health care services in local communities and that maintain stability of established
9 patient-physician relationships. ~~The AOA will request similar support on a national level by way~~
10 ~~of the Helping Families in Mental Health Crisis Act of 2015 (HR 2646).~~

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: PHYSICIAN GAG RULES – OPPOSITION TO - SOURCE: H340-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) is opposed to governmental actions and policies
7 that limit the rights of physicians and other health care practitioners to inquire of their patients
8 whether they possess guns and how they are secured in the home or to counsel their patients
9 about the potential dangers of guns in the home and safe practices to attempt to avoid those
10 potential dangers. The AOA opposes any further legislation or initiatives advocating physician
11 gag rules that limit physicians' right to free speech or other rights.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CONGRESSIONAL BUDGET OFFICE FISCAL SCORING - SOURCE: H343-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association supports the adoption of **DYNAMIC** ~~a longer term~~
6 ~~(30 year)~~ fiscal scoring by the Congressional Budget Office for health policy legislation.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED_

DATE _____JULY 17, 2021_____

SUBJECT: PAIN RELATED EDUCATION REQUIREMENTS - SOURCE: H344-A/16

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

3 RESOLVED, that the following changes are REAFFIRMED AS AMENDED.

4 The American Osteopathic Association will advocate for medical education for all practitioners
5 on proper opioid prescribing practices, **AND** ~~, but sees no reason for the federal government to~~
6 ~~mandate topic specific education requirements on physicians.~~ any state mandated pain
7 education ~~requirements~~ should include proper prescribing practices for opioids relating to pain
8 treatment, opioid addiction, and identification of prescription drug abuse, misuse and diversion.

Background Information: Provided by AOA Staff
2016

Current AOA Policy:
Similar to H211-A/19 Mandatory CME Course Requirements: While H211-A/19 states the AOA opposes any federal attempts to mandate CME requirements, H326-A/21 states that decisions on medical education requirements relating to pain should be made at the state level, and identifies specific topics for inclusion.

Prior HOD action on similar or same topic:
H211-A/19 Mandatory CME Course Requirement policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: NON-PHYSICIAN HEALTH CARE CLINICIAN - SOURCE: H346-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association will request of Congress and regulatory bodies that the
7 title "health care provider" not be used in favor of the title "physician and non-physician
8 clinician."

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: EUGENIC SELECTION WITH PREIMPLANTATION GENETIC DIAGNOSIS - SOURCE: H349-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be ~~REAFFIRMED~~ SUNSET.

6 The American Osteopathic Association supports legislation that regulates the use of
7 Preimplantation Genetic Diagnosis (PGD) to choose a fetus' traits unrelated to disease

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _REFERRED (***BFHP***)____

DATE ____JULY 17, 2021_____

SUBJECT: TRICARE HEALTH INSURANCE FOR OUR MILITARY - SOURCE: H350-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports member participation in TRICARE plans to
7 provide care for all armed service members, active or reserve, retirees, and their families.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN ~~THE CDC~~ CHRONIC PAIN MANAGEMENT GUIDELINES – INCLUSION OF-
SOURCE: H351-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the following changes are made to the policy statement.

The American Osteopathic Association (AOA) will educate the public and **POLICYMAKERS** ~~Centers for Disease Control and Prevention (CDC)~~ about the efficacy and cost-effectiveness of osteopathic manipulative treatment (OMT) and advocate for OMT as a clinically effective and cost-effective intervention for the treatment of chronic nonmalignant pain syndromes. The AOA will ~~petition the CDC to include~~ **ADVOCATE FOR THE INCLUSION OF** specific language regarding OMT in ~~the~~ recommendations for non-pharmacological interventions for chronic nonmalignant pain syndromes.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: ~~BABY FRIENDLY~~ **SUPPORT OF BREASTFEEDING** ~~HOSPITAL INITIATIVE (BFHI)~~ – SOURCE: H403-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association ~~will encourage~~ **SUPPORTS** all hospitals and birth
6 centers providing mothers with the information and skills to initiate and continue breastfeeding
7 their babies~~; and will promote and give special recognition to hospitals and birth centers who~~
8 ~~receive the Baby Friendly Hospital Initiative (BFHI) designation~~.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: ORGAN AND TISSUE DONATION AND TRANSPLANTATION INITIATIVES – COMMITMENT TO - SOURCE: H411-A/16

SUBMITTED BY: Bureau on Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau on Osteopathic Research and Public Health recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) affirms its support for organ and tissue
7 donation and transplantation programs at local and national levels; will develop and continue to
8 promote physician and public education programs to advance the cause of organ and tissue
9 donation and transplantation; urges the Osteopathic Family to volunteer personally as organ
10 and tissue donors, and in turn, actively encourage their patients to do the same; and encourages
11 osteopathic divisional and specialty organizations, osteopathic medical colleges, and other
12 members of the osteopathic family to develop organ and tissue donation programs in their
13 states and organizations. The AOA also affirms its support for blood donation on an ongoing
14 basis. Furthermore, the AOA is opposed to the sale of donated organs and tissues outside of
15 the United States, and opposed to the sale of organs and tissues for profit.

Background Information: Provided by AOA Staff

Current AOA Policy:
2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: VACCINE SUPPLY AND DISTRIBUTION - SOURCE: H416-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association shall actively advocate for federal policies that support
7 activities and processes for monitoring the supply of vaccines and coordinating vaccine supply
8 and preferentially direct vaccines to physicians, healthcare facilities and healthcare agencies
9 before they are made available to retail outlets.

Background Information: Provided by AOA Staff
Current AOA Policy:
2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: HEALTH LITERACY - SOURCE: H426-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association strongly supports the campaign for health literacy and
7 encourages all practitioners and medical facilities to create a shame-free environment where
8 low-literate patients can seek help.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: ONSITE LAB WORK NO. 1 - SOURCE: H600-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the adoption of national legislation payment
7 and regulation that enables the physician to perform and be compensated for CLIA certified in-
8 office laboratory tests and supports the adoption of national legislation on such policies which
9 enable the physician to perform and be appropriately compensated for medically indicated on-
10 site diagnostic procedures.

Background Information: Provided by AOA Staff
Current AOA Policy:
1999; 2004 Reaffirmed; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: MANAGED CARE REFERRALS - SOURCE: H602-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports and promotes legislation that enables patient
7 access to medical specialists by direct referral from primary care physicians without
8 preauthorization by a managed care company.

Background Information: Provided by AOA Staff

Current AOA Policy:
2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: MEDICARE PHYSICIAN PAYMENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT - SOURCE: H621-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association advocates for nationwide consistency in Medicare
7 physician payment policy, as it relates to osteopathic manipulative treatment (OMT) and
8 evaluation and management (E/M) services, leading to payment for OMT as a separately
9 identifiable procedure from the E/M in all contract regions.

Background Information: Provided by AOA Staff

Current AOA Policy:

1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: DRUG PLAN COVERAGE DENIALS - SOURCE: H628-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association will advocate to the appropriate regulatory agencies and
7 other health professional organizations to require drug benefit managers to fully explain any
8 denial of medication coverage, with explanations that must include but not be limited to the
9 following: (1) The medical reason for denial of a prescribed medication; (2) The criteria upon
10 which a reversal of the denial will be considered; (3) A listing within the notification of denial of
11 the approved alternatives to the prescribed medication; and (4) Listing of appeals process for
12 denials.

Background Information: Provided by AOA Staff
Current AOA Policy:
2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: PAYOR ADHERENCE TO CURRENT PROCEDURAL TERMINOLOGY (CPT) AND INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODING DEFINITIONS - SOURCE: H630-A/16

SUBMITTED BY: Council on Educational and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Educational and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Educational and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association will advocate for all payors to adhere to all CPT coding
7 conventions in developing payment policies; and will support action to prevent payors from
8 deviating from CPT definitions and promote autonomous, fair, and uniform interpretation of
9 CPT and ICD codes to allow for non-prejudicial treatment by payors in the reimbursement
10 arena.

Background Information: Provided by AOA Staff

Current AOA Policy:
2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: INTERFERENCE – LAWFUL OFF-LABEL TREATMENT OF PATIENTS - SOURCE: H634-A/16

SUBMITTED BY: Bureau of Federal Health Programs/Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Federal Health Programs/Council on State Health Affairs has
3 reviewed the policy; now, therefore be it

4 RESOLVED, that the Bureau of Federal Health Programs/Council on State Health Affairs
5 recommend that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) proactively supports the protection of a
7 physician's ability to prescribe treatments and to speak freely about lawful, evidence-based,
8 health care options, including off-label treatments or health care-related research, without fear
9 of being sanctioned by regulatory boards, insurance companies or employers.

10 The AOA supports state efforts to protect patients and prevent sanctions for physicians,
11 directly or indirectly through a subcontractor or otherwise, for making a patient aware of or
12 educating a patient about lawful, evidence-based, health care options, including 1) off-label use
13 of health care options; 2) health care-related research or data; and 3) for offering, providing or
14 making available lawful, evidence-based health care options.

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: APPROPRIATE PAYMENT MECHANISMS FOR PHYSICIAN-LED TEAM-BASED HEALTH CARE - SOURCE: H636-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs/Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Council on Economic and Regulatory Affairs/Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs/Council on State Health Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) will strongly advocate for effective payment models that appropriately **1)** incentivize high-quality care**,** and **2)** ensure physicians ~~can cover REIMBURSED~~ **RECEIVE PAYMENT FOR** the cost of providing this care.

The AOA will advocate to the Centers for Medicare and Medicaid Services (CMS) that any alternative payment models (APMs) proposed for inclusion in the Medicare Access and CHIP Reauthorization Act (MACRA) be reviewed through an administratively simple and transparent process, in a timely manner, and include an appeals process.

The AOA encourages public and private health insurers to develop a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: HUMAN IMMUNODEFICIENCY VIRUS (HIV) - SOURCE: H408-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the following changes are made to the policy.

5 In accordance with the American Osteopathic Association's Code of Ethics: (1) osteopathic
6 physicians **AND OSTEOPATHIC MEDICAL STUDENTS** should provide care for those
7 at risk and those infected with Human Immunodeficiency Virus (HIV), in an atmosphere of
8 compassion and nondiscrimination; (2) recognize their professional and ethical obligations to
9 care for such patients as they care for all patients; (3) osteopathic physicians **AND**
10 **OSTEOPATHIC MEDICAL STUDENTS** in their important role as humanitarian
11 resources to their patients, families, and communities, provide candid, effective nonjudgmental
12 preventive education for those at risk, and serve as effective resources for their patients' families
13 and loved ones; and (4) osteopathic physicians **AND OSTEOPATHIC MEDICAL**
14 **STUDENTS** should be educational resources for those at negligible risk in an effort to
15 promote enlightened attitudes in places of work, our schools, and communities in general;
16 **AND (5) OSTEOPATHIC PHYSICIANS AND OSTEOPATHIC MEDICAL**
17 **STUDENTS SHOULD ADVOCATE FOR THE REMOVAL OF LEGAL AND**
18 **SYSTEMIC BARRIERS TO ALLOW PATIENTS LIVING WITH HIV TO ACCESS**
19 **CARE, AND TO ALLOW HEALTHCARE WORKERS LIVING WITH HIV TO**
20 **PROVIDE CARE TO THEIR PATIENTS.**

Background Information: Provided by AOA Staff

Current AOA Policy:

1992; 1996 Reaffirmed as Amended; 2001 Reaffirmed as Amended; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $ 0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: WHITE PAPER - IMPROVING ACCESS TO PHYSICIAN-LED CARE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, the House of Delegates adopted H200-A/16 Rural Sites and Underserved/Inner City Areas – Osteopathic Education as its policy on encouraging clinical rotations in underserved areas by osteopathic students and graduates; and

WHEREAS, the House of Delegates adopted H200-A/19 Health Care Shortage in Rural America as its policy on developing teaching centers in rural areas so that residents can train and stay in these areas; and

WHEREAS, the House of Delegates adopted H201-A/20 Rural Sites – Osteopathic Education in as its policy on encouraging clinical rotations in rural settings; and

WHEREAS, the House of Delegates adopted H211-A/16 Rural Healthcare Provided by Current AOA GME Programs – Preservation of as its policy on ensuring the preservation of residencies in rural and underserved communities under the Single Accreditation System; and

WHEREAS, the House of Delegates adopted H311-A/17 Rural and Urban Practices – Disparities Between as its policy on supporting legislation to sustain a minimum geographic cost-of-practice index value for physicians' services at or above 1.000; and

WHEREAS, the House of Delegates adopted H317-A/20 Physician Incentives – to Underserved Areas as its policy on supporting physician loan repayment and tax deductions for individuals who practice in underserved areas; and

WHEREAS, the House of Delegates adopted H329-A/16 Graduate Medical Education Funding and Incentives as its policy on supporting the distribution of federal funds for GME, prioritizing areas in most need for DO and MD programs based upon geography and specialty; and

WHEREAS, the House of Delegates adopted H334-A/18 Rural Healthcare Payment Equity as its policy endorsing equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality healthcare in rural areas; and

WHEREAS, the House of Delegates adopted H339-A/17 Equity in Medicare & Medicaid Payments as its policy supporting legislation to include socioeconomic risk stratification in the evaluation of healthcare provider reimbursement to account for the challenges of serving socioeconomically disadvantaged or medically underserved patient populations to ensure continued timely access to appropriate clinical services; and

WHEREAS, the House of Delegates adopted H359-A/19 State Graduate Medical Education (GME) Funding Alternatives as its policy

WHEREAS, the House of Delegates adopted H613-A/16 Physician Supply in Rural, Underserved United States – Recommendations for Improving as its policy supporting the creation of alternative GME funding mechanisms and the alignment of this funding with state health care priorities (namely, addressing workforce shortages and providing care to the residents in greatest need); and

WHEREAS, the House of Delegates adopted H640-A/20 Non-Physician Clinicians as its policy supporting appropriate physician involvement in patient care provided by non-physician clinicians; and

WHEREAS, the first meeting of the American Osteopathic Association Board of Trustees following completion of the white paper, Improving Access to Physician-Led Care, was held on July 13, 2021; and

WHEREAS, the American Osteopathic Association Board of Trustees reviewed the white paper, Improving Access to Physician-Led Care, and approved it for submission to House of Delegates on Tuesday, July 13, 2021; and

WHEREAS, the Improving Access to Physician-Led Care white paper incorporates the principles outlined in the above policies into a cohesive argument for addressing access to care issues through a physician-led, team-based model of care; now, therefore be it

RESOLVED, that the American Osteopathic Association adopt the white paper, Improving Access to Physician-Led Care as its position on leveraging the physician-led, team-based model of care to meet our nation's growing health care needs in a safe and cost-effective manner.

Improving Access to Physician-led Care

<u>Overview</u>

This paper addresses the primary care physician workforce shortage, identifying potential solutions dispels notions that scope of practice expansions can address the issue.

<u>Background</u>

Numerous factors contribute to the growing physician workforce shortage in the United States, currently projected to exceed 139,000 physicians by 2030.[1] These include an aging population (including among physicians), an increase in the number of insured individuals following the enactment of the Affordable Care Act (ACA) and related state Medicaid expansions, and the arbitrarily low cap on Medicare-funded graduate medical education (GME, aka "residency") positions for physicians that was established by Congress in 1997, as well as Medicare, Medicaid and other payor payment rates which have failed to keep pace with the increasing cost of providing care

[1] X. Zhang, D. Lin, H. Pforsich, and V. W. Lin. 2020. Physician workforce in the United States of America: forecasting nationwide shortages. *Human Resources for Health.* Article, National Center for Biotechnology Information, Washington, DC.

67 According to a 2020 study published by the American Association of Medical Colleges, the
68 United States population is expected to grow by 10.4% (from about 327 million to 361
69 million) by 2033, while the population over age 65 is expected to grow by 45.1%.[2]
70 Further, more than 2 in 5 currently practicing physicians will reach retirement age in the
71 next decade.[3] In addition, more than 20 million Americans gained insurance coverage
72 over the past few years under the ACA. Further, if the states that have not expanded
73 Medicaid eligibility (12 as of January 2021) did so, nearly 4 million more individuals
74 would become eligible for coverage.[4] These factors combine to create an increasing
75 demand for physician services, while two major factors work against a supply-side
76 increase: (1) the freeze on Medicare funding and geographic distribution of residency
77 slots at their 1996 levels and locations, and (2) rising educational debt that is leading
78 physicians who might otherwise choose to practice in physician shortage areas or in
79 high need specialties to seek higher paying specialty positions in urban areas.[5]

80 **Legislative Proposals**

81 In order to address the growing physician shortage, some legislators have begun electing to
82 circumvent evidence-based physician licensure pathways to allow non-physician
83 clinicians (nurses, physician assistants, and even entirely new types of clinicians) to
84 practice equivalently to physicians without completing similar education, training or
85 testing.

86 There are several issues with this approach; namely, (1) that unlike physicians, the length,
87 content and type of training (online vs. in-person, didactic vs. clinical, academic vs.
88 practical, etc.) that these providers complete varies by state and sometimes even by
89 provider, (2) research demonstrates that these individuals are largely drawn to the same
90 areas where physicians are already practicing, and that (3) non-physicians tend to
91 overprescribe/overutilize diagnostic tests, which, combined with their history of seeking
92 pay parity with physicians legislatively once they achieve independent practice, makes it
93 unlikely that these individuals will actually solve the cost and access issues that
94 legislators are attempting to address.

95 Physician licensure requirements are largely the same across states, and require four years of
96 medical school, a comprehensive examination series followed by supervised
97 postgraduate ("residency") training with progressively greater autonomy before they are
98 allowed to independently treat patients. Medical school education is nationally
99 standardized and includes two years of didactic study totaling upwards of 750
100 lecture/practice learning hours just within the first two years, plus two more years of
101 clinical rotations done in community hospitals, major medical centers and doctors'
102 offices. Residency programs are also standardized by specialty, and are comprised of

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[2] No author. June 2020. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges. Report, IHS Markit Ltd., Washington, DC.
[3] *Id.*
[4] R. Garfield, K. Orgera and A. Damico. 2021. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Issue Brief, Kaiser Family Foundation, San Francisco, CA.

[5] The Consolidated Appropriations Act, 2021 enacted into law on December 27, 2020, provides the Centers for Medicare & Medicaid Services funding for 1,000 new residency slots. This will support approximately 200 new Medicare-funded residency positions per year for five years.

103 12,000 to 16,000 hours of supervised training through which physicians develop
104 advanced knowledge and clinical skills relating to a wide variety of patient conditions
105 over the course of three to seven years.

106 While physician licensure requirements remain largely the same across the country – and in fact,
107 the trend has been towards *increasing* physician education and training requirements over
108 the years – some states have begun granting similar licenses to non-physician clinicians,
109 upon completion of as little as a two-year master's degree (which may be done largely
110 online), a single examination and no supervised postgraduate training, as in the case of
111 nurse practitioners (NPs). [6] Not only do NPs complete far fewer supervised clinical
112 hours than physicians during their educational programs, their professional organization
113 (the American Academy of Nurse Practitioners; "AANP") actually *opposes* requiring
114 them to complete supervised residency training before becoming licensed to practice
115 independently.[7] Unsurprisingly based on their relatively short educational background,
116 evidence shows that non-physician clinicians tend to overprescribe medication[8], issue
117 poorer quality referrals to specialists[9] and order unnecessary diagnostic imaging[10]
118 compared to physicians, all of which expose patients to potentially costly, unnecessary
119 and high-risk interventions, because their training has not prepared them to determine
120 which cases warrant such care.

121 Some states have also begun allowing non-physician clinicians who complete doctorates to refer
122 to themselves as "doctors" regardless of whether the doctorate that they completed is
123 academic rather than clinical in nature. Use of the title "doctor" in a clinical setting can
124 easily confuse patients into thinking that they are being seen by a physician when the
125 individual making medical decisions has vastly different education and training.[11]

126 Despite these differences in education, training and testing, history shows that once non-
127 physician clinicians achieve independent practice they often return to state legislatures
128 to advocate for pay parity with physicians, thereby defeating any cost savings arguments
129 for independent practice. [12] All health care professions have an equal right to provide
130 stakeholder input to the Centers for Medicare & Medicaid Services (CMS), which makes
131 centralized decisions regarding health professional payment rates after taking into
132 account factors such as the time it takes to perform a service, the technical skill and
133 physical effort, the required mental effort, judgment and stress due to the potential risk
134 to the patient, as well as practice expenses and professional liability insurance costs.
135 Nonetheless, pay parity is a stated goal of organizations like the AANP, and their

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[6] *See* Master of Science in Nursing in Family Nurse Practitioner, Texas A&M University. Accessed on April 5, 2021. Available at: https://catalog.tamu.edu/graduate/colleges-schools-interdisciplinary/nursing/msn-family-practitioner/#degree-plan.

[7] *See* Position Statement: Mandated Residency and Fellowship Training. *American Association of Nurse Practitioners*, 2019.

[8] U. Muench, J. Perloff, C. Parks Thomas and P. Buerhaus. Prescribing Practices by Nurse Practitioners and Primary Care Physicians: A Descriptive Analysis of Medicare Beneficiaries. *Journal of Nursing Regulation*, April 1, 2017.

[9] R. Lohr, C. West, M. Beliveau, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings, Oct. 11, 2013.

[10] D. Hughes, M. Jiang and R. Duszak Jr. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Medicine*, January 2015.

[11] *See* DNP-PhD Comparison, Duke University School of Nursing. Accessed on April 5, 2021. Available at: https://nursing.duke.edu/academic-programs/dnp-program-nursing/dnp-phd-comparison.

[12] L. Kaplan, Louise and J. Gill. Advocating for Washington state ARNP payment parity. *The Nurse Practitioner*, Feb. 2020.

136 success achieving it legislatively rather than through evidence-based valuation protocols
137 may encourage other non-physician clinician associations to seek similar rate increases
138 from state legislatures. When combined with these providers' overutilization of costly
139 medical procedures and prescriptions, it is unlikely that granting independent practice
140 will have a positive impact on healthcare cost issues.[13]

141 In addition to cost concerns, research demonstrates that allowing non-physician clinicians to
142 practice independently does not solve access-to-care issues either. In fact, it shows that
143 these individuals largely choose to practice in areas where physicians are already
144 practicing.[14] To avoid this, some states have attempted to place initial geographic and
145 practice area (i.e. primary care only) limits on a provider group in order to improve
146 access in rural areas; however, historical trends show that once independent practice is
147 achieved, these groups return to the legislature year after year in attempts to erode any
148 remaining restrictions on their practice.[15] These patterns demonstrate that while the
149 stated goal of these groups may be to address cost and access issues, their true
150 motivation is a desire to achieve similar practice rights and reimbursement to physicians
151 without having to complete similar training and testing requirements that help to ensure
152 patient safety.

153 **A Better Way: the Physician-led, Team-based Model of Care**

154 Rather than the fragmented, two-tiered healthcare system described above, studies show that
155 the optimal way to deliver high quality, cost-effective medical care is through a team-
156 based model that utilizes the various strengths of each member of the healthcare team
157 with a physician at the head.

158 A recent study by the National Academy of Medicine (NAM) found that "multidisciplinary
159 team-based care is associated with better performance on traditional measures of health
160 care quality, such as emergency department utilization and hospital readmissions. In
161 addition, several studies have concluded that optimizing team-based care is a cost-
162 effective intervention."[16] These findings are consistent across settings, including
163 ambulatory emergency departments, intensive care units, and nursing homes, as well as
164 other settings. Among the research cited in the NAM analysis, a 2015 review of 52
165 studies of team-based care for hypertension found that teams achieved controlled blood
166 pressure in 12 percent more patients than routine care did. They also cite another study
167 finding that a team-based care model "that works in collaboration with primary care
168 clinicians and patient-centered medical homes to provide home-based geriatric care
169 management was associated with 7.1 percent fewer emergency department visits, 14.8
170 percent fewer 30-day readmissions, 37.9 percent fewer hospital admissions, and 28.5
171 percent fewer total bed days of care, saving an estimated $200,000 per year after
172 accounting for program costs."

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[13] *See* https://www.aanp.org/news-feed/the-american-association-of-nurse-practitioners-aanp-is-now-100-000-strong.
[14] *See* sample NP workforce maps for Wyoming, Delaware.
[15] *See* e.g. Massachusetts - 244 CMR 4.00 of 2012 (established independent practice for certified nurse midwives) and MA House Bill 552 of 2017-18 and MA House Bill 1028 of 2019-2020 (seek payment parity)
[16] Smith, C. D., C. Balatbat, S. Corbridge, A. L. Dopp, J. Fried, R. Harter, S. Landefeld, C. Martin, F. Opelka, L. Sandy, L. Sato, and C. Sinsky. 2018. Implementing optimal team-based care to reduce clinician burnout. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC.

173 The best approach to improving healthcare quality while expanding system capacity is through
174 expanding a physician and non-physician clinician workforce that is effectively trained
175 in team-based care. Authorizing independent practice for non-physician clinicians is
176 counterproductive to this effort, insufficiently supported by evidence, and potentially
177 harmful to patient outcomes. There have been few randomized control trials (RCTs)
178 assigning patients to different providers to compare cost and quality between physicians
179 and non-physician clinician groups. Most studies have relied on analyses of claims and
180 encounter data, and the few RCTs that have been conducted were plagued with serious
181 methodological flaws.

182 A June 2019 Medicare Payment Advisory Commission (MedPAC) report to Congress noted
183 that practices that employ both NPs or physician assistants (PAs) and physicians might
184 systematically direct lower acuity patients to NPs or PAs. Patients may also choose
185 among physicians, NPs, and PAs based on their preferences or the perceived severity of
186 their illness. To the extent that systematic differences exist in the types of patients
187 treated by physicians compared with those treated by NPs or PAs that are not
188 observable in the data (and thus cannot be adjusted for), these studies may not
189 effectively isolate the effects of clinician type from other confounding factors.

190 Additionally, the roles and responsibilities of nurses can vary in different settings, and
191 definitions of autonomy varied between some RCTs conducted. An analysis published
192 in 2014 found that "[i]n the evaluated studies, the assumption is that nurses possess the
193 competence required for substituting physicians, but the level of substitution does not
194 seem equal among studies. While the level of training may be a critical factor for an
195 effective outcome, the studies report incomplete descriptions of nurses' roles and
196 competencies".[17] Among the few RCTs that have been conducted, long-term outcomes
197 and condition management for complex cases are also not sufficiently accounted for.

198 An analysis published in the *International Journal for Quality in Health Care* in 2015 describes the
199 limitations encountered in their analysis, stating that "the physiologic outcomes
200 addressed in current research focused on changes in parameters such as blood pressure;
201 a more meaningful outcome would be the proportion of subjects attaining disease
202 control over time. Future studies should also examine rates of preventable
203 hospitalizations and appropriate preventive care, such as vaccines and disease screening.
204 Finally, studies with longer follow-up periods will allow for assessment of rates of
205 retention in care".[18] A consistent concern among existing RCTs is the length of the
206 follow-up period and the outcomes tracked over that period. Often, studies comparing
207 advanced practice registered nurses and physicians have been limited to a single
208 encounter or one month time frame.[19]

209 The growing responsibilities that non-physician clinicians take on in our health care system,
210 especially within collaborative care models, are critical. However, this is not sufficient to
211 justify scope of practice expansions that can negatively impact patient care. While

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[17] Martinez-Gonzalez et al. "Substitution of physicians by nurses in primary care: a systematic review and meta-analysis". *BMC Health Services Research*. 2014, 14:214.
[18] Swan et al. "Quality of primary care by advanced practice nurses: a systematic review". *International Journal for Quality in Health Care*. 2015 Oct;27(5):396-404. doi: 10.1093/intqhc/mzv054.
[19] Id.

212 numerous studies highlight the quality of care provided by non-physician clinicians, it is
213 critical to also recognize the shortcomings of the research and factors that they have
214 been unable to account for.

215 Additionally, while not well-documented, it is self-evident that that there is more fragmented
216 care where independent practice for non-physicians exists, and physicians are often
217 called upon following an initial misdiagnosis or negative outcome resulting from care
218 from a lesser-trained clinician.

219 **Evidence-based Solutions**

220 ***Targeted Funding***

221 The cost to produce a physician in the U.S. is staggering, and recent studies show that 76
222 percent of all medical school graduates graduate with student loans, averaging
223 approximately $190,000. With interest growing over the course of a three-to-seven-year
224 residency program, the eventual repayment total for many physicians can exceed
225 $400,000.[20] Recognizing the importance of a physician-lead medical workforce, a
226 number of states have implemented successful graduate medical education and loan
227 repayment programs that can serve as models for other states to help them attract
228 physicians to provide care in much-needed specialties and areas.[21]

229 One recent example is Oregon's Health Care Provider Incentive Fund (Fund), which was
230 established in 2017 through an initial $16 million allocation to build health care
231 workforce capacity in rural and medically underserved parts of Oregon and to provide
232 resources for the Health Care Provider Incentive Program (HCPIP).[22] The funding is
233 administered by the Oregon Health Authority (OHA) in partnership with the Oregon
234 Office of Rural Health (OORH), and utilizes loan forgiveness, loan repayment,
235 insurance subsidies and scholarships (including one at the Pacific Northwest College of
236 Osteopathic Medicine) to assist qualified health care providers who commit to serving
237 the state's Medicaid and Medicare beneficiaries for a certain period of time in rural and
238 underserved areas of the state.

239 Specifically, the primary care loan forgiveness program provides loans to postgraduate trainees
240 who agree to:

241 1. Practice for one to three years in an underserved Oregon community that has been
242 federally defined as a Health Professional Shortage Area (HPSA), and

243 2. Serve Medicaid and Medicare members in at least the same percent as is present in the
244 community.

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[20] M. Runge. Public service loan forgiveness can help fix the shortage of primary care and rural physicians. *STAT+,* August 11, 2017.

[21] No author. Loan Repayment/Forgiveness/Scholarship and Other Programs. *Association of American Medical Colleges*, no date.

[22] No author. Health Care Provider Incentive Program: Evaluation of Program Effectiveness. *Oregon Health Authority, Health Policy and Analytics Division, Primary Care Office*, Nov. 2020.

245 If the provider still has debt upon completion of the program, they then become eligible for a
246 loan repayment award.

247 In addition, the HCPIP also provides subsidies for malpractice insurance premiums for
248 providers serving at a location that meets the OHA's definition of a rural practice.
249 Subsidy payments from OHA are a percentage of the provider's malpractice premiums,
250 with the highest subsidies awarded to providers of obstetrical care.

251 Lastly, the HCPIP funds scholarship awards at schools equal to the cost of a year of education,
252 in exchange for a 1-year HPSA service obligation for each year funded.

253 As a result of these incentives, nine of the 16 areas identified as "target areas" for the program
254 in 2018 have seen an increased number of full-time providers. A program evaluation
255 identified COVID-19 as an obstacle to the growth and sustainability of the program in
256 the last year; however, the program has adjusted to account for the increased use of
257 telemedicine among awardees and also plans to increase targeted outreach to clinicians
258 who are representative of those they serve to improve the program's reach to
259 marginalized communities.

260 Another example of state success – as well as the negative impact associated with cutting
261 funding for training programs – is the state of Texas, which has provided varying levels
262 of funding for rural and primary care training programs through its Higher Education
263 Coordinating Board (THECB) since the 1980s. Funded programs include:

264 - The Statewide Primary Care Preceptorship Program, which provides funding support to
265 preceptorship programs in family practice, general internal medicine and general pediatrics, with
266 the goal of encouraging Texas medical students to choose primary care careers by offering
267 direct student support for a month-long experience in one of the specialties. A comprehensive
268 nine-year study showed that students who participated in a family medicine preceptorship were
269 almost twice as likely to pursue a career in family medicine, and of the 238 medical students
270 who completed the preceptorships in 2009, 93 percent said the experience made them more
271 receptive to primary care as a career[23];

272 - The Physician Education Loan Repayment Program, which provides loan repayment funds for
273 physicians who agree to provide health care services to recipients enrolled in Medicaid and the
274 Texas Children's Health Insurance Program (CHIP), or in a Texas Juvenile Justice Department
275 or Texas Department of Criminal Justice facility, for at least four years;

276 - The State Rural Training Track Grant Program, which provides funding for residency programs
277 in rural areas, with the goal of attracting physicians to remain in those areas to practice; and

278 - The Family Practice Residency Program, which provides grants to the state's 31 nationally
279 accredited family medicine residency programs, located in every region of the state, in order to

[23] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf

280 help increase the number of physicians who pursue family medicine and establish their practices
281 in rural and underserved communities in Texas.[24]

282 Although 66 percent of the physicians who completed residency training in Texas between 2008
283 – 2017 chose to remain in the state upon completion[25] – indicating a high return on
284 investment for the aforementioned programs – funding has been variable and over the
285 years some programs have been forced to close permanently:[26]

286 - The Kelsey-Seybold Family Medicine Residency Program – considered a model for training new
287 physicians in a team-based, multispecialty environment – announced its closure due to financial
288 instability in 2009;

289 - The Texas Tech University Rural Program in Abilene closed its doors for financial reasons in
290 2008; and

291 - The Christus St. Elizabeth Family Medicine Residency Program in Beaumont was forced to
292 close in 2002 due to a lack of financial support. Of the 74 graduates from the program
293 practicing medicine in 2005, 88 percent practiced in health professional shortage areas.

294 According to a recent report from the Department of State Health Services, Texas will need
295 approximately 3,400 more primary care physicians than it is on track to produce by 2030
296 to meet demand. Despite this, the 2021 state budget cuts the Family Practice Residency
297 Program from $5 million a year to $4.75 million and reduces funding for family
298 medicine residents from $14,300 per resident in 2011 to just $5,400 in 2021.[27]

299 Considering the fact that it costs the state approximately $168,000 to produce one medical
300 school graduate, and in 2016 (the most recent year for which data was available) it
301 produced 180 more graduates than it had first-year residency slots – representing a lost
302 investment of $30 million in that one year alone – any cost savings to the state by
303 reducing funding for residency programs that have been proven effective in producing
304 Texas-based primary care physicians is far outweighed by the financial loss that it incurs
305 when physicians leave the state to train (and frequently remain) elsewhere.[28]

306 It is important to note that the osteopathic profession has a longstanding commitment to
307 providing care in rural and underserved areas, and many of the beneficiaries of the
308 abovementioned programs are DOs. According to the 2019 Osteopathic Medical
309 Profession Report, 57% of DOs currently practice in primary care specialties, surpassing
310 the percentage of MDs entering primary care, which has been on the decline since
311 2011.[29] Many osteopathic medical schools are located in rural and underserved areas,

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[24] https://www.highered.texas.gov/institutional-resources-programs/institutional-grant-opportunities/family-medicine-residency-program/
[25] https://www.aamc.org/data-reports/students-residents/interactive-data/table-c6-physician-retention-state-residency-training-state
[26] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf
[27] https://www.tafp.org/news/tfp/q1-2021/lege-update
[28] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf
[29] Knight, Victoria. "American Medical Students Less Likely To Choose To Become Primary Care Doctors." *Kaiser Health News*, July 3, 2019. https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/.

312 and nine out of the top ten medical schools with the most graduates practicing primary
313 care are osteopathic schools.[30] Further, in 2020, the Oklahoma State University College
314 of Osteopathic Medicine at the Cherokee Nation became the first tribally-affiliated
315 college of medicine in the United States.[31]

316 ***Driving Specialty Decisions at the Undergraduate Medical Education Level***

317 The experiences of students during their first four years of medical education are critical in
318 shaping professional interests. An analysis of the last 10 years of data from the
319 American Association of Colleges of Osteopathic Medicine's (AACOM) graduate
320 survey found that mentoring by faculty may have an outsized influence in decision
321 making on future specialty and practice setting. In 2019, students who indicated that
322 they intended to practice in primary care or in a rural setting also tended to be more
323 satisfied with their faculty mentoring during the undergraduate medical career.[32] A
324 similar survey by the Association of American Medical Colleges had similar findings,
325 where 52.1 percent of respondents cited "role model influence" as having a strong
326 influence on their specialty choice in 2020. The June 2019 report by MedPAC evaluated
327 the current pipeline of primary care physicians, and it came to similar conclusions
328 regarding the influence of the undergraduate medical education experience on practice
329 decisions.[33]

330 This evidence suggests that specialty decisions are made well before graduation from medical
331 school. Building training programs where students gain exposure to high-quality
332 mentors in primary care, and even engage in community-oriented primary care
333 education may ultimately make students more likely to go into a primary care specialty
334 or practice in underserved settings.[34] Several Health Resources and Services
335 Administration (HRSA) programs seek to strengthen primary care training and steer
336 students at the undergraduate medical education level. Expanding these programs can
337 be a useful tool in expanding the primary workforce in underserved communities.

338 HRSA's 2020 report to the HHS Secretary states that expanding the availability of longitudinal
339 training programs, instead of 4-8 week rotations, provide meaningful education in
340 health promotion, disease prevention, and care management for the chronically ill, while
341 also making students more likely to ultimately specialize in primary care.[35] [36] While
342 HRSA has some grant programs that can help institutions develop innovative

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[30] No Author. "DO Schools Lead in Primary Care, Rural Care and Caring for Underserved in U.S. News' Medical Schools Ranking." American Osteopathic Association, April 2, 2021. https://osteopathic.org/2021/04/02/do-schools-lead-in-primary-care-rural-care-and-caring-for-underserved-in-us-news-best-medical-schools-ranking/.

[31] https://medicine.okstate.edu/hastings/index.html.

[32] American Association of Colleges of Osteopathic Medicine. "Osteopathic Medical School Graduates: Evaluation of Faculty Mentoring". 2020.

[33] "Issues in Medicare beneficiaries' access to primary care". Medicare Payment Advisory Commission Report to Congress. June 2019. http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

[34] Magzoub, Mohi Eldin M. A. MD, PhD; Schmidt, Henk G. PhD A Taxonomy of Community-based Medical Education, Academic Medicine: July 2000 - Volume 75 - Issue 7 - p 699-707

[35] Pfarrwaller E, Sommer J, Chung C, Maisonneuve H, Nendaz M, Junod Perron N, Haller DM. Impact of Interventions to Increase the Proportion of Medical Students Choosing a Primary Care Career: A Systematic Review. J Gen Intern Med. 2015 Sep;30(9):1349-58. doi: 10.1007/s11606-015-3372-9. PMID: 26173529; PMCID: PMC4539313.

[36] "Seventeenth Annual Report to the Secretary of the United States Department of Health and Human Services and the Congress of the United States". Health Resources and Services Administration. October 2020.

343 undergraduate medical education programs to address workforce shortages, much of
344 HRSA's work focuses on graduate medical education. A grant program for innovation
345 in primary care and development of longitudinal programs could help expand the
346 pipeline of students who choose primary care upon graduation.

347 Data from HRSA also suggests that there is strong demand for primary care training, and
348 additional funding for students could support more students in pursuing a medical
349 education that emphasizes this type of practice. The National Health Service Corps
350 (NHSC) is one program that supports students who choose to pursue a medical
351 education and practice in primary care. The NHSC scholarship program has been highly
352 successful, but it can only support a limited number of applicants. In 2019, the program
353 saw nearly 1,900 applicants, but only 200 new awards were granted. Identifying more
354 students who are interested in primary care early in their careers, encouraging
355 commitment, and providing financial support for their education in this specialty can
356 help produce more providers who are ready to meet the needs of rural and underserved
357 communities across the country.

358 ***Enhancing Payment for Medicaid***

359 Medicaid enrollees comprise a significant share of primary care visits and ensuring that
360 physician practices that serve Medicaid populations receive payment at level that is
361 needed to remain viable is critical to promoting access in rural and underserved
362 communities. On average, state Medicaid programs pay for healthcare services at 72
363 percent of the Medicare rate; for primary care services, that number drops to 66
364 percent.[37]

365 Increasing Medicaid payment to at least an equal level with Medicare will allow more physicians
366 to accept Medicaid patients and attract them to practice in high-need settings. An
367 analysis by Health Affairs describes how physicians cite low reimbursement rates as a
368 deterrent to participation. Additionally, a MACPAC and University of Minnesota
369 analysis of National Ambulatory Medical Care Survey data found that the proportion of
370 physicians accepting new patients varies significantly based on patient coverage type.
371 Providers were less likely to accept new patients with Medicaid, with 70.8 percent
372 accepting new patients, than with Medicare (85.3 percent) or private insurance (90.0
373 percent). MACPAC also found in their analysis that state Medicaid reimbursement was
374 correlated with new patient acceptance. Every 1 percentage point increase in the
375 Medicaid-to-Medicare fee ratio appears to increase acceptance by 0.78 percentage
376 points.[38]

377 Other studies have confirmed the MACPAC finding. A recent study by the Federal Reserve
378 Bank of Chicago analyzed the impact of the Medicaid primary care rate increase that
379 was implemented by the ACA and expired in 2015. The study found that the increase in
380 Medicaid payments was associated with improvements in access and health measures

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[37] Zuckerman, Skopec, and Epstein. "Medicaid Physician Fees after the ACA Primary Care Fee Bump." Urban Institute, March 2017. https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf

[38] Holgash and Heberlein. "Physician Acceptance of New Medicaid Patients". Medicaid and CHIP Payment and Access Commission. January 2019. Presentation. https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

among Medicaid beneficiaries. The study also found a correlation between Medicaid rates and usage of health care services by beneficiaries. The researchers identified that a $10 increase in physician reimbursement is associated with a 0.29 percentage point (1.5 percent) increase in the probability that respondents covered by Medicaid went to a doctor's office in the preceding two weeks.[39] This is likely because increased availability of providers and appointment times supports patient engagement in their own care, as well as longitudinal relationships between patients and providers.

Federal policies should ensure that Medicare payment rates serve as a floor for Medicaid rates. Improving Medicaid rates will help primary care practices afford to practice in settings with a larger share of Medicaid patients.

Conclusion

Effectively leveraging a physician-led, team-based model of care delivery is critical to meeting our nation's growing health care needs moving forward. Although the investment required of state and federal governments in order to adequately address these issues is significant, as the research above demonstrates, effectively training physicians in areas of high need and utilizing the physician-led team model will help us achieve cost-effective solutions without sacrificing quality of care.

Physicians remain the only category of health care professional to complete comprehensive medical education, training and competency demonstration requirements that is designed to ensure the highest, uniform standards of care nationwide. While other provider types have sought to increase their education and training in recent years, the fact remains that there is a lack of consistency, uniformity and information about the long-term outcomes of these providers, who largely resist physician involvement while continuing to seek equivalent rights and reimbursement once they achieve independent practice, which defeats the stated goals of legislatures in granting them such rights.

All patients deserve to be treated by fully trained and licensed medical professionals, regardless of location or ability to pay, and the physician-led, team-based model of care ensures that fully licensed physicians are appropriately involved in patient care while valuing the unique training and skill sets of all health care providers.

Background Information: Provided by AOA Staff

Current AOA Policy:

H200-A/16 Rural Sites and Underserved/Inner City Areas – Osteopathic Education
H200-A/19 Health Care Shortage in Rural America
H201-A/20 Rural Sites – Osteopathic Education in
H211-A/16 Rural Healthcare Provided by Current AOA GME Programs – Preservation Of
H311-A/17 Rural and Urban Practices – Disparities Between
H317-A/20 Physician Incentives – To Underserved Areas
H329-A/16 Graduate Medical Education Funding and Incentives
H334-A/18 Rural Healthcare Payment Equity
H339-A/17 Equity in Medicare & Medicaid Payments

[39] Alexander and Schnell. "Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health"

H359-A/19 State Graduate Medical Education (GME) Funding Alternatives
H613-A/16 Physician Supply in Rural, Underserved United States – Recommendations For Improving
H640-A/20 Non-Physician Clinicians

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: WHITE PAPER - REFORMING THE HEALTH IT LANDSCAPE TO IMPROVE THE PATIENT AND CLINICIAN EXPERIENCE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, the House of Delegates adopted H632-A/19 Patient Matching Of Electronic Health Record Data, which outlines the need for corrections in errors and missing information associated with EHRs; and

WHEREAS, the House of Delegates adopted H605-A/20 Interoperability Of Health Information Technology, which outlines the need for clinically driven, standardized products that are interoperable so that physicians have access to data at the point of care; and

WHEREAS, the House of Delegates adopted H642-A/20 Prior Authorization, which merged policies H343-A/13, H602-A/15; H632- A/17, H635-A/19, H637-A/19, and H640-A/16, and outlines the need for the prior authorization process need to be standardized in order to reduce cost, improve timely access to care and reduce physician burden; and

WHEREAS, the House of Delegates adopted H342-A/17 Shared Principles Of Primary Care, which outlines policy to encourage primary care providers to seek out the impact of social determinants of health and societal inequities, and to partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution; and

WHEREAS, the House of Delegates adopted H632-A/19 Patient Matching Of Electronic Health Record Data, which outlines how being able to effectively capture, track, and share data relating to patients' social determinants of health is crucial to delivering high-value care management and promoting well-being outside of a hospital; and

WHEREAS, the House of Delegates adopted H301-A/19 Medical Websites And Smartphones/Tablet Computer Apps To Diagnose Illness, which recognizes the value that health information websites and third-party apps provide patients and encourages their use for patients to gain information about their health, and will encourage its members to recommend patients use evidence-based resources so that they may continue to actively engage in their own health care; and

WHEREAS, the first meeting of the American Osteopathic Association Board of Trustees following completion of the white paper, Reforming the Health IT Landscape to Improve the Patient and Clinician Experience, was held on July 13, 2021; and

WHEREAS, the American Osteopathic Association Board of Trustees reviewed the white paper, Reforming the Health IT Landscape to Improve the Patient and Clinician Experience, and approved it for submission to House of Delegates on Tuesday, July 13, 2021; and

WHEREAS, the Reforming the Health IT Landscape to Improve the Patient and Clinician Experience white paper incorporates the principles outlined in the policies above into a cohesive argument for addressing solutions focused on improving interoperability and protections for patient data for the betterment of patient care and reduced administrative burden; now, therefore be it

RESOLVED, that the American Osteopathic Association adopt the white paper, Reforming the Health IT Landscape to Improve the Patient and Clinician Experience as its position on policies to empower consumers with their personal health data while ensuring that information is seamlessly provided to physicians at the point of care.

Reforming the Health IT Landscape to Improve the Patient and Clinician Experience

Overview

This paper addresses the evolution of health information technology (HIT), recent HIT efforts and shortcomings, opportunities to improve HIT infrastructure to support patient care and clinicians and identifies potential solutions.

Introduction

Information technology in the healthcare industry has steadily advanced over the past two decades. Much of this growth can be attributed to the widespread adoption and meaningful use of electronic medical records (EHRs). However, adoption and utilization of EHRs has not been easy for physician practices or free from burden.

As the use of EHRs has increased, recent legislative activities have shifted to address longstanding barriers to interoperability and electronic exchange of healthcare information. This paper discusses the evolution of health information technology (HIT) and describes specific policy solutions to enhance interoperability of healthcare data, improve accuracy, increase efficiency, and reduce administrative burden.

The Evolution of Health Information Technology

The first major incentive for HIT started with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when the federal government mandated that health plans, healthcare clearinghouses, and certain healthcare providers comply with technical data requirements for electronic transactions. HIPAA established standards for electronic exchange of data; code set standards for diagnosis, procedures and diagnostic tests; unique identifiers for employers, providers and health plans; standards for storage of data at medical facilities, health insurance companies, and billing clearinghouses; and privacy standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent or knowledge.

In 2001, the Administrative Simplification Compliance Act required that all initial Medicare claims be submitted electronically, except in limited situations. However, it was the

HIPAA provisions for simplifying administration of health insurance that encouraged the healthcare industry to computerize patients´ medical records. This specific part of the Act spawned the Health Information Technology for Economic and Clinical Health Act (HITECH).

The use of the EHR has been a consistent topic of frustration and burnout for physicians across the U.S. healthcare system. When the HITECH Act passed in 2009, its purpose was to make health data storage, sharing, and reporting more seamless and efficient, easing provider workloads, enhancing the patient experience, and improving care quality.

In 2011, the meaningful use (MU) component of HITECH was implemented to expand the adoption of HIT and facilitate the use of EHRs. The HITECH Act authorized the Centers for Medicare & Medicaid Services (CMS) to establish the Medicare and Medicaid EHR Incentive Programs. These programs paid approximately $35 billion in incentive payments to eligible professionals, hospitals, and critical access hospitals to adopt, implement, upgrade, and demonstrate the use of certified EHR technology (CEHRT).i The reporting requirements involve the ability of an EHR to perform such functions as generating problem lists, exchanging patient clinical data, or e-prescribing.3 The MU program launched in three stages beginning in 2011. The focus of Stage 1 was data capture and sharing. In 2014, the Office of the National Coordinator for Health IT (ONC) created Stage 2, which sought to extend the requirements of Stage 1 and promote more advanced clinical processes. Stage 3 focused on improving overall outcomes. The combination of incentive payments for participation, paired with a penalty for failing to meet meaningful use criteria using the ONC certified technology, resulted in significantly expanded use of EHRs.

To qualify for federal funds, eligible healthcare professionals and hospitals not only had to adopt EHRs but also demonstrate meaningful use of CEHRT by achieving minimum core objectives in each stage of the MU program. It was also necessary to demonstrate compliance with the HIPAA security and privacy rules by conducting risk assessments. Even with the financial incentives, the requirements of the MU program were overly burdensome for physician practices and failure to meet them resulted in reduction of Medicare and Medicaid payments. While interoperability was one of the goals for the MU program, it failed in that regard. However, the financial incentive to adopt EHRs gave birth to an industry whose technology was not quite ready for its intended purpose, which is evident by the lack of uptake in the free market.

In 2016, MU was wrapped into the Merit-Based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act (MACRA). In 2018, CMS renamed the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability Programs to better align with MACRA provisions for electronic exchange of healthcare information.

MACRA sought to promote "widespread interoperability" which it defined as "the ability of two or more health information systems or components to exchange clinical and other information and use the information that has been exchanged by means of common standards to provide access to longitudinal information for health care providers to facilitate coordinated care and improve patient outcomes."ii

In 2009, only 12.2 percent of hospitals had adopted a basic EHR system. By 2017, the number of hospitals with an ONC certified EHR systems increased to 96 percent of hospitalsiii and 80 percent of office-based physiciansiv. Despite this rapid adoption of EHR technology, the vision of the HITECH Act and MACRA, an interoperable health data ecosystem that promoted efficiency and value in the healthcare system, was far from realized.

Data systems across the country became fragmented and were not interoperable. This was partially due to misaligned incentives in the HITECH Act that were heavily focused on provider requirements, with emphasis on adoption of an EHR with basic capabilities. As the program progressed, incentives were not shifted towards information exchange until MACRA, at which point a highly siloed health data environment had formed. In 2016, a survey of healthcare providers found that "only 6% of healthcare providers report that information accessed from exchange partners on a different EMR is delivered in an effective way that facilitates improvement to patient care." Additionally, platforms often were not designed in a usable manner, with only 8 percent of providers reporting that data could be received and located within the workflow.v The lack of efficient technology manifests in high rates of burnout and time taken away from patients. An observational study of physician practices found that physicians spend 27 percent of their time with patients and 49.2 percent of their time on EHR and desk work. While in the examination room with patients, physicians spent approximately 53 percent of the time face-to-face with patients and 37 percent on the EHR.vi

Recent HIT Efforts and Shortcomings

Congress addressed the fragmentation of data and lack of exchange in our healthcare system in the 21st Century Cures Act (Cures Act). Like MACRA, it mandated support for interoperable network exchange to be spearheaded by the ONC in collaboration with the National Institute of Standards and Technology and other divisions of HHS. ONC engaged in rulemaking in 2018 and 2019 to implement the interoperability and information blocking provisions of the Cures Act. This was done in tandem with the CMS Interoperability and Patient Access final rule, which developed new HIT compliance requirements for providers and certain payers to improve the electronic exchange of healthcare data and enable patients to safely and securely access their medical information through a third-party application of their choice.

The ONC rule made sweeping changes to HIT regulation to promote data sharing, empower consumers by granting them greater control over their data, and prevent healthcare entities from blocking the sharing of health data. The rule established a standard for the development of application programming interfaces (APIs), required EHR developers publish their APIs to ensure that different softwares and networks are able to effectively exchange information, and updated EHR certification criteria with a focus on interoperability. The update involves replacing the Common Clinical Data Sets required for certification with the new United States Core Data for Interoperability (USCDI).

The new data requirements are more extensive and will promote patient matching, tracking origins of data, and supports the sharing of clinical notes. Ultimately, USCDI establishes standards and formats for data to allow more seamless sharing. The rule also defines what entities are covered by information blocking, defines what constitutes information

blocking, and outlines exceptions. The information blocking provisions of ONC's Cures Act final rule took effect on April 5th, 2021, with various compliance dates staggered through 2023.vii

These recent actions have helped level the playing field and create a regulatory framework that enables true interoperability across the U.S. healthcare ecosystem. However, much work needs to be done to ensure that the promise of true interoperability is realized, and that seamless health information exchange can be used to support population health and enhance the patient and clinician experiences.

Opportunities to Improve HIT Infrastructure to Support Patient Care and Clinicians

The next step in this process is to ensure that information is readily available to physicians and other clinicians at the point of care to improve the quality and efficiency of care, and to ensure that the health IT infrastructure is improved to better serve communities that are often left behind in our health care system. Areas that critically need to be addressed to achieve these goals include the following:

Effective matching of patient data

Patient identification (patient matching) remains a persistent problem in ensuring that electronic health record (EHR) data is complete and accurate. Errors and missing information remain common in the electronic health record ecosystem, with several studies indicating that between 8 to 22 percent of all records are split or duplicate.viii ix These high-duplication and mismatched rates often translate into unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate information. A 2016 report indicated that 4 percent of duplicate records result in negative clinical care and outcomes.x Split and mismatched records make it difficult for physicians to have the full picture of a patient's health and care received, and it also makes it more difficult for the patient to have access to their full record.

Access to Data at the Point of Care

Access to a patient's complete medical history, including procedures, chronic conditions, and medication history, is critical to delivering high quality care. However, patients frequently misreport and or provide incomplete histories, which can result in negative outcomes due to harmful drug interactions or procedures conducted without knowledge of another comorbid condition. A study of 2,063 patients whose histories were collected during emergency department (ED) triage found that of all patients identified as taking medications, 48 percent failed to identify at least one of their medications, with a median of two drugs missed. Of the drugs missed at triage, 73 percent were prescription medications.xi Patients will often omit parts of their medical history for various reasons: focusing only on information the patient believes to be important, forgetting of information due to complex histories or medication lists, or intentional omission. While improved interviewing can improve this issue, access to comprehensive records at the point of care is the optimal and most efficient way to obtain a complete picture of a patient's health. Enhanced sharing of patient data can also be used to create analytics tools built into EHR workflows.

Streamlining Prior Authorization Processes to Eliminate Care Delays

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for diagnostic procedures and medical treatments before they can render care to their patients. While the process is often conducted electronically, prior authorization sometimes needs to be obtained over the phone or via fax. Even when obtained electronically, payors have different processes, policies, and electronic platforms. The process for obtaining this approval is costly. The Council for Affordable Quality Healthcare (CAQH) estimated that the financial impact of prior authorization requirements to providers in 2019 was approximately $528 million, and the average transaction takes 21 minutes of provider staff time.xii If the healthcare industry were to fully shift to electronic prior authorizations with consistent technical standards that allow submissions from a single platform, providers could save 17 minutes per transaction and $355 million per year. However, for providers who do submit electronic prior authorizations, the process is still partially manual, as they need to log into separate portals for each payor and complete varying documentation requirements. Because prior authorization platforms do not integrate with the provider's EHR system, the process generates significant barriers to the efficient care of patients. The current method for prior authorization is costly for providers, detracts from time spent with patients, and often forces patients to go without care or delays care. This can lead to needless increased suffering for the patient and worsening of their condition, ultimately leading to increased cost of care. In order to have a truly effective prior authorization process, fully integrated electronic universal standards must be incorporated by all payers.

Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health

A quickly growing body of research indicates that social determinants of health may have a greater impact on a patient's overall health and outcomes than treatment they receive. The HHS Healthy People 2030 initiative defines social determinants of health as the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." It groups these factors into five domains, which include economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.xiii A recent article published in Health Affairs compiles various studies that estimate the relative impact of various health determinants on outcomes.xiv A study published by the University of Wisconsin-Madison found that behaviors contribute to 30 percent of outcomes, social circumstances contribute to 40 percent, environment contributes to 10 percent, and medical care contributes to 20 percent of outcomes. Overall, other studies have come to similar conclusions that 80 percent of the contributors to health outcomes are social determinants of health.xv

The COVID-19 pandemic particularly highlighted the impact of social determinants on outcomes and how social factors can drive disparities. Over the course of the pandemic, data has demonstrated that housing status, socioeconomic factors, and behaviors such as smoking were significant determinants of whether an individual contracted COVID-19 and the severity of their case. A study published in 2020 highlights how beyond

infection, there are other downstream consequences from the pandemic. For example, children who depend on school lunches may face nutrition issues due to school closures.xvi During the pandemic, the U.S. also saw unprecedented use of telehealth to expand access to health services and improve care. However, there are clear gaps in health IT infrastructure that prevent social determinants from being recorded and addressed.

The U.S. health system, and healthcare infrastructure, are not historically well equipped for coordinating care or capturing data outside the clinical setting. While ICD-10 codes exist for capturing information about social determinants of health in health records, many providers are not well educated on how to use them. Additionally, these codes often lack precision. At the same time, a regulatory framework for sharing health information and coordinating care with community-based organizations is relatively weak. These organizations often use different information management tools than health providers, and standards do not exist for data exchange. Even amongst certified health IT products, ONC does not have a required technical standard for sharing information related to social determinants of health. These challenges not only prevent sharing of individual level data for informed clinical decision making, but also stifle the aggregation of patient data to better understand the impact of social determinants.xvii

Capturing and sharing social determinants of health information is critical to improving care coordination and management both within and outside of a clinic's four walls. However, the task of capturing this data should not fall solely on physicians. Ultimately, to build a health care system that is equipped to address social determinants of health, and to build an infrastructure for value-based care systems, changes to current HIT infrastructure are critical.

Appropriate Use of Data by Third-Party Apps and Patient Protections

Patient engagement in their own care and health maintenance is critical to overall well-being and promoting better outcomes. Patient health applications provide not only an opportunity for patient engagement in their own care, but they can also empower patients to share data with physicians and provide a clearer picture of their medical history. This is the goal of the CMS Interoperability and Patient Access final rule. However, third party apps are not properly regulated, and health data, which comprises some of the most sensitive information about an individual, can be compromised and exploited when downloaded onto third-party platforms. When patients want to use a health management application, they are often required to agree to user "terms and conditions" which often contain language permitting the developer to pass along user information to third parties. A recent study examining the 24 top-rated Android apps for health medicine management found that 19 of the 24 apps shared user data with third parties. Of these apps that shared data, 66 percent of the third parties that these apps shared data with "provided services related to the collection and analysis of user data, including analytics or advertising, suggesting heightened privacy risks."xviii

Solutions

Effective Matching of Patient Data

ONC should create technical standards and best practices governing how patients can monitor, update, or verify their information through applications and portals. The ONC's final rule on interoperability gives patients unprecedented ownership over their own data, and this creates an opportunity to allow them to review demographic information that can impact the movement and matching of their record across platforms. Additionally, minor changes to data standards will help facilitate exchange of certain patient information. ONC should also standardize address formats within the USCDI and add a standard for gender identity.

Access to Data at the Point of Care

The CMS Interoperability and Patient Access rule finalized in 2020 requires Medicare Advantage plans, Medicaid and Children's Health Insurance Program (CHIP) managed care plans, state agencies and Qualified Health Plans on federally facilitated exchanges to enable payor-patient exchange of claims data via FHIR API. This capability should be expanded to enable a payor-provider claims data exchange via FHIR API, and this should also apply to ACA qualified plans and Employee Retirement Income Security Act (ERISA) plans. The API should be similar to CMS' Data at the Point of Care pilot enabled by the Blue Button 2.0 initiative. The pilot program has sought to give providers insight into patients' claims and medication histories within their EHR workflow so they could make more informed clinical decisions during a patient encounter. A change of this nature would require legislative action to grant federal agencies authority to regulate this information sharing and qualify non-compliance as a form of information blocking. Additionally, having data on cost and coverage can prevent loss to follow-up care, particularly for patients where out-of-pocket cost is likely to result in deferred care, and also reduce administrative burden associated with prior authorization.

Streamlining Prior Authorization Processes to Eliminate Care Delays

Because of the growing burden created by prior authorization processes, some congressional and regulatory action has been taken to begin to address the issue. Most recently, CMS issued transaction standard for electronic prior authorization (ePA) under the Part D e-prescribing program. These ePA transaction standards would allow prescribers to use an electronic prescribing (eRX) system or an EHR with an eRX system to determine whether a patient's Part D plan requires prior authorization for a given medication and to receive responses in real time.xix While this regulation had many positive aspects, overall, given the limited scope of the part D program, it did little to address the larger issues of standardizing prior authorization across the healthcare system. Congress has also made a legitimate effort to respond to this issue and develop policy to standardize electronic prior authorization. However, nothing has passed into law at the time of this publication, and active legislation during the 117th Congress is limited in scope to just Medicare Advantage (MA) plans.xx

To achieve fully standardize electronic prior authorization that integrates into a provider's workflow, legislation must be enacted that establishes technical requirements for private insurance plans regulated under the ACA and ERISA, as well as all CMS contractors that administer MA plans. This legislation must establish a universal electronic prior authorization (ePA) program and require all healthcare plans to adopt ePA capabilities that follow a single technical specification that allows payor platforms to seamlessly connect to other certified health IT. As is current practice, prior authorizations should still be reviewed by qualified medical professionals, and finally, there should be a streamlined process for reviewing prior authorization policies on routinely approved items and services. These changes are critical to ensuring that a provider's workflow is efficient, and that patient care is not delayed or impeded, resulting in worse outcomes.

Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health

In order to ensure that health IT can be leveraged to address social determinants of health, several changes to the current environment are needed. These changes would address the issues of data capture, interoperability and exchange, value-based care and payment.

To address improved data capture, three key changes will help ensure that health records contain more robust information on social determinants. First, ICD codes need to be made more granular to ensure appropriate information capture, and providers need to be educated on how to use relevant codes. Additionally, universal reimbursement standards should be developed to ensure consistent coding and appropriate payment for screening for social determinants and linkage to appropriate services. To address interoperability and exchange, ONC should add a data class to the USCDI to ensure that data relating to social determinants of health can be captured and shared in certified health IT. Health Level Seven (HL7) launched an initiative called the Gravity Project to create national standards for representing social determinant data in health IT. In October 2020, the Gravity Project submitted two approaches to ONC for adding a new data class for social determinants of health.xxi Testing and adopting these standards will help ensure improved information sharing. In addition to the new USCDI data class, the AOA encouraged ONC to develop a pilot project to identify how to help community-based organizations better integrate their data systems with certified health IT.

Once health IT infrastructure is strengthened, HHS, plans, and providers can leverage newly available data to drive development of value-based initiatives. Because factors beyond the care rendered by a physician have such significant influence on a patient's outcomes, it is critical that efforts to address social determinants are incorporated into value-based initiatives. Several efforts to achieve this are ongoing. An analysis by one managed care organization found that its efforts to meet patients' needs for social services by referring them to resources for transportation, food programs, financial assistance for utilities, education programs, and housing services helped reduce health expenditures by as much as 10 percent for patients who had social needs met.xxii However, action by providers at the point of care can have a greater impact, and models should be designed that incentivize and reward providers who help identify and address patients' social needs.

Appropriate Use of Data by Third-Party Apps and Patient Protection

In 2021, the comment period closed on a proposed rule by the HHS Office for Civil Rights (OCR) to modify HIPAA. The rule fell short in advancing the security of sensitive patient data as it relates to third party apps. While the rule adds a definition for a "patient health application", it does not consider these applications covered entities. Since the user of a third-party application agrees to the "terms and conditions", and the applications are not covered entities, individually identifiable consumer health information collected by the apps or on personal health trackers often does not have to be stored and used in compliance with HIPAA requirements for protected health information (PHI). As such, third-party apps are allowed to transfer, sell, or share patient's data without informing the consumer to obtain consent.

OCR should recognize applications on which patients can download PHI as a covered entity or require them to develop business associate agreements with vendors from whom they download data. Alternatively, if these approaches are not feasible, OCR should create a new class of entity that is subject to HIPAA privacy rules that captures these applications. HHS should also develop standards for authenticating patient identities to ensure that the third-party apps are held to similar standards as patient portals of HIT vendors.

While most of these solutions may be able to be address through the rule making process, some reforms will have to be codified through new federal legislation. In light of this, legislation which prevents data mining, sharing, or selling of personal health data by third-party apps must be passed into law.

There has been a willingness to work on this issue in Congress, in particular in the Senate Committee on Health, Education, Labor and Pensions (HELP), which has discussed this during public hearings, and with the introduction of legislation which seeks to address these gaps. Healthcare stakeholders must advocate for the passage of legislation which guarantees that no third-party entities are not allowed to transfer, sell or share any individually identifiable consumer health information collected regardless of the modality used to collect such data so that patients may continue to be an active participant in their own healthcare and be protected under the law without fear of losing their privacy by their use of third-party apps.

Conclusion

Throughout its history, HIT and EHR data entry has been a consistent topic of administrative burden and burnout for physicians across the U.S. Even when the government provided monetary incentives, it had become abundantly clear that reaching the goal of a fully interoperable EHR ecosystem that aids physician clinical decision making and lowers cost while improving quality of care is easier said than done. While the topics outlined in this document are by no means a fully comprehensive list of every concept or solution needed to fix the HIT ecosystem, it is clear that to fully realize the benefits of digital health information, we must first have truly meaningful data.

419 As outlined above, this includes, but is not limited to, the implementation of legislative and
420 regulatory policies which empower consumers with their personal health data while
421 ensuring that information is seamlessly provided to physicians at the point of care.
422 However, to have the greatest impact, we must go beyond just access to medical data
423 for physicians. In this new digital world, we must also provide appropriate patient
424 protections for any data which is acquired and used by any third-party apps. Finally, we
425 must support and help implement future policies that improve community well-being by
426 enhancing the HIT regulatory frameworks that influence non-medical social
427 determinants of health factors that affect health outcomes. While much of the legislative
428 and regulatory work is slow and tedious, if implemented correctly, effective EHR data
429 has the possibility to improve quality of care while lowering costs, ultimately resulting in
430 promoting healthy communities across the United St

Background Information: Provided by AOA Staff

Current AOA Policy:

H632-A/19 Patient Matching Of Electronic Health Record Data
H605-A/20 Interoperability Of Health Information Technology
H642-A/20 Prior Authorization
—which merged policies H343-A/13, H602-A/15; H632- A/17, H635-A/19, H637-A/19, and H640-A/16.
H342-A/17 Shared Principles Of Primary Care
H301-A/19 Medical Websites And Smartphones/Tablet Computer Apps To Diagnose Illness – Use Of

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

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SUBJECT: SUPPORT ~~ENDORSE~~ NUTRITIONALLY BALANCED, LOW COST OR FREE MEALS FOR CHILDREN IN SCHOOLS

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Public Affairs

WHEREAS, obesity rates in the United States for children aged 2–19 have increased from 7% to 18%[1] over the last five decades[2], and 1 in 6 American children live in food insecure households and may not regularly receive sufficient nutrient intake;[3] and

WHEREAS, Americans consistently do not meet federal dietary recommendations, and current dietary quality in children and adolescents remains below optimal;[4] and

WHEREAS, the increase in obesity is directly linked to the increased consumption of processed, starchy and high-sucrose foods—all of which are the most inexpensive and accessible foods to any demographic nationwide;[5] and

WHEREAS, research has shown that American families classified as the working poor and their children living in disadvantaged neighborhoods experience the greatest increase in obesity and unhealthy lifestyle;[5] and

WHEREAS, nutritionally balanced dietary changes~~, such as those outlined at www.choosemyplate.gov,~~ in childhood lead to proper growth and development and have been shown to reduce disease in adulthood;[6] and

WHEREAS, school lunch programs are a means of both increasing food accessibility and reducing food insecurity, and with the Healthy, Hunger-Free Kids Act of 2010 (HHFKA), these lunches have the potential to deliver nutritional necessities focused on an increase in fruits, vegetables and whole grains, as well as a decrease in processed foods high in trans-fats and sodium;[7] and

WHEREAS, data shows that children served school lunches that comply with HHFKA standards are not only eating healthier, but also continue to choose healthier foods—mostly fruits and vegetables—for meals and snacks long term;[7] and

WHEREAS, federally assisted meal programs, such as the National School Lunch Program (NSLP), are associated with reduced obesity by offering a more balanced diet, including vitamins and minerals. Children in low-income areas consume more than half of their daily fruits and vegetables within the school menu;[12] and

WHEREAS, monetary spending for quality childhood education and socioeconomic support has been shown to provide significant effects in long-term economic benefits and can function as effective cost saving measures;[13] and

WHEREAS, the ~~Tenants~~**TENETS** of Osteopathic Medicine, as approved by the American Osteopathic Association (AOA), emphasize the person is a unit of body, mind and

32 spirit, and osteopathic medical education teaches nutrition is an integral part of
33 maintaining vital functions and a core principle of preventive care;[14] and

34 WHEREAS, the American College of Osteopathic Family Physicians (ACOFP) has historically
35 taken a strong position advocating development and funding programs that increase
36 access to nutritious food options in all communities.[15]ACOFP supports the concept of
37 nutrition as an essential aspect of disease prevention and health improvement;[16] and

38 WHEREAS, the American College of Osteopathic Family Physicians Congress of Delegates
39 passed a resolution in 2021 advocating for legislative efforts in support of widely
40 accessible, nutritionally-balanced, low-cost or free meals for all children in the US Pre-K
41 through 12 schools; now, therefore be it

42 RESOLVED, that the American Osteopathic Association (AOA) advocate for legislative
43 efforts in support of widely accessible, nutritionally-balanced, low-cost or free meals for
44 all children in the US Pre-K through 12 schools.

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: SUPPORTING PUBLIC POLICY TO ENCOURAGE WHOLESOME FOOD DONATIONS TO THOSE IN NEED IN AMERICA

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, 42 million Americans are estimated to go hungry during 2021; and

2 WHEREAS, the USDA states that food waste is estimated to be between 30-40 percent of the
3 food supply in the United States; and

4 WHEREAS, an estimated 31% of that food waste is at the retail and consumer levels; and

5 WHEREAS, approximately 133 billion pounds and $161 billion worth of food in 2010 is
6 wasted; and

7 WHEREAS, this equates to approximately $370/person annually or a family of four
8 approximately $1500/year, which could be saved; and

9 WHEREAS, the IRS Code 170e provides tax deductions to businesses/farmers/organizations
10 to support donation of wholesome, unsold foods; and

11 WHEREAS, The Bill Emerson Good Samaritan Food Donation Act of 1996 encourages the
12 donation of food and grocery products to nonprofit organizations for distribution to
13 those in need; and

14 WHEREAS, there are standards and protections created under this act to the persons and
15 gleaners and nonprofit organizations who participate in wholesome food donation; and

16 WHEREAS, Feeding America and its network of food banks, under this act, have rescued 3.6
17 billion pounds of food yearly in cooperation with organizations utilizing IRS Code 170e;
18 now, therefore be it

19 RESOLVED, that the American Osteopathic Association (AOA) stands in support of our
20 current public policy that increases access to food for all Americans; and, be it further

21 RESOLVED, that the AOA supports increasing access to donations of wholesome food
22 through the use of qualified food banks.

Background Information: Provided by AOA Staff

Current AOA Policy:

H435-A/19 Recognizing Food Insecurity as a Public Health Issue

Prior HOD action on similar or same topic:

H435-A/19 Recognizing Food Insecurity as a Public Health Issue – Reaffirmed 2019

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: COLLECTION OF PUBLIC HEALTH DATA CONCERNING FIREARM FATALITIES

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the United States Center for Disease Control (CDC) defines firearm injuries as a serious public health problem and collects data on gun fatalities and non-fatal injuries resulting from handguns, rifles and shotguns; and

WHEREAS, in 2018, CDC reported 39,740 firearm-related deaths in the United States with 6 out of every 10 deaths from suicides and more than 3 out of every 10 resulting from firearm homicides, and 7 out of every 10 medically treated firearm injuries were from assaults using a firearm, and 2 out of every 10 were unintentional firearm injuries; and

WHEREAS, Firearm-related injuries are among the 5 leading causes of death for people ages 1-64 in the United States. Males account for 85% of all victims of firearm death and 88% of nonfatal firearm injuries. Rates of firearm violence also vary by age and race/ethnicity. Firearm homicide rates are highest among teens and young adults 15-34 years of age, and among Black, American Indian/Alaskan Native, and Hispanic populations. Firearm suicide rates are highest among adults 75 years of age and older and among American Indian/Alaskan Native and non-Hispanic white populations; and

WHEREAS, People who survive a firearm-related injury may experience long-term consequences. These include problems with memory, thinking, emotions, and physical disability from injury to the brain; paralysis from injury to the spinal cord; and chronic mental health problems from conditions such as post-traumatic-stress disorder; and

WHEREAS, the effects of firearm violence extend beyond victims and their families. Mass shooting incidents, including those in schools, houses of worship, workplaces, shopping areas, and community events as well as other firearm homicides and assaults can affect the sense of safety and security of entire communities and impact everyday decisions; and

WHEREAS, the economic impact of firearm violence is also substantial. Firearm violence costs the United States tens of billions of dollars each year in medical and lost productivity costs alone; and

WHEREAS, the resultant PTSD of firearm violence has a substantial cost in terms of human suffering, disability, cost of treatment and can lead to significant medical maladies, SUD and chronic pain being two major consequences; and

WHEREAS, Firearm violence has tremendous impact on the overall safety and wellbeing of Americans. Using a public health approach is essential to addressing firearm violence and keeping people safe and healthy; and

WHEREAS, the CDC's approach to preventing firearm injuries focuses on three elements: providing data to inform action; conducting research and applying science to identify effective solutions; and promoting collaboration across multiple sectors to address the problem; and

WHEREAS, the statistics on type of firearm used in gun violence are based on information submitted by state and local police departments, and not all agencies participate or provide complete information each year; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports the collection of public health data concerning firearm fatalities separated by homicides, including the number of domestic violence homicides, suicides and accidents, and non-fatal firearm related injuries, further separated by the ages of the victims of each category, ~~and the type, make and model of the firearm used,~~ and hospitalizations that occurred as a result of a firearm that did not result in death and the ~~type, make and model of~~ **CALIBER OF** firearm used; and be it further

RESOLVED, that the AOA will advocate to make this data publicly available ~~to inform public policy~~ and develop **HEALTHCARE** guidance **AND INFORM PUBLIC POLICY**. ~~for family physicians, etc~~.

References:

1. Pew Research
2. Center for Disease Control

Background Information: Provided by AOA Staff

Current AOA Policy:

The following are similar policies, however none address the collection of public health data:

H446-A/20 Background Checks and Firearms Safety Training as a Condition of Firearms Purchase
H318-A/16 Firearms – Commission of a Crime while using a Firearm
H418-A/20 Firearms and Non-Powdered Guns – Education for Users
H437-A/19 Firearm Violence
H442-A/20 Firearm Violence
H425-A/19 Firearm Safety

Prior HOD action on similar or same topic:

H446-A/20 Background Checks and Firearms Safety Training as a Condition of Firearms Purchase - Adopted 2020
H318-A/16 Firearms – Commission of a Crime while using a Firearm - Reaffirmed 2016
H418-A/20 Firearms and Non-Powdered Guns – Education for Users - Adopted as Amended 2020
H437-A/19 Firearm Violence – Adopted 2019
H442-A/20 Firearm Violence - Adopted as Amended 2020
H425-A/19 Firearm Safety - Reaffirmed as Amended 2019

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: PATIENT CENTERED TREATMENT FOR PAIN MANAGEMENT AND APPROPRIATE USE OF OPIOIDS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the Centers for Disease Control (CDC) 2016 recommendations on opioid prescribing were mostly level 3 and 4 evidence and were completed with little input from specialists in pain management or substance use disorder (SUD); or respective societies; and

WHEREAS, the same guidelines were specifically created for primary care providers (both physicians and mid-levels), with the intent to decrease opiate poisoning (overdose) rates arising from opiates assumed to have been diverted from legitimate chronic pain treatment prescriptions; and

WHEREAS, the opioid poisoning cases involving greater than 100 morphine equivalents were enumerated without: consideration of polypharmacy, habituation, or control for misuse or illicit use; and

WHEREAS, these same guidelines were misapplied in many states as laws rather than recommendations, and as insurance company policies created the impression in the public and among many pharmacies and other healthcare providers that to work outside those guidelines constitutes malpractice; and

WHEREAS, of all people exposed to an opioid, fewer than 7-10% develop a subsequent SUD; and

WHEREAS, NSAIDs and gabapentin, although touted as "safer" alternatives, still do not have a better safety profile and are associated with significant mortality and morbidity and gabapentin is a drug of abuse; and

WHEREAS, Osteopathic Manipulative Medicine (OMM) is useful for a great many pain syndromes but cannot be applied as a replacement for opioid pain management; and

WHEREAS, the unintended consequences of this recommendation have included:
Stigmatization of patients who use appropriately being managed with opioids;

Decreased patient resources, forced tapering and increased patient self-harm;

Tremendous administrative burden on the physicians who still manage chronic pain with opioids, in requirements to validate the need for these medications and to justify their actions to pharmacists;

29 Physicians and institutions discontinuing pharmacologic pain management due to fear,
30 ignorance or misunderstanding of the metrics, resulting in increased volume burden on
31 the few remaining prescribers;

32 Payors refusing to cover prescriptions for certain medications;

33 People with chronic pain being forced to choose between reduced level of functioning
34 or self-paying for their medications, either at pharmacies or through illicit sources

35 Patients with SUD not using fewer opioids, but are using more dangerously because the
36 illicit sources have demonstrated in increase in trafficking of heroin and foreign
37 manufactured fentanyl;

38 An increase in the state of Maine, in the opioid poisoning fatality rate the year that the
39 new policies were implemented; now, therefore be it

40 RESOLVED, that the American Osteopathic Association (AOA) support increased access to
41 evidence-based pharmacotherapy for treatment of chronic pain, with a lens that places
42 value on the functional status of the patient rather than the Milligram Morphine
43 Equivalent (MME) of the prescription.; and, be it further

44 RESOLVED, that the AOA continue to support risk management in terms of toxicology
45 monitoring, volume prescribed, and the use of the Prescription Monitoring Program
46 (PMP); and, be it further

47 RESOLVED, the AOA continue to promote referral for patient centered treatment when a
48 SUD is diagnosed.

Background Information: Provided by AOA Staff

Current AOA Policy:

The following are similar policies addressing pain management and opioid use and abuse:

H327-A/15 Intractable and/or Chronic Pain (Not Associated with End of Life Care)

H337-A/20 Prescribing Opioids for Chronic Pain – United States, 2016, - CDC Guideline For

H344-A/16 Pain Related Education Requirements

H452-A/20 Breastfeeding while on Methadone Maintenance

H443-A/17 Harm Reduction Modalities for People who Inject Drugs

H331-A/17 Interstate Opioid Database

H632-A/18 Naloxone Use for Opioid / Opiate Overdose – Increasing the Education and Preventative Prescription of

H423-A/18 "Opioid Overdose" Deaths in America, Epidemic

H330-A/17 Patient Load Restrictions to Increase Pharmacological Opioid Addiction Treatment Access – Abolishment of

H300-A/19 Training – Extended Release-Long Acting (Er/La) Opioid Risk Evaluation and Mitigation Strategy (Rems)

H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs for

H414-A/18 Substance Use Disorder

H444-A/20 Substance Use Disorders -- Adopting And Promoting Non-Stigmatizing Language For Substance Use Disorders

H203-A/18 Substance Use Disorders Education

H322-A/20 Prescription Drug Diversion and Abuse – Education, Research, and Advocacy

Prior HOD action on similar or same topic:

H327-A/15 Intractable and/or Chronic Pain (Not Associated with End of Life Care) - [referred to Council on State Health Affairs 2020

H337-A/20 Prescribing Opioids for Chronic Pain – United States, 2016, - CDC Guideline For - Adopted as Amended 2020

H344-A/16 Pain Related Education Requirements – Reaffirmed 2016

H452-A/20 Breastfeeding while on Methadone Maintenance - Adopted 2020

H443-A/17 Harm Reduction Modalities for People who Inject Drugs – Adopted 2017

H331-A/17 Interstate Opioid Database – Reaffirmed 2017

H632-A/18 Naloxone Use for Opioid / Opiate Overdose – Increasing the Education and Preventative Prescription of – Reaffirmed 2018

H423-A/18 "Opioid Overdose" Deaths in America, Epidemic - Reaffirmed 2018

H330-A/17 Patient Load Restrictions to Increase Pharmacological Opioid Addiction Treatment Access – Abolishment of – Reaffirmed 2017

H300-A/19 Training – Extended Release-Long Acting (Er/La) Opioid Risk Evaluation and Mitigation Strategy (Rems) – Reaffirmed 2019

H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs for – Reaffirmed 2016

H414-A/18 Substance Use Disorder - Reaffirmed as Amended 2018

H444-A/20 Substance Use Disorders -- Adopting And Promoting Non-Stigmatizing Language For Substance Use Disorders – Adopted 2020

H203-A/18 Substance Use Disorders Education - Reaffirmed as Amended 2018

H322-A/20 Prescription Drug Diversion and Abuse – Education, Research, and Advocacy – Adopted 2020

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: PHYSICIAN COMMUNICATION TO PATIENTS REGARDING ~~COVID 19 PREVENTION~~ **PUBLIC HEALTH CRISES**

SUBMITTED BY: New York State Osteopathic Medical Society (NYSOMS)

REFERRED TO: Committee on Public Affairs

WHEREAS, the people of the United States and the world at large have suffered through the COVID 19 pandemic that has resulted in millions of deaths and unknown numbers of morbidities; and

WHEREAS, the burgeoning scientific evidence for the use of masks, frequent hand-cleansing hygiene, social distancing and more recently, vaccinations have been established as methods of mitigating the spread of this respiratory disease; and

WHEREAS, there are individuals and groups who continue to resist such methods and substitute their opinions based on pseudoscience and misplaced sense of imposition on their personal rights; and

WHEREAS, when such persons are physicians and communicate it to general public, they further place the general public, including their own patients, in danger at worst and into a state of confusion at best; and

WHEREAS, when physicians act in a manner that disregards evidence-based medical and public health information including Centers for Disease Control and Prevention (CDC) Guidelines in their own practices, they may directly place patients, staff, themselves, and by extension, their families and others in peril, and

WHEREAS, guidelines issued by state authority evolve, and it is important that physicians, **DOs AND MDs** ~~MD and DO,~~ follow such guidelines; now, therefore be it

RESOLVED, that THE American Osteopathic Association (AOA) **ENCOURAGE** ~~notify~~ its members ~~of the importance of~~ **TO** following ~~State and~~ **THE CURRENT CDC** guidelines **DURING A PUBLIC HEALTH CRISIS**. ~~in order to contain the pandemic.~~

References:

1. https://osteopathic.org/2020/12/23/aoa-statement-regarding-vaccine-misinformation-and-hoaxes/
2. https://osteopathic.org/2017/01/11/american-osteopathic-association-affirms-support-for-vaccination/
3. https://www.journalofosteopathicmedicine.com/article/S1746-0689(21)00005-5/fulltext
4. https://www.aacom.org/news-and-events/news-detail/2021/01/13/statement-of-the-american-association-of-colleges-of-osteopathic-medicine-regarding-vaccination-against-covid-19

5. https://www.axios.com/osteopathic-physician-millions-anti-vaccine-movement-6d727ad3-2ee8-40b5-ae19-56c7851eeeaa.html
6. https://www.google.com/search?q=joseph+mercola+do&source=hp&ei=E9JsYNXaCIaStQW5gqh4&iflsig=AINFCbYAAAAAYGzgI1p3DE2xWIYD0j_qqNc85AcqNXiG&oq=joseph+mercola+do&gs_lcp=Cgdnd3Mtd2l6EAMyAggAMgIILjIGCAAQFhAeMgYIABAWEB4yBggAEBYQHjIGCAAQFhAeMgYIABAWEB4yBggAEBYQHjIGCAAQFhAeOgoIABDqAhAKEI8BOggIABDqAhCPATOICAAQsQMQgwE6CAguELEDEIMBOgsILhCxAxDHARCjAjoFCC4QsQM6CwguELEDEIMBEJMCOgUIABCxAzoICC4QxwEQowI6CwguEMcBEKMCEJMCOggILhDHARCvATOICC4QsQMQkwI6BQguEJMCOgcIABCxAxAKUM0UWM9FYMFVaAFwAHgAgAG1AogB9xOSAQgzLjEzLjAuMZgBAKABAaoBB2d3cy13aXqwAQo&sclient=gws-wiz&ved=0ahUKEwiVsPLDx-rvAhUGSa0KHTkBCg8Q4dUDCA0&uact=5#spf=1617744413274
7. https://en.wikipedia.org/wiki/Sherri_Tenpenny
8. https://www.youtube.com/watch?v=BKpBNWgkQTM
9. https://www.politifact.com/factchecks/2021/mar/04/sherri-tenpenny/covid-19-vaccine-does-not-cause-death-autoimmune-d/

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $2,600
The notification of members would require staff time to compile the appropriate this information from each state and the CDC, verify that this information is consistent with AOA policy and formulate either a general communication to all members or state specific communications. The expense associated with such an effort is estimated to range from $2,500 to $2,600.

ACTION TAKEN __ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: ADDRESSING DERMATOLOGIC HEALTH DISPARITIES IN PEOPLE OF COLOR

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, current data on racial and ethnic differences in skin structure, physiology, and function is scarce[1]; and

WHEREAS, multiple studies have noted a lack of empirical data on epidemiology, clinical presentation, complications, and treatment of skin diseases in people of color[2-4]; and

WHEREAS, more than 50% of active osteopathic physicians practice in primary care settings[5]

WHEREAS, dermatologic conditions are frequently seen and treated in the primary care setting[6-8]; and

WHEREAS, differences in cutaneous structure and function can result in skin conditions with distinct presentations and varying prevalence that require unique treatment[9]; and

WHEREAS, skin cancer is associated with greater morbidity and mortality in patients of color when compared with that of white patients[10,11]; and

WHEREAS, people of color are more likely to go undiagnosed with psoriasis when compared with white people[12]; and

WHEREAS, a study reviewing visual representations of race and skin tone in medical textbook imagery revealed an overrepresentation of light skin tones and underrepresentation of dark skin tones, in addition to an absence of skin tone diversity at the chapter and topic level[13]; and

WHEREAS, a review of published medical imagery suggests there is underrepresentation, compared to the general population, of people of color within medical literature which may be contributing to inequities in health care[14]; and

WHEREAS, previous studies have demonstrated that medical students are less accurate in diagnosing various dermatologic conditions in people of color[15]; and

WHEREAS, medical student exposure to pathology on brown and black skin has been shown to increase confidence in diagnosing pathology in this population[16]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage increased education and research regarding dermatologic conditions in people of color to aid in the diagnosis of disease

References:

1. Taylor SC. Skin of color: biology, structure, function, and implications for dermatologic disease. *J Am Acad Dermatol.* 2002;46(2 suppl understanding):S41-S62
2. Buster KJ, Stevens EI, Elmets CA. Dermatologic health disparities. *Dermatol Clinics*. 2012;30(1):53-9,viii. doi:10.1016/j.det.2011.08.002
3. Cornelison, RL Jr. Cutaneous diseases in Native Americans. *Dermatolol Clinics*. 2003;21(4):699-702. DOI: 10.1016/s0733-8635(03)00076-7
4. Charrow, A., Xia, F. D., Joyce, C., & Mostaghimi, A. (2017). Diversity in Dermatology Clinical Trials: A Systematic Review. *JAMA dermatology*, *153*(2), 193–198. https://doi.org/10.1001/jamadermatol.2016.4129
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9. Kundu, R. V., & Patterson, S. (2013). Dermatologic conditions in skin of color: part I. Special considerations for common skin disorders. *American family physician*, *87*(12), 850–856.
10. Gloster, H. M., Jr, & Neal, K. (2006). Skin cancer in skin of color. *Journal of the American Academy of Dermatology*, *55*(5), 741–764. https://doi.org/10.1016/j.jaad.2005.08.063
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13. Louie, P., & Wilkes, R. (2018). Representations of race and skin tone in medical textbook imagery. *Social Science & Medicine*, *202*, 38–42. https://doi.org/10.1016/j.socscimed.2018.02.023
14. Massie, J. P., Cho, D. Y., Kneib, C. J., Sousa, J. D., Morrison, S. D., & Friedrich, J. B. (2021). A Picture of Modern Medicine: Race and Visual Representation in Medical Literature. *Journal of the National Medical Association*, *113*(1), 88–94. https://doi.org/10.1016/j.jnma.2020.07.013
15. . Fenton, A., Elliott, E., Shahbandi, A., Ezenwa, E., Morris, C., McLawhorn, J., Jackson, J. G., Allen, P., & Murina, A. (2020). Medical students' ability to diagnose common dermatologic conditions in skin of color. *Journal of the American Academy of Dermatology*, *83*(3), 957–958. https://doi.org/10.1016/j.jaad.2019.12.078
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Background Information: Provided by AOA Staff

Current AOA Policy:

The following are similar policies however do not address dermatologic health disparities:

H409-A/16 Minority Health and Osteopathic Medical Education: This current policy is extremely broad and addresses not only diseases in minority populations but under representation of minority populations in osteopathic medicine.

H428-A/20 Minority Health Disparities.

H215-A/17 Cultural Competency Dialogue on Eliminating Health Care Disparities – Longitudinal Approach to.

Prior HOD action on similar or same topic:

H409-A/16 Minority Health and Osteopathic Medical Education – Reaffirmed 2016

H428-A/20 Minority Health Disparities - Adopted as Amended 2020

H215-A/17 Cultural Competency Dialogue on Eliminating Health Care Disparities – Longitudinal Approach to – Reaffirmed 2017

FISCAL IMPACT: $0

ACTION TAKEN NOT ADOPTED

DATE JULY 17, 2021

SUBJECT: ADDRESSING LAW ENFORCEMENT DISPROPORTIONATE USE OF FORCE DURING INTERACTIONS WITH MARGINALIZED GROUPS AS A PUBLIC HEALTH ISSUE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association (AOA) has previously called on Congress to label gun violence as a national public health issue[1]; and

WHEREAS, the American Public Health Association (AHPA) acknowledges the current law enforcement system mediates the physical and psychological violence directed against marginalized populations that results in the disproportionate death, injuries and trauma of these marginalized populations[2]; and

WHEREAS, police violence is a leading cause of death for minority populations; with the mortality rates among non-Hispanic Black and Hispanic individuals 2.8 and 1.7 times higher, respectively, when compared to that among their White counterparts[3]; and

WHEREAS, a review of literature found that individuals who were shot by police had a higher median probability of being unarmed black individuals than being armed white individuals[4]; and

WHEREAS, race and bias are recognized as important social determinants of health[5]; and

WHEREAS, minority communities with a high concentration of use of force by police against pedestrians is associated with an increased risk of diabetes and obesity[6]; and

WHEREAS, the World Health Organization has cited norms that support the use of excessive force by police as a societal aspect of violence as it relates to a growing public health problem[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) acknowledges the disproportionate use of force by law enforcement against marginalized groups and its physical and mental health effects on these communities.

References

1. AOA Policy Search. (n.d.). Retrieved from https://osteopathic.org/about/leadership/policy-search/.
2. AHPA, (2019, January 29). Addressing Law Enforcement Violence as a Public Health Issue. (n.d.). Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence
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4. Ross, C. T. (2015). A Multi-Level Bayesian Analysis of Racial Bias in Police Shootings at the County-Level in the United States, 2011–2014. *PLOS ONE*, *10*(11). https://doi.org/10.1371/journal.pone.0141854
5. Johnson, T. J. (2020). Intersection of Bias, Structural Racism, and Social Determinants With Health Care Inequities. *Pediatrics*, *146*(2). https://doi.org/10.1542/peds.2020-003657
6. Sewell, A. A. (2017). The Illness Associations of Police Violence: Differential Relationships by Ethnoracial Composition. *Sociological Forum*, *32*, 975–997. https://doi.org/10.1111/socf.12361
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Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies do not address use of force by law enforcement:

H630-A/18 Comprehensive Gun Violence Reform: In the first Whereas statement, the author refers to current AOA policy which labels gun violence as a national public health issue. This is current AOA policy H630-A/18 Comprehensive Gun Violence Reform which states: The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that: 1. Labels gun violence as a national public health issue. 2. Funds appropriate research on gun violence as part of future federal budgets. 3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. H630-A/18 has no mention of law enforcement.

H441-A/17 Violence and Abuse Prevention and Education: This policy addresses domestic violence since it mentions abuse and neglect, advocating for victims and rehabilitating abusers. There is no mention of violence or abuse caused by law enforcement.

Prior HOD action on similar or same topic:

H630-A/18 Comprehensive Gun Violence Reform – Reaffirmed 2018
H441-A/17 Violence and Abuse Prevention and Education - 2017

FISCAL IMPACT: $0

ACTION TAKEN ____NOT ADOPTED___

DATE _____JULY 17, 2021_____

SUBJECT: ADDRESSING THE CHANGE IN CLIMATE EFFECTS ON NATIONAL HEALTH

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, rising average temperatures will lead to increased frequency and longevity of heat waves[1]; and

WHEREAS, exposure to extreme heat can lead to heat stroke and dehydration, as well as cardiovascular, respiratory, and cerebrovascular disease[2]; and

WHEREAS, certain patient populations will be more vulnerable to extreme heat due to impaired heat regulatory functions, including young children, pregnant women, the elderly, and persons with inherent medical conditions and/or disabilities[2]; and

WHEREAS, climate change is projected to increase the vulnerability of urban populations to heat-related health impacts in the future[2]; and

WHEREAS, warmer temperatures are associated with periods of stagnant air, leading to increases in air pollution and associated health effects[1]: asthma attacks and other respiratory and cardiovascular health effects[2]: and

WHEREAS, warm, stagnant air tends to increase the formation of ozone, therefore, climate change is likely to increase levels of ground-level ozone in already-polluted areas of the United States, thereby further decreasing air quality[2]; and

WHEREAS, projections show that within the next 80 years these environmental changes will translate to poorer health outcomes in the United States, potentially resulting in tens of thousands of additional deaths[2]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage ~~continued education and awareness of the potential adverse~~ **RESEARCH OF THE** ~~public~~ health ~~effects~~ **IMPACT** of **CHANGING** climateS~~ change~~.

References:

1. USGCRP (2016). Impacts of Climate Change on Human Health in the United States: A Scientific Assessment. Crimmins, A., J. Balbus, J.L. Gamble, C.B. Beard, J.E. Bell, D. Dodgen, R.J. Eisen, N.Fann, M.D. Hawkins, S.C. Herring, L. Jantarasami, D.M. Mills, S. Saha, M.C. Sarofim, J.Trtanj, and L.Ziska, Eds. U.S. Global Change Research Program, Washington, DC. 312 pp. dx.doi.org/10.7930/J0R49NQX.
2. CCSP (2008). Analyses of the effects of global change on human health and welfare and human systems. A Report by the U.S. Climate Change Science Program and the Subcommittee on Global Change Research. Gamble, J.L. (ed.), K.L. Ebi, F.G. Sussman, T.J. Wilbanks, (Authors). U.S. Environmental Protection Agency, Washington, DC, USA.

Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies are similar however do not address climate change:

H402-A/18 Environmental Health
H417-A/20 Environmental Responsibility – Waste Materials
H405-A/20 Protection of Safe Water Supply

Prior HOD action on similar or same topic:

H402-A/18 Environmental Health – Reaffirmed 2018
H417-A/20 Environmental Responsibility – Waste Materials – Adopted 2020
H405-A/20 Protection of Safe Water Supply – Adopted 2020

FISCAL IMPACT: $ 0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: INCREASED LAW ENFORCEMENT RESOURCES AND TRAINING FOR RESPONSE IN MENTAL HEALTH CRISES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, law enforcement officers often serve as first-line responders and primary
2 gatekeepers that determine whether the mental health or criminal justice system can best
3 meet the needs of the individual suffering from an acute psychiatric crisis [1-3]; and

4 WHEREAS, approximately 1 in 4 deaths by law enforcement involves a person with a mental
5 health illness[4]; and

6 WHEREAS, mentally ill prisoners make up 56% of state and 45% of federal prisons[5]; and

7 WHEREAS, inmates housed in inpatient mental health units have the greatest risk for
8 completing suicide[6];

9 WHEREAS, relative to law enforcement; encounters with patients exhibiting signs of excited
10 delirium are 70% less likely to end in fatality when paramedics are first to respond[7]; and

11 WHEREAS, CIT training is a specialized police curriculum that aims to reduce the risk of
12 serious injury or death during an emergency interaction between persons with mental
13 illness and police officers[4]; and

14 WHEREAS, officers' confidence in their abilities and preparedness to handle calls involving
15 persons with mental illness is positively associated with implementation of CIT
16 training[8]; and

17 WHEREAS, one study found that CIT-trained officers chose less escalation (use of force) than
18 non–CIT-trained officers in situations involving a subject with psychosis[9]; and

19 WHEREAS, CIT-trained officers become better able to identify mental health crises and refer
20 more often to mental health services with subsequent decreased arrest rates[10]; now,
21 therefore be it

22 RESOLVED, that the American Osteopathic Association (AOA) encourage increased
23 resources and training initiatives, such as the crisis intervention team (CIT) and other
24 continued best practices, for law enforcement to improve patient safety and reduce
25 negative outcomes for patients.

References:

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2. Krameddine YI, Silverstone PH. How to Improve Interactions between Police and the Mentally Ill. Front Psychiatry. 2014;5:186. https://doi.org/10.3389/fpsyt.2014.00186
3. Lamb, H. R., Weinberger, L. E., & DeCuir, W. J. (2002). The Police and Mental Health. *Psychiatric Services*, *53*(10), 1266–1271. https://doi.org/10.1176/appi.ps.53.10.1266
4. Rogers MS, McNiel DE, Binder RL. Effectiveness of Police Crisis Intervention Training Programs. *J Am Acad Psychiatry Law*. 2019;47(4):414-421. doi:10.29158/JAAPL.003863-19
5. James, D.J., Glaze, L.E. (2006). Mental health problems of prison and jail inmates. *Bureau of Justice Statistics*.
6. Boren, E. A., Folk, J. B., Loya, J. M., Tangney, J. P., Barboza, S. E., & Wilson, J. S. (2018). The Suicidal Inmate: A Comparison of Inmates Who Attempt Versus Complete Suicide. *Suicide & life-threatening behavior*, *48*(5), 570–579. https://doi.org/10.1111/sltb.12374
7. Strömmer, E.M.F., Leith, W., Zeegers, M.P. *et al.* The role of restraint in fatal excited delirium: a research synthesis and pooled analysis. *Forensic Sci Med Pathol* 16, 680–692 (2020). https://doi.org/10.1007/s12024-020-00291-8
8. Bonfine, N., Ritter, C., & Munetz, M. R. (2014). Police officer perceptions of the impact of Crisis Intervention Team (CIT) programs. *International Journal of Law and Psychiatry*, *37*(4), 341–350. https://doi.org/10.1016/j.ijlp.2014.02.004
9. Michael T. Compton, Berivan N. Demir Neubert, Beth Broussard, Joanne A. McGriff, Rhiannon Morgan, Janet R. Oliva, Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject With Schizophrenia, *Schizophrenia Bulletin*, Volume 37, Issue 4, July 2011, Pages 737–745, https://doi.org/10.1093/schbul/sbp146
10. Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, B. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. *Psychiatric services* (Washington, D.C.), 65(4), 523–529. Retrieved September 21, 2020 from https://doi.org/10.1176/appi.ps.201300108

Background Information: Provided by AOA Staff

Current AOA Policy:

The following policies are similar:

H440-A/16 Substance Use Disorders (SUD) – Evidence Based Treatment Programs for
H338-A/16 Behavioral Health Patients in Emergency Departments
H449-A/20 Homeless Support

Prior HOD action on similar or same topic:

H440-A/16 Substance Use Disorders (SUD) – Evidence Based Treatment Programs for – Reaffimed 2016
H338-A/16 Behavioral Health Patients in Emergency Departments – Reaffirmed 2016
H449-A/20 Homeless Support – Adopted as Amended 2020

FISCAL IMPACT: $0

ACTION TAKEN REFERRED (*SOMA*)

DATE JULY 17, 2021

SUBJECT: REFFERRED RESOLUTION FIREARM POLICY COMPENDIUM – SOURCE H437-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Public Affairs Committee

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1 WHEREAS, the House of Delegates adopted H437-A/19, Firearm Violence, which requires
2 the American Osteopathic Association to develop a comprehensive policy that
3 consolidates all current firearm violence policies into a single unified policy and present
4 it for consideration by the 2020 AOA House of Delegates; and

5 WHEREAS, consolidated, unified policies can have the unintended consequence of disrupting
6 continuity of American Osteopathic Association policy; and

7 WHEREAS, background and history on a given topic can be lost through the consolidation and
8 elimination of multiple policies into a single policy, making additions or changes to
9 future policy more difficult; and

10 WHEREAS, having a broad array of policies on a given topic allows the American Osteopathic
11 Association to accurately respond to federal and state legislative and regulatory concerns
12 with nuanced and specific policy to reference; and

13 WHEREAS, the American Osteopathic Association risks having no policy relating to firearm
14 violence should a portion of a single, consolidated policy on firearms be found to be no
15 longer germane in future years; and

16 WHEREAS, H448-A/20, Firearms Policy, was referred to the Bureau on Federal Health
17 Programs and has been updated to account for Delegate feedback as well as resolutions
18 adopted by the 2020 House of Delegates; now, therefore, be it

19 RESOLVED, that H437-A/19 is superseded by this resolution; and

20 RESOLVED, that the American Osteopathic Association (AOA) House of Delegates adopts
21 the attached policy compendium, which includes all current American Osteopathic
22 Association policies relating to firearm violence.

AOA Policy Compendium – Firearm Policy

Introduction

The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.

The 2019 AOA House of Delegates (HOD) adopted a resolution, H437-A/19, Firearm Violence, which states that the AOA *"will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates."* In response to the adoption of this policy, the Bureau on Federal Health Programs (BFHP) concluded that having a broad array of policies on a given topic allows AOA staff to accurately respond to federal and regulatory concerns. With nuanced policy to reference, the bureau determined that the best approach to implementing this policy is to develop a comprehensive document that includes all current AOA policies relating to firearm violence. This approach is also intended to preserve any relevant background and history of individual resolutions and avoid any potential impediments to future policy changes.

The BFHP submitted a white paper to the 2020 HOD in response to the direction provided in H437-A/19 that included an overview of AOA firearm policy through 2019. Questions were raised by delegates at the 2020 HOD regarding the scope of the document submitted and whether more current data was available, and it subsequently was referred back to the BFHP. In response to this referral, the BFHP has updated its research; firearms resolutions adopted by the 2020 HOD along with updated federal statistics and citations are included in this compendium.

Background

Much of the AOA's policy is predicated on an understanding of the role of firearms on public health in the United States. According to the Centers for Disease Control and Prevention (CDC), firearm-related deaths in the U.S. reached a twenty year high in 2017[i]. In 2018, there were 39,740 firearms-related deaths in the U.S., with 109 people dying from firearm-related injury each day[ii]. The CDC estimates that 6 in 10 of these are suicide and 3 in 10 are homicide[iii]. Additionally, in 2018, more U.S. deaths were attributed to firearms than motor vehicle accidents[iv].

An analysis of 2010 data showed that the U.S. had the highest rate of firearm-related violence, suicides, and accidents among industrialized countries[v]. Beyond the impact on the health and well-being of Americans, there is an economic impact, with gun violence in the U.S. costing $229 billion in 2015[vi].

Policies Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death, as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services.

Current Resolutions on Firearm Education:

- **H425-A/19 FIREARM SAFETY**

  The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians educate families on the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014; reaffirmed as amended 2019

- **H418-A/20 FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS**

  The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015; adopted as amended 2020 ***[Editor's Note: Non-powdered guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]***

- **H340-A/16 PHYSICIAN GAG RULES – OPPOSITION TO**

  The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights. 2016

- **H428-A/19 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE**

  While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. 2013; reaffirmed 2019

<u>Policies on Advancing Research to Reduce Firearm Violence</u>

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other research entities, to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Current Resolutions on Firearm Research:

- **H442-A/20 FIREARM VIOLENCE**

  The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health

care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety"; (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015; adopted as amended 2020

AOA Policy Statement – Firearm Violence

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms, is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. The AOA supports the administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

- **H630-A/18 COMPREHENSIVE GUN VIOLENCE REFORM**

The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that:

1. Labels gun violence as a national public health issue.
2. Funds appropriate research on gun violence as part of future federal budgets.
3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. 2018

Additional Policies Supporting Reduced Firearm Injury

- **H318-A/16 FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM**

  The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011; reaffirmed 2016

- **H446-A/20 BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE**

  The American Osteopathic Association (AOA) recognizes public health data demonstrating the impact of firearms on mortality and wellness in the United States and will support federal legislation requiring comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and the AOA will support efforts to require firearms safety training, including military or law enforcement training, as a condition to purchase any class of firearms. H421-A/15 is superseded by this resolution. adopted 2020

Conclusion

As noted above, the AOA House of Delegates adopted a policy in 2019 that calls for the identification of all current firearm violence policies in a single document. This compendium reflects that policy and highlights the wide range of issues addressed in AOA firearm policies which includes eight individual policies. At least two resolutions (H425-A/19 and H418-A/20) support education and recommend safety precautions for gun owners. One (H340-A/16) opposes any governmental action that would limit the right of physicians to discuss with their patients the topic of responsible gun ownership and safe storage. Another (H428-A/19) opposes any mandated reporting of patient gun ownership. Two policies (H442-A/20 and H630-A/18) support federal funding for research on firearm violence. H630-A/18 also labels gun violence as a national public health issue and supports federal legislation that would establish constitutionally appropriate restrictions on the manufacturing and sale of certain classes of firearms. Lastly, H446-A/20 supports federal legislation requiring comprehensive background checks for firearms as well as efforts to require firearm safety training.

There is a separate and distinct focus in most of these policies, with covered issues ranging from education, to protecting the rights of physicians, support for research, and support for certain restrictions on sales. As such, these policies, as well as any future firearm-related policies, should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

References:

[i] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[ii] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html
[iii] Id.
[iv] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html
[v] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.
[vi] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.

SUBJECT: IMPROVING OUTCOMES IN BEHAVIORAL HEALTH CARE IN THE EMERGENCY DEPARTMENT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, the demands for behavioral health services from the emergency department increased 44.1% from 2006 to 2014; (1) and

WHEREAS, the total cost of providing these behavioral health services in the emergency department is high – more than $5.6B in 2017 alone; (2) and

WHEREAS, public payers bear a significant portion of these costs, with Medicaid paying the cost for 38% of suicidal complaints, 36.3% of schizophrenia complaints, and 34.7% of alcohol-related complaints in emergency departments in 2017; (2) and

WHEREAS, the emergency department is not the best environment for crisis stabilization; and

WHEREAS, comprehensive behavioral health response should include appropriate stabilization of crisis in an environment conducive to caring for the unique needs of behavioral health patients; and

WHEREAS, a specialized unit called an emPATH (emergency psychiatric assessment, treatment, and healing) unit provides a calm environment, staff trained in de-escalation techniques, and immediate access to a psychiatrist, whether in-person or via telehealth; (3) and

WHEREAS, access to a psychiatrist is not always readily available, especially in more rural areas, and an emPATH unit that utilizes telepsychiatry will help address this issue in remote and underserved areas; (4) and

WHEREAS, emPATH units have been shown to decrease hospitalizations by 75%, with 80% of patients seen in these units discharged in less than 16 hours; (5) and

WHEREAS, with the decrease in length of stay as well as decrease in hospitalization, public payers like Medicaid would save an estimated $32B in annual costs for behavioral health care; (6) now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports innovative models that increase availability of emergency behavioral health care~~, such as emPATH units,~~ for crisis stabilization.

References:

1. Statistical Brief #227: Trends in Emergency Department Visits, 2006-2014. Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality. September 2017. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf
2. Statistical Brief #257. Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality. May 2020, revised October 2020. https://hcup-us.ahrq.gov/reports/statbriefs/sb257-ED-Costs-Mental-Substance-Use-Disorders-2017.pdf
3. Zeller, Scott. Zeller, Scott. What Psychiatrists Need to Know: Patients in the Emergency Department. Psychiatric Times. August 2018. https://www.vituity.com/media/2305/psytimes_zeller_aug2018-v2.pdf
4. Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry. 2007;29(3):199-206. doi:10.1016/j.genhosppsych.2007.01.013 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1986661/
5. Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med. 2014 Feb;15(1):1-6. doi: 10.5811/westjem.2013.6.17848. PMID: 24578760; PMCID: PMC3935777.
6. Statistical Brief #249. Inpatient Stays Involving Mental and Substance Use Disorders, 2016. Healthcare Cost and Utilization Project. Agency for Healthcare Research. March 2019. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _ADOPTED AS AMENDED_____

DATE _____JULY 17, 2021_____

SUBJECT: COVID-19 ANTI-ASIAN DISCRIMINATION AND ABUSE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, there has been a rise in Anti-Asian sentiment, specifically in respects to the COVID-19 pandemic and Americans have seen over 3,800 Anti-Asian incidents in 2020, with this rise representing an increase of nearly 150% from the year prior; and

WHEREAS, these incidents included extensive physical, verbal, emotional and psychological abuse to the Asian community with Asian women reporting hate incidents 2.3 times more than men;

WHEREAS, with the education of our patients and medical community we could collectively have an impact on reducing these hate crimes specifically in relation to the COVID-19 pandemic; therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) support efforts to educate the public, physicians and the medical community on the issue of Anti-Asian Sentiment; and be it further

RESOLVED, that by dispelling an Asian correlation with the COVID-19 pandemic, we direct our medical community's efforts to collectively combat Anti-Asian acts of discrimination and abuse.

References:

1. Center for the Study of Hate and Extremism, CSUSB, Anti-Asian Prejudice (https://www.csusb.edu/sites/default/files/FACT%20SHEET-%20Anti-Asian%20Hate%202020%20rev%203.21.21.pdf)
2. Stop AAPI Hate National Report, 3/19/20-2/28/21, Russell Jeung, Ph.D, Aggie Yellow Horse, Ph.D, Tara Popovic, and Richard Lim (https://secureservercdn.net/104.238.69.231/a1w.90d.myftpupload.com/wp-content/uploads/2021/03/210312-Stop-AAPI-Hate-National-Report-.pdf)
3. Center for the Study of Hate and Extremism, CSUSB, Anti-Asian Prejudice www.csusb.edu/sites/default/files/FACT%20SHEET-%20Anti-Asian%20Hate%202020%203.2.21.pdf) STOP AAPI HATE NATIONAL REPORT, 3/19/20 - 2/28/21, Russel Jeung, Ph.D, Aggie Yellow Horse, Ph.D, Tara Popovic, and Richard Lim

Background Information: Provided by AOA Staff

Current AOA Policy:

None. The AOA released a statement denouncing systemic racism and inequality; however, it is not specific to Anti-Asian sentiment as it relates to the COVID-19 pandemic.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___NOT ADOPTED___

DATE _____JULY 17, 2021_____

SUBJECT: DRUG SAMPLES - SOURCE: H327-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (1) encourages the pharmaceutical industry to continue
7 the distribution of drug samples, and/or vouchers to physicians, including those drugs whose
8 patents have expired, (2) will petition the Food and Drug Administration to not limit the
9 manufacturers' distribution of drug samples and/or vouchers; and (3) will continue to defend
10 and support policies that allow osteopathic physicians to provide drug samples (including stock
11 bottles or vouchers when appropriate) free-of-charge to patients.

Background Information: Provided by AOA Staff
Current AOA Policy:
1995; 1996 Reaffirmed; 2001 Amended; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CONCUSSION, RETURN-TO-PLAY AND RETURN-TO-LEARN - SOURCE: H352-A/16

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

3 RESOLVED, that the Council on State Health Affairs recommends that the following policy
4 be REAFFIRMED AS AMENDENDED.

5 The American Osteopathic Association (AOA) approves the Youth Concussion and Return-
6 To-Play white paper as its position on concussion, return-to-play and return-to-learn.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

Youth Concussion and Return-To-Play White Paper

Since 2009, every state has passed some form of legislation to address concussion safety in youth athletics. Most states' laws address the following five common areas:

1. Parent and student education,
2. Parent and student signature requirements,
3. Coach training, removal and return-to-play [RTP],
4. Return-to-learn [RTL] and
5. Clearing provider types

State laws vary, however, in the precise degree of detail and rigor of their respective requirements. The American Osteopathic Association (AOA) is committed to helping states work to address this public health risk by providing evidence-based guidance on concussion as a part of the spectrum of traumatic brain injuries (TBIs), as well as RTP and RTL protocols for youth athletes. We support policies that are backed by current scientific evidence, with appropriate clarification regarding the definitions of terms and protocols. The AOA believes that allopathic and osteopathic physicians (MDs and DOs) possess the complete medical knowledge and training needed to recognize and diagnose the subtle, varying and evolving symptoms of concussion, but that coordination across all levels of the physician-led team is imperative for timely evaluation and intervention, and appropriate follow-up care. In order to ensure the appropriate level of care, team physicians should possess up-to-date documentation of knowledge, skills and experience in this area of medicine. The goal of this paper is to encourage greater consistency among the terminology used by health care organizations, and to utilize current evident to help states create a standardized approach to concussion, RTP and RTL.

Background

In recent years, a consensus has emerged among the scientific community that head injuries resulting from contact sports, including football, soccer, boxing, ice hockey and others, can have devastating long-term effects.[1] Among the consequences of repeated head injuries are headache, dizziness, difficulty concentrating or completing tasks, and in some cases, increased risk of depression and suicide.[2] Children and teenagers are especially susceptible to concussion-related injuries, because their brains lack the coating and insulation of adult brains and their heads are relatively heavy, and necks weak, compared to adults.[3] Thus, children are at risk of sustaining more serious brain injuries than adults when exposed to the same amount of force. According to the CDC, the number of TBI-

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[1] McCrory, Paul, Meeuwisse, Willem H., Aubry, Mark, et al. "Consensus Statement on Concussion in Sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012." *British Journal of Sports Medicine,* 2013;47:250-258.. Available at: http://bjsm.bmj.com/content/47/5/250.full

[2] No author. "Long-term Effects of Brain Injuries." *Weill Cornell*, no date. ~~Accessed on Feb. 3, 2016.~~ Available at: http://weillcornellconcussion.org/about-concussions/long-term-effects-brain-injuries.

[3] No author. "Parents Vigilance Can Head Off Kids' Concussion Risk." *USA Today*, Sept. 29, 2012. Available at: http://www.usatoday.com/story/news/nation/2012/09/29/concussion-kids-cantu/1581173/.

related emergency department visits among youth doubled from 2002 to 2010, from approximately 500 to 1,000 per 100,000 people.[4] Further, female athletes appear to be more susceptible to sustaining concussions than males.[5]

To address this issue, all states have now implemented some form of concussion and RTP legislation. The National Center for Injury Prevention and Control (NCIPC) conducted a case study on two states that were early implementers of these laws, Washington and Massachusetts, to evaluate differences in their laws and approaches to addressing youth sports-related injuries.[6]

Washington became the first state to implement a concussion law with the passage of the "Zackery Lystedt Law" in May 2009.[7] This law mandates that youths suspected of having sustained a head injury or concussion should be removed from competition, and returned to play *only* after an evaluation and written medical clearance from a "licensed health care provider* trained in the evaluation and management of concussion."[8] The law requires individual school districts to develop information to educate youth athletes, their parents and coaches about the nature and risk of concussions, but it does not provide any specific requirements for the content of those guidelines. The law does not require any coach training, and students are not required to complete concussion history forms.

Massachusetts' law, by contrast, requires stakeholder groups including parents, coaches, trainers, school athletic directors and school-employed physicians and nurses to participate in an athletic head injury safety training program developed by the Department of Public Health.[9] It directs the Department to utilize materials from the Centers for Disease Control and Prevention to create the program, which shall include (1) current training in recognizing the symptoms of concussions and

(2) providing students who participate in athletic activities a summary of the medical protocol for recognizing concussion symptoms, a protocol for post-concussion participation in athletics, and the short- and long-term consequences of concussions. It requires schools to implement an RTP protocol containing 17 specific items including procedures for medical review of all concussion history forms and plans for gradual RTP following injury. It also mandates that schools establish their own RTP protocol implementation teams. The law requires students to provide information about their concussion and head injury history at the start of each sports season on a form that must be signed by the student and ~~his or her~~ THEIR parent or guardian and forwarded to ~~his or her~~ THEIR coach(es). A student who becomes unconscious or is suspected of having suffered a concussion must be

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[4] No author. "Rates of TBI-related Emergency Department Visits by Age Group — United States, 2001–2010." *Centers for Disease Control and Prevention*, no date. ~~Accessed on June 20, 2016.~~ Available at: http://www.cdc.gov/traumaticbraininjury/data/rates_ed_byage.html.

[5] Franks, R. Robert. "Why are Concussions Worse in Females? " *Philly.com*, Apr. 12, 2013. http://www.philly.com/philly/blogs/sportsdoc/Why-are-concussions-worse-in-females.html.

[6] No author. "Implementing RTP: Learning from the Experiences of Early Implementers." *National Center for Injury Prevention and Control*, no date. ~~Accessed on June 20, 2016.~~ Available at: http://www.cdc.gov/headsup/pdfs/policy/rtp_implementation-a.pdf.

[7] No author. "Youth Sports—Concussion and Head Injury Guidelines." Revised Code of Washington 28A.600.190 (2009). Available at: http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.600.190.

[8] *Id.*

[9] No author. "Interscholastic Athletic Head Injury Safety Training Program." Massachusetts General Laws 111 §222 (2010). Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section222.

* Licensed Health Care Provider is undefined by the law, and may be a volunteer.

removed from practice or competition and not returned to the practice or competition during which the concussion or suspected concussion occurred. The student may only return to subsequent athletic activities with the written clearance of a physician, neuropsychologist, certified athletic trainer or other "appropriately trained or licensed health care professional as determined by the Department of Public Health."

Numerous state laws in addition to Massachusetts' include athletic trainers and nurses among the "clearing provider types" who may allow a youth to return to athletic activity following a concussion. Forty-nine states (with the exception of California) license and regulate athletic trainers, and all require that certified athletic trainers work within their state practice act under the direction of a physician. All forty-nine states recognize certification by the National Athletic Trainers' Association, which will soon increase the minimum education required for certification from a bachelor's degree to a master's degree from an accredited professional athletic training education program.[10] Graduates must then pass a comprehensive examination, and meet ongoing continuing education requirements. Education programs include training in the identification of signs, symptoms, interventions and RTP criteria for brain injury including concussion, but continuing education requirements vary widely (some states require concussion management as a part of these continuing education requirements, while others do not).[11, 12, 13]

While all states license and regulate nurses, nursing education varies more widely and concussion education is not mandatory. The National Association of School Nurses (NASN) recommends a four-year bachelor's degree and registered nurse (RN) certification as the minimum standard for a school nurse.[14] The NASN has issued a position statement on the importance of the school nurse on the concussion management team; however, the RN examination does not include concussion among the list of topics and not all states require continuing education for nurses.[15, 16] As athletic trainers and school nurses are frequently on the front lines of youth concussion evaluation and management, more robust state education and training requirements are needed to ensure that these health care professionals receive ~~up-to-date~~ CURRENT, EVIDENCE-BASED training in this area, particularly when these providers are listed among the state's "clearing provider types."

Washington and Massachusetts' laws illustrate the wide variation in approaches that states have taken to attempt to address concussion among student athletes, and while all 50 states now possess similar laws, these laws differ significantly in their provisions. Several physician specialty organizations have examined this issue, and published position statements which include evidence-based guidance for states.

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[10] No author. "After 2.5 Years of Diligent Analysis, Leaders of the Key Athletic Training Organizations Have Decided to Change the AT Degree Level to a Master's." *AT Strategic Alliance*, May 20, 2015. Available at: http://atstrategicalliance.org/statements/strategic-alliance-degree-statement.

[11] NO AUTHOR. "ATHLETIC TRAINING EDUCATION COMPETENCIES (5TH EDITION)." *NATIONAL ATHLETIC TRAINERS' ASSOCIATION*, RELEASED 2011. AVAILABLE AT: HTTPS://WWW.NATA.ORG/SITES/DEFAULT/FILES/COMPETENCIES_5TH_EDITION.PDF.

[12] NO AUTHOR. "CONTINUING EDUCATION REQUIREMENTS FOR ATHLETIC TRAINERS." *TEXAS DEPARTMENT OF LICENSING AND REGULATION*, NO DATE. AVAILABLE AT: HTTPS://WWW.TDLR.TEXAS.GOV/AT/ATCE.HTM#RENEW.

[13] NO AUTHOR. "CURRENT RULES AND REGULATIONS." *WYOMING ATHLETIC TRAINING BOARD*, APRIL 16, 2020. AVAILABLE AT: HTTPS://RULES.WYO.GOV/SEARCH.ASPX?AGENCY=065&PROGRAM=0001.

[14] No author. "Education, Licensure, and Certification of School Nurses: Position Statement." National Association of School Nurses, Jan. 2012. Available at: ~~https://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/26/Default.aspx~~ . HTTPS://WWW.NASN.ORG/ADVOCACY/PROFESSIONAL-PRACTICE-DOCUMENTS/POSITION-STATEMENTS/PS-EDUCATION.

[15] NO AUTHOR. "NCLEX-RN® EXAMINATION." *NATIONAL COUNCIL OF STATE BOARDS OF NURSING*, EFFECTIVE APRIL 2013. AVAILABLE AT: HTTPS://WWW.NCSBN.ORG/2013_NCLEX_RN_TEST_PLAN.PDF.

[16] NO AUTHOR. "STATE CE REQUIREMENTS FOR LICENSURE." *MEDSCAPE*, MARCH 29, 2021. AVAILABLE AT: HTTPS://WWW.MEDSCAPE.ORG/PUBLIC/NURSECESTATEREQUIREMENTS.

The American Osteopathic Academy of Sports Medicine (AOASM), as a contributing author on the 2013 paper *Concussion and the Team Physician: A Consensus Statement (TPCC)*, WHICH IS STILL CURRENT, advocated for on-field and sideline protocols such as neurological assessments and a plan for post-injury follow-up, as well as post-game-day evaluation and treatment.[17] AOASM, via the *TPCC*, urged guidelines that encourage individualized RTP decisions not based on a rigid timeline, with the physician ultimately bearing responsibility for making the decision. The paper also advocates that treating physicians should understand the complications of concussion, including that cumulative concussions may increase subsequent risk for concussion, and other neurological and physical symptoms. Physicians should also understand prevention principles, including helmet use and the utility of educating athletes, parents and coaches about concussion risks in advance.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) PUBLISHED GUIDELINES ON THE DIAGNOSIS AND MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY AMONG CHILDREN IN 2018.[18] "RECOMMENDATIONS FROM THE CDC PEDIATRIC TBI GUIDELINES INCLUDE:

1. DO NOT ROUTINELY IMAGE PATIENTS TO DIAGNOSE TBI.
2. USE VALIDATED, AGE-APPROPRIATE SYMPTOM SCALES TO DIAGNOSE TBI.
3. ASSESS EVIDENCE-BASED RISK FACTORS FOR PROLONGED RECOVERY.
4. PROVIDE PATIENTS WITH INSTRUCTIONS ON RETURN TO ACTIVITY CUSTOMIZED TO THEIR SYMPTOMS.
5. COUNSEL PATIENTS TO RETURN GRADUALLY TO NON-SPORTS ACTIVITIES AFTER NO MORE THAN 2-3 DAYS OF REST."

THE CDC HAS ALSO DEVELOPED AN EDUCATIONAL PROGRAM CALLED "HEADS UP: CONCUSSION IN YOUTH SPORTS."[19]

THE AMERICAN ACADEMY OF NEUROLOGY (AAN) HAS A POSITION STATEMENT ON SPORTS CONCUSSION (2020) CALLED CONCUSSION POLICY FOR YOUTH AND HIGH SCHOOL SPORTS.[20] THE AAN SUPPORTS EDUCATIONAL RESOURCES SUCH AS THE CDC'S HEADS UP: CONCUSSION IN YOUTH SPORTS ONLINE TRAINING COURSE FOR COACHES AND PARENTS AND PROCESSES TO CONFIRM THAT THE

EDUCATION IS UNDERSTOOD BY PARENTS AND ATHLETES. THE AAN SUPPORTS REMOVAL FROM PARTICIPATION FOR ANY ATHLETE WHO IS EXHIBITING SYMPTOMS OR SIGNS OF A CONCUSSION UNTIL THEY ARE EVALUATED BY A QUALIFIED HEALTHCARE PROVIDER PROPERLY TRAINED IN THE ASSESSMENT AND MANAGEMENT OF CONCUSSION, SUCH AS A NEUROLOGIST AND AS DEFINED BY STATE LAW. AAN RECOMMENDS THAT STUDENT ATHLETES SHOULD NOT RETURN TO ATHLETIC COMPETITION UNTIL THE SIGNS AND SYMPTOMS OF CONCUSSION HAVE RESOLVED AND HAVE BEEN CLEARED BY A QUALIFIED HEALTHCARE PROFESSIONAL TRAINED IN THE MANAGEMENT OF CONCUSSION, SUCH AS A NEUROLOGIST. STUDENT ATHLETES SHOULD RETURN TO FULL ACADEMIC PARTICIPATION BEFORE RETURNING TO COMPETITION.

~~The American Academy of Neurology (AAN) recommends that youth athletes, families and coaches receive counseling about risk factors for concussion by a licensed health care professional (LHCP) experienced in the diagnosis and management of sports concussions.[13] Schools and athletic associations should implement a tool such as the Sports Concussion Assessment Tool – Version 3 (SCAT3) for youth ages 13-18 or Child SCAT3 for ages five-12 which non-physicians can use on the sidelines to evaluate whether he or she has suffered a concussion. Athletes with concussions should be prohibited from returning to play or practice until they are asymptomatic without medication and an LHCP whose scope of practice includes being properly trained in the evaluation and management of concussion has determined that the concussion has resolved. LCHPs should consider any baseline information or neurocognitive testing results available for the athlete in determining whether the concussion has resolved. AAN also provides a summary of evidence-based guidelines for coaches and athletic trainers, clinicians and patients and their families, as well as a Concussion Quick Check guide to help evaluate concussion symptoms and determine whether the athlete may need to see a LHCP trained in the evaluation and management of concussion). Use of the self-evaluative Post-Concussion Symptom Scale for ages 12 and under, and 13 and over, and the Graded Symptom Scale Checklist by clinicians are also recommended to help health care providers and athletic officials evaluate and monitor concussion symptoms.~~

~~The American Academy of Orthopaedic Surgeons (AAOS) recommends that concussed athletes be removed from practice or competition immediately and that there be no same-day RTP, even if the athlete's initial symptoms resolve.[14] This is supported by a 2014 study by Boston Children's Hospital, which found that youth athletes who returned to full cognitive activity after a concussion took two to five times as long to recover as those who initially limited such activity, thus, early detection and intervention are key to improving health outcomes.[15] The athlete should be assessed by a "health care provider" (undefined), with no RTP until he or she is cleared by the provider. Management and treatment of concussions should be individualized, and it is desirable that a physician help develop a standardized baseline assessment tool that incorporates prior concussion history, neurological examination emphasizing cognitive function and balance, and a symptoms checklist. The physician should help coordinate evaluation and treatment of a concussed athlete with a concussion~~

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[17] ~~No author~~ AMERICAN COLLEGE OF SPORTS MEDICINE, AMERICAN ACADEMY OF FAMLY PHYSICIANS, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE, AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE, AND AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE. "Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement." ~~*American Osteopathic Academy of Sports Medicine*, no date~~. 2013. ~~Accessed on June 20, 2016MARCH 3 2021.~~ Available at:

https://cdn.ymaws.com/www.aoasm.org/resource/resmgr/PositionPapers/ConcussionandtheTeamPhysicia.pdf~~http://www.aoasm.org/default/assets/File/ConcussionandtheTeamPhysician.pdf.~~

18 CENTERS FOR DISEASE CONTROL AND PREVENTION GUIDELINE ON THE DIAGNOSIS AND MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY AMONG CHILDREN JAMA PEDIATR. 2018 NOVEMBER 01; 172(11): e182853. doi:10.1001/jamapediatrics.2018.2853

~~No author. "Evaluation and Management of Concussion in Athletes: Recommendations from the AAN." *American Family Physician*, Apr. 1, 2014.. Available at: http://www.aafp.org/afp/2014/0401/p585.html.~~

19 NO AUTHOR. "HEADS UP TO YOUTH SPORTS." *CENTERS FOR DISEASE CONTROL AND PREVENTION*, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/YOUTHSPORTS/INDEX.HTML.

20 AAN POSITION: SPORTS CONCUSSION 2020. AVAILABLE AT HTTPS://WWW.AAN.COM/POLICY-AND-GUIDELINES/POLICY/POSITION-STATEMENTS/SPORTS-CONCUSSION.

~~Boyajian-O'Neill, Lori, Franks, R Robert et al. "Team Physician Consensus Statement: 2013 Update." *Official Journal of the American College of Sports Medicine*, 2013. Available at: http://www.acsm.org/docs/other-documents/team_physician_consensus_statement__2013_update-24.pdf?sfvrsn=0.~~

~~15 Brown NJ, Mannix RC, O'Brien MJ, Gostine D, Collins MW, Meehan WP. "Effect of Cognitive Activity Level on Duration of Post-Concussion Symptoms." *Pediatrics* 2014;133(2):1-6.~~

~~management team that includes certified athletic trainers, school officials and emergency response personnel. He or she should also educate athletes, parents/guardians, coaches and caregivers about the signs and risks of concussion, including the increased risk of subsequent concussions, if an athlete returns to activity before the concussion has completely resolved. AAOS notes that while helmets are improving, there is no concussion-proof helmet.~~

THE AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE (AMSSM) RECENTLY PUBLISHED AN UPDATE TO THEIR 2013 POSITION STATEMENT ON CONCUSSION IN SPORT IN 2019.[21] AMSSM RECOMMENDS THAT ANY ATHLETE SUSPECTED OF HAVING A CONCUSSION BE REMOVED FROM THE ACTIVITY AND ASSESSED BY A LICENSED HEALTHCARE PROVIDER TRAINED IN THE EVALUATION AND MANAGEMENT OF CONCUSSIONS "REASONS FOR IMMEDIATE REMOVAL AND PROMPT EVALUATION INCLUDE LOSS OF CONSCIOUSNESS (LOC), IMPACT SEIZURE, TONIC POSTURING, GROSS MOTOR INSTABILITY, CONFUSION, OR AMNESIA. ANY OF THESE REPORTED OR OBSERVED SIGNS SHOULD RESULT IN REMOVAL FROM PRACTICE OR COMPETITION FOR AT LEAST THE REST OF THE DAY." SINCE CONCUSSIONS CAN CAUSE CHANGES IN ATTENTION, LEARNING, AND SHORT-TERM MEMORY THAT MAKE LEARNING DIFFICULT, RETURN TO LEARN SHOULD BE COORDINATED WITH SCHOOL PERSONNEL TO QUICKLY IMPLEMENT A SCHOOL SUPPORT PLAN WITHOUT DELAY. AMSSM RECOMMENDS THAT "CONCUSSION-RELATED SYMPTOMS AND SIGNS SHOULD BE RESOLVED BEFORE RETURNING TO SPORT. A RETURN-TO-PLAY PROGRESSION INVOLVES A GRADUAL, STEPWISE INCREASE IN PHYSICAL DEMANDS AND SPORT-SPECIFIC ACTIVITIES WITHOUT RETURN OF SYMPTOMS BEFORE THE FINAL INTRODUCTION OF EXPOSURE TO CONTACT."

~~The American Medical Society for Sports Medicine (AMSSM) recommends that any athlete suspected of having a concussion be removed from the activity and assessed by a "licensed healthcare provider trained in the evaluation and management of concussions."[16] Initial assessment~~

~~of a concussion should be guided by a symptoms checklist that includes balance tests and cognitive evaluations that should be tracked over several evaluations and compared to baseline results. There should be no same-day RTP for an athlete diagnosed with a concussion, and symptoms should be resolved completely before the athlete receives medical clearance from a licensed health care provider and returns to play. An appropriate RTP progression involves gradually increasing physical activity and the potential for contact. If symptoms appear during the progression, the athlete should stop and restart at the last symptom-free activity level. While recovering from a concussion, students should receive academic accommodations such as reduced workload and extended time for tests. AMSSM believes that greater efforts should be made to educate athletes, parents, coaches and officials to improve concussion recognition, management and prevention, and physicians should be prepared to counsel patients on the health risks from concussions.~~

THE AMERICAN ACADEMY OF PEDIATRICS (AAP) UPDATED THEIR CLINICAL REPORT ON SPORT-RELATED CONCUSSION IN CHILDREN AND ADOLESCENTS IN 2018.[22] AAP RECOMMENDS THAT "TESTING AFTER A SPORT-RELATED CONCUSSION SHOULD BE PERFORMED AND CONDUCTED BY PROVIDERS WHO HAVE BEEN TRAINED IN THE PROPER ADMINISTRATION AND INTERPRETATION OF THE TESTS." ALL ATHLETES WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PLAY. THEY SHOULD NOT RETURN TO FULL SPORTS PARTICIPATION UNTIL THEY HAVE COMPLETED A RETURN-TO-SPORT PROGRESSION WITHOUT A RETURN OF CONCUSSION SYMPTOMS. HEALTH CARE PROVIDERS SHOULD BE AWARE OF THEIR STATE'S LAWS REGARDING RETURN TO PLAY AFTER A CONCUSSION.

~~The American Academy of Pediatrics (AAP) has issued a clinical report which contains guidance for returning student athletes to learn after a concussion. The report places normal concussion recovery time for youth at three weeks or less from the time of injury, and states that academic adjustments may be needed during this time, as using a concussed brain to learn may exacerbate concussion symptoms.[17] AAP provides self-assessment tools for kindergarten through sixth graders, and seventh graders and up, that can be used to track symptom resolution over this period. A multidisciplinary team, ideally led by a physician, is recommended to help ease reentry into school for students suffering from a concussion. Students may be able to tolerate some subjects better than others and school officials should be flexible about reducing student exposure to more difficult classes by allowing for adjustments to class schedules. Physicians should employ the proper language when discussing follow-up care with school officials. A request for "academic adjustments," means informal changes to the student's environment that do not alter the curriculum or standardized testing for symptomatic students during the normal one to three week period. "Academic accommodations" refers to longer-term needs and may encompass changes to testing, extended time on work and changes to the curriculum. "Academic modifications" means more prolonged and permanent changes to a student's education, requiring an Individualized Education Plan (IEP). The student's pediatrician should establish contact with a point person at the school to make the appropriate requests and stay apprised of the student's recovery, making adjustments as needed.~~

~~Parents should sign a form that satisfies both the Family Education Rights and Privacy Act (FERPA) permission required by educational agencies and Health Insurance Portability and~~

[21] HARMON KG, CLUGSTON JR, DEC K, ET AL. AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE POSITION STATEMENT ON CONCUSSION IN SPORT. BRITISH JOURNAL OF SPORTS MEDICINE. 2019; 53:213-225. AVAILABLE AT HTTPS://BJSM.BMJ.COM/CONTENT/53/4/213.

[22] HALSTEAD ME, WALTER KD, MOFFATT K. SPORT-RELATED CONCUSSION IN CHILDREN AND ADOLESCENTS. PEDIATRICS. 2018; 142(6):e20183074.

~~Harmon, Kimberly G., Drezner, Jonathan A., et al. "American Medical Society for Sports Medicine Position Statement: Concussion in Sport." *British Journal of Sports Medicine*, 2013. Available at: http://bjsm.bmj.com/content/47/1/15.long.~~
~~[17] Halstead, Mark E., McAvoy, Karen et al. "Returning to Learning Following a Concussion.." *American Academy of Pediatrics*, November 2013; Volume 132, Issue 5. Available at: http://pediatrics.aappublications.org/content/132/5/948.~~

~~Accessibility Act (HIPAA) permission for medical personnel to allow for communication among all team members.~~

As the above position statements demonstrate, there is a need for a stronger, unified voice from the medical community in order to provide state legislatures with the best tools and up-to-date guidance as they work to combat this public health concern. The AOA believes that emphasizing the physician-led, team-based model of care, where licensed health care providers at all levels possess current education and training in concussion management, will ensure that medical professionals with comprehensive knowledge of scientific evidence and advancements are appropriately involved in patient care.

AOA Policy Development

~~At present, the AOA does not have a policy on concussion, RTP or RTL for youth athletes.~~ Strong evidence of the serious, negative long-term health effects of concussions~~, however,~~ underscores the need to create policy in this AREA to help guide osteopathic advocacy in response to current and proposed state legislation. Unified, evidence-based advocacy from medical groups, including the AOA, will benefit states as they update their concussion and RTP laws, which currently vary widely. The AOA adopts the following policy statements as its official position on concussion, RTP and RTL~~.~~, AND ENCOURAGES STATES, AS WELL AS SCHOOLS, SPORTS CLUBS AND PROFESSIONAL LEAGUES TO DEVELOP OFFICIAL RULES THAT PROMOTE EDUCATION AND PREVENTION OF TBIS BY INCORPORATING THESE TENETS:

1. **Parent and Student Education.** The AOA believes that educating students, parents and guardians about the nature, symptoms, risks and short- and long-term health effects of concussions and traumatic brain injuries will improve student safety by increasing awareness of concussion warning signs and allowing for early treatment. This has been shown to decrease the risk of subsequent injuries during recovery and improve long-term outcomes. Education should also include clarification of the ~~return-to-play (~~RTP~~)~~ and ~~return-to-learn (~~RTL~~)~~ processes. The AOA believes that all schools and youth athletic organizations should disseminate evidence-based teaching tools ~~and information sheets~~ such as those issued by the Centers for Disease Control (CDC), Sports Safety International (SSI), certain state members of the Brain Injury Alliance (BIA) or other nationally recognized health or medical organizations to students, parents and guardians prior to the start of every school year or athletic season.[23]

2. **Parent and Student Signature.** The AOA supports requiring signatures from parents/ guardians and students on an information sheet acknowledging that they have received the aforementioned education and been made aware of the risks of concussion inherent in athletic activities, and understand appropriate steps for concussion evaluation and management, prior to every school year or athletic season.

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23 NO AUTHOR. "HEADS UP TO YOUTH SPORTS: PARENTS." CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/YOUTHSPORTS/PARENTS.HTML.

3. **Coach/Official Training.** The AOA encourages states to adopt mandatory annual training for coaches, athletic directors, school nurses and other school and youth sports officials based upon materials published by the CDC, SSI, BIA or other nationally recognized health or medical organizations.[24] Training should emphasize prevention as well as the need for early identification of concussions and improve treatment and management strategies, with an emphasis on prohibiting same-day return-to-play for concussed athletes in all circumstances and requiring clearance from a physician (as defined elsewhere in AOA policy) prior to allowing a concussed athlete to return to athletic activity.

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24 NO AUTHOR. "HEADS UP TO SCHOOLS: TEACHERS, COUNSELORS, AND SCHOOL PROFESSIONALS." CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/SCHOOLS/TEACHERS.HTML.

4. **Removal and Return-to-Play.** The AOA believes that it is vital that youth suspected of having sustained a concussion be removed from practice or competition immediately, and examined by a member of the physician-led team who is a licensed health care provider (LHCP) with documentation reflecting current concussion training, whose scope of practice includes the evaluation and management of concussions. The AOA supports the use of baseline testing conducted by a trained health care professional prior to the start of each athletic season or school year to assess a youth's balance and cognitive function as well as the presence of any concussion symptoms.[25] At the time of a suspected concussion, results from this baseline testing can be compared to results from post-concussive testing again assessing balance and cognition. ~~The Standardized Assessment of Concussion – Version 3 (SCAT-3) for youth ages 13 to 18 or Pediatric SCAT-3 for ages five to 12 is the preferred **A** method of sideline clinical assessment. If a youth's SCAT3 indicates a possible concussion, or if~~ IF the provider ~~otherwise~~ suspects a possible concussion, ~~he or she~~ THE ATHLETE should be evaluated by a physician immediately. There should be no same-day return-to-play for athletes diagnosed with a concussion, and no subsequent return-to-play without written clearance by a physician with documented current concussion training. For students diagnosed with a concussion, examining physicians should work with parents/guardians, coaches, athletic trainers and other stakeholders on ongoing concussion management and gradual RTP and RTL for the student athlete. The examining physician should also coordinate with a multi-disciplinary team that may include physical therapists, occupational therapists, neuropsychologists, cognitive rehabilitation specialists and certified athletic trainers, among others, as the patient recovers from suffering from a concussion.

5. **Clearing Provider Type.** The AOA believes a LHCP member of the physician-led team who is trained in the evaluation and management of concussions, such as a certified athletic trainer or school nurse, may conduct a sideline assessment. If a youth's sideline assessment indicates a possible concussion, ~~he or she~~ THE YOUTH must be evaluated by an allopathic or osteopathic physician with expertise in concussion management, who shall establish a clinical diagnosis. Proof of this expertise may include concussion training in sports medicine fellowship, or documentation of course completion in a recognized concussion course such as one from the CDC or SSI. Physicians possess the most comprehensive education and training of any health care provider, which enables them to recognize the variable and often subtle signs of concussion. The evaluating physician shall create a treatment plan and work with other members of the physician-led team to implement it, and the youth may only return to athletic activity with written clearance from the evaluating physician.

6. **Return-to-Learn.** The AOA recommends that the evaluating physician work with school officials to implement an RTL protocol for students following a concussion. The physician may adjust the protocol with school officials as the patient's symptoms evolve and gradually improve, usually within one to three weeks after the injury. Each concussion is an individualized entity, however, and as such should be treated by the physician on an individualized basis with the physician making the deciding determination regarding RTL. The physician should communicate the importance of cognitive rest following a concussion to parents and school officials, emphasizing that a student may require a lighter workload, exemption from classes that appear to exacerbate concussion symptoms, and/or testing extensions until symptoms improve or disappear.

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[25] NO AUTHOR. "FAQS ABOUT BASELINE TESTING." CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/BASICS/BASELINE_TESTING.HTML.

SUBJECT: OSTEOPATHIC MEDICINE - AUTONOMY OF - SOURCE: H401-A/16

SUBMITTED BY: Board of Trustees

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Board of Trustees has reviewed the policy; now, therefore be it

3 RESOLVED, that the Board of Trustees recommends that the following policy be
4 REAFFIRMED.

5 Policy of the American Osteopathic Association states that the osteopathic profession, in the
6 interest of providing the best possible healthcare to the public, shall maintain its status as a
7 complete and distinct philosophy of medicine.

Background Information: Provided by AOA Staff

Current AOA Policy:

1959; 1965 Reaffirmed, 1974 Reaffirmed; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1996 Reaffirmed, 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CHELATION THERAPY - SOURCE: H406-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association does not endorse chelation therapy as **A USEFUL**
6 **TREATMENT** for other than its **CURRENT** ~~currently~~ Food and Drug Administration
7 approved **USE**, and ~~ad~~ **AS** medical evidence supports.

Background Information: Provided by AOA Staff

Current AOA Policy:

1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Referred; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED___

DATE _____JULY 17, 2021_____

SUBJECT: MINORITY HEALTH AND OSTEOPATHIC MEDICAL EDUCATION – SOURCE: H409-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association encourages the development of internal programs to address the disproportionate incidence of preventable diseases in minority populations, ~~the lack of proper medical treatment for such diseases, the pervasive lack of~~ **THE IMPAIRED ACCESS TO** quality healthcare in minority communities, and the under representation of minority populations in osteopathic medicine; and will work with the American Association of Colleges of Osteopathic Medicine (AACOM), and towards eliminating such disparities within its osteopathic medical educational processes, and collaborate with federal/state governments, academia, and the healthcare industry to develop programs to eliminate medical and academic disparities between minority and non-minority groups in the US.

Background Information: Provided by AOA Staff

Current AOA Policy:

1996; 2001 Reaffirmed; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: OBESITY IN CHILDREN - SOURCE: H410-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports programs which advocate physical fitness and
7 good nutrition for children and families.

Background Information: Provided by AOA Staff
Current AOA Policy:
2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: FITNESS, SPORTS AND NUTRITION - SOURCE: H412-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed this policy;
3 now, therefore be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association supports the President's Council on ~~Fitness,~~ Sports,
6 **FITNESS** and Nutrition.

Background Information: Provided by AOA Staff
Current AOA Policy:
1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED__

DATE ____JULY 17, 2021_____

SUBJECT: PLASTIC BEVERAGE AND FOOD CONTAINER RECYCLING ACT-
SOURCE: H413-A/16

SUBMITTED BY: Bureau on Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Osteopathic Research and Public Health has reviewed this policy;
3 now, therefore be it

4 RESOLVED, that the Bureau on Osteopathic Research and Public Health recommends that
5 the following policy be REAFFIRMED.

6 The American Osteopathic Association supports conservational recycling and encourages that
7 materials are made from recycled products.

Background Information: Provided by AOA Staff

Current AOA Policy:

1990, 1995 Reaffirmed as Amended; 2000 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: CHILDHOOD AND TEENAGE SEXUAL EXPOSURE - SOURCE: H414- A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association: (1) encourages osteopathic physicians to provide
7 anticipatory guidance to minor children about the risks of sexual exposure and sexually-
8 transmitted diseases, and provide this same guidance to their parents and/or caregivers; (2)
9 encourages osteopathic physicians to support the development of curriculum by local, state and
10 national educational organizations that will lead to the prevention of unwanted pregnancy and
11 transmission of disease, using medically appropriate measures, preferably abstinence and
12 avoidance of high risk sexual behavior; and (3) support public education efforts to prevent
13 unwanted pregnancy and sexually transmitted **INFECTIONS**.

Background Information: Provided by AOA Staff
Current AOA Policy:
2005; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: TOBACCO CONTROL – THE FRAMEWORK CONVENTION ON – SOURCE: H415-A/16

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of International Osteopathic Medicine has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Bureau of International Osteopathic Medicine recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the efforts of international health agencies in
7 eliminating the use of tobacco products, smokeless tobacco products, and vaporizing products
8 from their societies, and encourages the United States to use its experience in tobacco products
9 control, smokeless tobacco products control, and vaporizing products control to help
10 developing countries with this health issue and supports the public health initiatives of the
11 World Health Organization for tobacco products control, smokeless tobacco products control,
12 and vaporizing products control by promoting the Framework Convention on Tobacco
13 Control (FCTC) and urges the President of the United States to submit the framework
14 convention on tobacco products control, smokeless tobacco products control, and vaporizing
15 products control to the United States Senate for ratification.

Background Information: Provided by AOA Staff

Current AOA Policy:

2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: DAMAGE TO HEARING FROM USE OF HEADPHONES – SOURCE: H417-A/16

SUBMITTED BY: Bureau on Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Bureau on Osteopathic Research and Public Health has reviewed the policy; now, therefore be it

RESOLVED, that the following changes are made to the policy statement.

The American Osteopathic Association (1) supports public education campaigns to increase awareness among children and their parents of the potential risk of noise-induced hearing loss that can occur from listening to headphones at high volumes for extended periods of time; (2) **ENCOURAGES** ~~advocates for~~ manufacturers to include information about the hazards of unsafe volume levels on or within product packaging and to recommend implementation of built-in mechanisms that can be enabled to limit a product's decibel output; and (3) **ENCOURAGES** ~~believes that~~ osteopathic physicians ~~should~~ **TO** actively educate young people and parents about the safety concerns of using headphones and the necessary safeguards to prevent hearing damage.

Background Information: Provided by AOA Staff

Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED____

DATE _____JULY 17, 2021_____

SUBJECT: DANGERS OF THE CHOKING GAME - SOURCE: H418-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports increasing awareness among parents,
7 educators, counselors and physicians of the risks and warning signs associated with the choking
8 game and of the resources available for educating teens about the dangers of the choking game;
9 and supports the inclusion of information about the dangers of the choking game in classroom
10 education and other school-sponsored discussions about drugs and risky behaviors.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: MEDICAL USE OF CANNABIS – RESEARCH ON - SOURCE: H419-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 policy be REAFFIRMED.

6 The American Osteopathic Association supports well-controlled clinical studies on the use of
7 cannabis, commonly referred to as marijuana, and related cannabinoids for patients who have
8 significant medical conditions for which current evidence suggests possible efficacy; and
9 encourages the National Institutes of Health (NIH) to facilitate the development of well-
10 designed clinical research studies into the medical use of cannabis.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: SPORTS AND PREVENTION OF TRAUMATIC BRAIN INJURY-
SOURCE: H420-A/16

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

3 RESOLVED, that the Council on State Health Affairs recommends that the following policy
4 be ~~REAFFIRMED~~ SUNSET.

5 The American Osteopathic Association supports the development of official sports rules that
6 promote education and prevention of traumatic brain injury for school sports, sports clubs and
7 professional leagues.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED (**for Sunset**)____

DATE ____JULY 17, 2021_____

SUBJECT: BLOOD DONORS, PROTECTION FROM DEPLETION OF IRON – SOURCE: H423-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association encourages blood collection facilities to establish
7 guidelines to identify frequent blood donors, and institute the necessary testing to monitor their
8 iron stores.

Background Information: Provided by AOA Staff
Current AOA Policy:
2006; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: 5-2-1-0**+10** CAMPAIGN FOR AMERICA'S CHILDREN - SOURCE: H424-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association recommends the continued support of the 5-2-1-0**+10**
7 campaign for America's children. **5-2-1-0+10 STANDS FOR 5 SERVINGS OF FRUITS**
8 **AND VEGETABLES EACH DAY, 2 HOURS OR LESS OF RECREATIONAL**
9 **SCREEN TIME PER DAY, 1 HOUR OF PHYSICAL ACTIVITY PER DAY, 0**
10 **SWEETENED OR SUGARY DRINKS, AND 10 HOURS OF SLEEP EVERY NIGHT**
11 **FOR CHILDREN.**

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: HEALTHY, HUNGER-FREE KIDS ACT - SOURCE: H425-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be ~~REAFFIRMED~~ SUNSET.

6 The American Osteopathic Association supports the Healthy, Hunger-Free Kids Act of 2015 in
7 its present form.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED (*for Sunset*)

DATE JULY 17, 2021

SUBJECT: MANDATORY INFLUENZA VACCINE OF HEALTHCARE PERSONNEL - SOURCE: H429-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association recommends mandatory seasonal Influenza vaccination
7 of all healthcare personnel and that medical exemptions to required influenza immunization
8 (e.g., life threatening allergic reaction after receiving an influenza vaccine or severe allergy to a
9 vaccine component) should be kept at a minimum to ensure high coverage rates and granted
10 only on an individual basis.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: TITLE X FUNDED FAMILY PLANNING SERVICES – SUPPORT FOR – SOURCE: H433-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association believes that Title X funded family planning services
7 are critical components of public health and primary health care and shall advocate for Title X
8 funded family planning services.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: SHACKLING OF PREGNANT INMATES - SOURCE: H435-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association acknowledges the potential harm shackling can cause to
7 both the mother and fetus, including miscarriage, and premature birth; and supports restricting
8 the use of any form of shackling on an inmate who is pregnant or in labor unless the woman is
9 an immediate and serious threat to herself or others or if the woman is a substantial flight risk.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CANCER CLINICAL TRIALS – EXPLORE **ETHICAL** INCENTIVES **FOR AND** ~~TO~~ INCREASE **AWARENESS OF** PATIENT INVOLVEMENT IN- SOURCE: H438-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports ETHICAL EXPLORATION OF
7 INCENTIVES FOR CLINICAL TRIAL PARTICIPATION, WHILE SIMULTANEOUSLY
8 PROVIDING CANCER PATIENTS WITH EDUCATIONAL TOOLS AND RESOURCES
9 TO INCREASE PATIENT AWARENESS AND ACCESS TO TREATMENT.~~increasing the~~
10 ~~number of cancer patients that are enrolled in clinical trials via educational promotions and~~
11 ~~increase patients' awareness of clinical trial opportunities.~~

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN REFERRED (*to Finance Committee*)

DATE JULY 17, 2021

SUBJECT: LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER / QUESTIONING, **INTERSEX, ASEXUAL** PROTECTION LAWS - SOURCE: H439-A/16

SUBMITTED BY: Bureau of Federal Health Programs/Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Federal Health Programs/Council on State Health Affairs has
3 reviewed the policy; now, therefore be it

4 RESOLVED, that the Bureau of Federal Health Programs/Council on State Health Affairs
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay,
7 Bisexual, Transgender, Queer/Questioning, **INTERSEX, ASEXUAL (LGBTQIA+)**
8 ~~(LGBTQ)~~ individuals from discriminating practices and harassment and reaffirms equal rights
9 and protections for all patient populations as stated in **THE AOA RULES AND**
10 **GUIDELINES ON PROFESSIONAL CONDUCT**. ~~policy H506-A14~~.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE ____JULY 17, 2021_____

SUBJECT: SUBSTANCE USE DISORDERS (SUD) – EVIDENCE BASED TREATMENT PROGRAMS FOR - SOURCE: H440-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the following changes are made to the policy statement.

5 The American Osteopathic Association (AOA) supports evidence-based treatment protocols ~~as~~
6 ~~developed by the American Osteopathic Academy of Addiction Medicine (AOAAM) and the~~
7 ~~American Society for Addiction Medicine (ASAM)~~ and will help educate the public about
8 substance use disorder (SUD) and effective treatment options ~~and~~. The **AOA**
9 **ENCOURAGES** communities to work collaboratively with law enforcement agencies to
10 implement evidence-based referral resources and ~~advocate for~~ **SUPPORTS** Medication
11 Assisted Treatment (MAT) programs as the most clinically effective and cost-effective
12 intervention for sustained recovery and reduction of criminal activity and mortality.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN REFERRED (*BORPH*)

DATE JULY 17, 2021

SUBJECT: OSTEOPATHIC MANIPULATIVE MEDICINE (OMM) AND OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) – AFFIRMING THE SCIENTIFIC AND MEDICAL FOUNDATION OF - SOURCE: H605-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association continues to affirm its position that the scientific and
7 medical foundation of osteopathic manipulative medicine (OMM) and osteopathic manipulative
8 treatment (OMT) is integral to this distinctive practice; and advocates for proper recognition of
9 the scientific and medical foundation of osteopathic manipulative medicine (OMM) and
10 osteopathic manipulative treatment (OMT) to all political bodies, research groups, third party
11 payers, and any other entity that formulates policy on OMM and OMT.

Background Information: Provided by AOA Staff
Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _ADOPTED_____

DATE ____JULY 17, 2021_____

SUBJECT: THIRD PARTY PAYORS CHANGING CLASSES OF MEDICATIONS – SOURCE: H607-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports all efforts to end the practice of requiring a
7 change in class of medication, thereby decreasing the administrative burden and improving
8 access to care.

Background Information: Provided by AOA Staff
Current AOA Policy:
2006; 2011 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: PHYSICIAN COMPARATIVE UTILIZATION & PROFILING – SOURCE: H610-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) adopts the following principles on physician comparative utilization and physician profiling (2016).

The physician comparative utilization, rating, and profiling programs should exclusively use metrics that are developed with physician involvement. Where possible, measure sets and/or data points should be evidenced-based and vetted by relevant physician specialty or professional societies. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. Additionally, all evidenced-based measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.

Comparative utilization, profiling, and rating should only occur once data has been acquired from a statistically significant sample of a physician's patient population **WHICH HAS BEEN RISK ADJUSTED.**

Comparisons between physicians should be based on geographic/demographic (rural, urban, suburban) comparisons of similar practice specialty.

Anonymous patient satisfaction data, whether in a formal profiling program or through an informal consumer website, should be excluded.

Physicians should have the opportunity to review any data or rating for accuracy and be afforded the right to request changes to inaccurate information in advance of the publication of that data. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.

If comparative utilization or physician profiling data were to be made public, only measures that are deemed sensitive and specific to the care being delivered are used and appropriate context and methodology are shared with the public.

The physician rating and profiling program(s) should not adversely impact the physician-patient relationship or unduly intrude upon physicians' medical judgment.

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING - SOURCE: H613-A/16

SUBMITTED BY: Bureau on Federal and Health Programs/Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Bureau on Federal and Health Programs/Council on State Health Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the following changes are made to the policy statement.

The American Osteopathic Association will work toward improving rural physician supply and monitor the potential for nationwide implementation of the following recommendations:

RECOMMENDATIONS FOR IMPROVING PHYSICIAN SUPPLY
IN RURAL UNDERSERVED AMERICA

1. Support Practice Incentive/Benefit and Other Recruitment Programs
   - Federal and state rural practice incentive/benefit programs should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.
   - Physicians, medical students and residents should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, and application forms readily accessible and user-friendly.
   - Area Health Education Centers need to be adequately funded through federal and state funding sources to: a) provide recruitment and retention services in rural areas; b) assist in locating reasonable housing for student and resident preceptorships; and c) provide practice support services to providers and communities, as referenced in other principles listed herein.
   - Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time practice in rural, underserved communities located within a reasonable distance of their primary practice site. Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to augment their secondary practices.
   - Physicians are urged to adopt telemedicine services in their practices as outreach to patients in underserved communities, within the scope of their licensure and receive appropriate payment, when applicable and purposeful in meeting health care needs.
   - Physicians should be informed of the potential impact of the employed-practice model on their scope of practice before signing hospital employment contracts, including resources provided.
2. Support Promotion of Rural Practice
   - Information on rural physician shortage areas should be readily available through coordinated websites of state agencies AND, area health education centers FOR; practicing physicians, medical students, and residents seeking ~~rural~~ practice opportunities IN RURAL AND , ~~as well as to~~ underserved communities. To assist physicians in selecting practice opportunities,

comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics {percentage child-bearing (for obstetrical needs), aged (for adult medicine-needs), etc.}, insurance status, supply of physicians and other health professionals, degree of physician shortage, socioeconomic status, as well as educational and recreational opportunities.

- Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly funded locum tenens programs, tax credits, loan repayment opportunities, etc. Further, they should be informed of the health care infrastructure in their area, including systems of care such as federally qualified health centers, indigent care clinics, rural health clinics, hospitals (including Critical Access Hospitals), long-term care facilities, emergency medical services, and hospice. They also should be informed about the availability of other health providers and services such as nursing, pharmacies, therapists, medical equipment, etc.
- ~~Physicians should be informed by state authorities, of the unique peer review services offered for rural hospitals and physicians.~~
- County medical societies, hospitals, and other health facilities (when available) should facilitate communication between new physicians and physicians with established practices in the community to help new physicians be better prepared for entering practice in an underserved community.
- Physicians who receive benefits through state loan repayment programs also should be informed by state authorities of specialized practice support services, including practice start-up, billing, locum tenens, professional development and CME, staff recruitment and training, telemedicine, etc.
- Physician practice re-entry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities. Further, when physicians allow their medical license to lapse, they should be informed by the relevant state licensing authority of the potential obstacles to re-licensure should they decide to re-enter practice following an extended absence from practice.
- Outreach should be provided by state authorities to physicians without a full-time medical practice to promote volunteer work or part-time practice at clinics in underserved communities.
- Federal and state policies that impact rural medicine, e.g., payment policies, should be monitored for their potential impact on the viability of rural practices. The American Osteopathic Association should continue to advocate for payment parity between Medicaid and Medicare. ~~beyond the two-year period authorized by the Affordable Care Act. In addition, payment policies which discount professional services to be delivered in rural communities discourage rural practice and should be addressed.~~
- Physicians in practice and those in training programs should be informed by state authorities, of special state medical licensing provisions applicable for practice in rural, underserved areas.

3. Support for Preparing Physicians for Rural Practice
   - Medical schools and residency programs should be incentivized by state authorities to develop and adequately support rural education and training tracks.
     Examples:
     a. Bonuses for medical students or residents who participate in rural training tracks; and

b. Additional state formula funding for medical student and residents in rural training tracks.

- Appropriate criteria should be used by POST-DOCTORAL TRAINING PROGRAMS ~~medical schools~~ for identifying student-applicants and residents most likely to be successful in rural practice.
- To measure outcomes, assessments should be conducted to identify whether students and residents who participate in rural educational or training tracks are retained in the state for practice after completion of training.
- Area health education centers should offer opportunities for community physicians who volunteer as preceptors to access information and knowledge of practices that contribute to a positive clinical learning experience. Further, educational institutions should provide adequate support and incentives to recruit and retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts. This will become increasingly important as community physicians face continuing pressures to increase productivity.
- Medicare GME policies should allow for residency program-specific support rather than institutional support for resident training to allow GME funding to follow the resident throughout their training.
- ~~Primary Care Residency Review Committees (RRCs) of t~~ The Accreditation Council for Graduate Medical Education, ~~and Primary Care Residency Review Committees of the American Osteopathic Association~~, should consider allowing more flexibility for residents to travel away from their core programs to rural areas in order to achieve established training goals for minimum numbers of procedures or encounters.

- The impact of changes in resident duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution-based residency programs.

4. Support for Rural Access to Care
   - ~~Discussions are needed to d~~ Develop solutions for providing after-hours care for patients of federally-funded health clinics requiring urgent or emergent care to prevent undue burdens on community physicians.

Background Information: Provided by AOA Staff

Current AOA Policy:

2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: ALTERNATIVE PAYMENT MODELS – ENSURING DO OPPORTUNITIES AND PATIENT ACCESS IN – SOURCE: H616-A/16

SUBMITTED BY: Council on State Health Affairs/Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs/Council on Economic and Regulatory Affairs
3 has reviewed the policy; now, therefore be it

4 RESOLVED, that the Council on State Health Affairs/Council on Economic and Regulatory
5 Affairs recommend that the following policy be REAFFIRMED.

6 The American Osteopathic Association will advance federal and state polices to ensure
7 alternative payment models (APM) that: (1) offer high quality healthcare to all patients; (2)
8 empower physicians to engage patients in making decisions involving their healthcare, including
9 both economic and clinical decisions; (3) permit freedom of choice of hospital and doctors
10 within the scope of the care model; (4) allow participation of osteopathic physicians, including
11 as part of the leadership, board, or other administrative body of the APM; permit the patient to
12 make economic decisions involving his healthcare; (5) will not exclude DOs on the basis of
13 degree or AOA certification or training; (6) will provide providers with information about the
14 costs, risk, and payments associated with practicing in the APM; (7) apprise participating
15 physicians of the progress of the APM; (8) do not exclude physicians and hospitals who are not
16 part of the APM from honest competition for any segment of the marketplace; (9) afford all
17 physicians appropriate hearing and appeal processes

Background Information: Provided by AOA Staff

Current AOA Policy:

1988; 1993 Reaffirmed as Amended, 1994 Reaffirmed, 1999 Reaffirmed; 2004 Referred; 2006 Reaffirmed; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: HEALTH INSURANCE COVERAGE FOR MEDICAL AND SURGICAL TREATMENTS FOR GOOD ORAL HEALTH - SOURCE: H619-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports the concept that medical insurance coverage
7 should include medical and surgical treatments as needed to support good oral health, especially
8 for patients with comorbid conditions.

Background Information: Provided by AOA Staff
Current AOA Policy:
2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: PHYSICIAN PROFILES - SOURCE: H623-A/16

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; now, therefore be it

3 RESOLVED, that the Council on State Health Affairs recommends that the following policy
4 be REAFFIRMED.

5 Because the American Osteopathic Association believes that state medical or osteopathic
6 boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to
7 collect, maintain, and disseminate physician profile information to the public, the AOA; (1)
8 supports the position that any legislation or regulations which mandate the release of physician
9 profile information provide funding for the creation and maintenance of the profiling system
10 without added expense to the physician; (2) supports the position that only physician profiles
11 that incorporate all of the following five principles (fairness, relevancy, timeliness, accuracy, and
12 reliability) should be released to the public; (3) opposes the inclusion of medical malpractice
13 histories within physician profiles due to their susceptibility to misinterpretation and inherently
14 prejudicial effect; (4) supports the position that before physician profiles are released to the
15 public, every physician has the opportunity to verify the accuracy of the information and to
16 contest any incorrect information before it is disseminated to the public; (5) believes that the
17 state licensing boards must include an appeal mechanism in their regulations that a physician
18 may pursue if any information in his or her profile is inaccurate, and institute appropriate
19 corrections.

Background Information: Provided by AOA Staff
Current AOA Policy:
2001; 2006 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: CLARIFYING STUDENT REPRESENTATION AT THE AMERICAN OSTEOPATHIC ASSOCIATION HOUSE OF DELEGATES CONSTITUTION AMENDMENT
FIRST READ ONLY IN JULY 2021

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Constitution and Bylaws
(to be presented to 2021 House of Delegates for First Reading)

WHEREAS, the use of "Student Council" within the nomenclature of the American Osteopathic Association's (AOA) Constitution is frequently and unintentionally misinterpreted as referring only to the American Association of Colleges of Osteopathic Medicine's (AACOM's) Council of Osteopathic Student Government Presidents (COSGP); and

WHEREAS, Article V, Section 12 of the AOA Bylaws explicitly bars a Student Osteopathic Medical Association (SOMA) delegate or alternate from simultaneous membership within a divisional society's delegation, and suggests that the student delegate position of a divisional state society may be represented by any student of a college of osteopathic medicine located within that state, and that eligibility is not exclusive to COSGP members; and

WHEREAS, the SOMA delegate represents the views of the Student Osteopathic Medical Association; and

WHEREAS, the Student delegate of a divisional society's delegation represents the views of the students in the colleges of osteopathic medicine located only within the state represented by the divisional society; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates approve the following amendments to the American Osteopathic Association Constitution:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

<u>Article VI - House of Delegates, Section 1B</u>
Student ~~Council~~ Representation in Divisional Societies
Divisional societies shall be awarded one additional delegate as a student ~~council~~ representative for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society, such student delegate to be elected according to the Bylaws of the American Osteopathic Association.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN FIRST READ

DATE JULY 17, 2021

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION– NEW PHYSICIAN IN PRACTICE DEFINITION
FIRST READ ONLY IN JULY 2021

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, the AOA Constitution and Bylaws currently describes a "new physician in practice" in the AOA Constitution, Article VIII, Section 1-C. as, "… an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College Accreditation within the last 10 years"; and

WHEREAS, the AOA Department of Professional Affairs/Membership categorizes "new physicians in practice" as osteopathic physicians in the first three years following completion of their postdoctoral training program[1]; and

WHEREAS, the AOA policy H349-17 defines a new physician in practice as a "physician no more than five years past the completion of postdoctoral training"; now, therefore be it,

RESOLVED, that the AOA House of Delegates clarifies the "new physician in practice" definition by approving the following amendments to the American Osteopathic Association Constitution & Bylaws:

AOA Constitution

<u>Article VIII, Section 1-C</u>

One new physician in practice member elected by the House of Delegates to serve for one year. Candidates for the new physician in practice position (osteopathic physicians who have completed their postdoctoral training within the past five years) shall be nominated by the Bureau Of Emerging Leaders. Candidates must be members in good standing of the AOA.

References:

1. Membership Dues Rates. The American Osteopathic Association. https://osteopathic.org/about/aoa-membership/membership-dues-rates. Accessed March 11, 2021.

<u>Background Information: Provided by AOA Staff</u>

Current AOA Policy:

H349-A/2017 The American Osteopathic Association defines a new physician in practice as a "physician is no more than five years past the completion of postdoctoral training".

Prior HOD action on similar or same topic:
H349-A/2017 Defining New Physicians in Practice – Reaffirmed 2017

FISCAL IMPACT: $0
If we were to add two additional years of discounted membership (i.e. year four and five), it is estimated that there would be a revenue reduction of $122,240. At these discounted membership rates, it is estimated that it would require the addition of at least 305 New Physicians in Practice as AOA members to offset this revenue reduction. If the resolution is misinterpreted to apply discounts to years four and five of the new definition of New Physicians in Practice this could result in an inadvertent fiscal impact in the amount of $122,240.

ACTION TAKEN ___FIRST READ____

DATE _____JULY 17, 2021_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – DEFINITION OF STUDENT MEMBER

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) and CAGOS Subcommittee on AOA Constitution & Bylaws

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Bylaws (Article II–Membership, Section 2-Membership Requirements, part e – Student Member) defines a student as an "undergraduate student in an approved college of osteopathic medicine"; and

WHEREAS, the term "undergraduate student" can be confused with students enrolled in a baccalaureate degree program; and

WHEREAS, student membership should be limited to osteopathic medical students enrolled in colleges of osteopathic medicine accredited by the AOA's Commission on Osteopathic College Accreditation; now, therefore, be it

RESOLVED, that the AOA House of Delegates approves the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

e. Student Member
Student membership shall be granted to each ~~undergraduate~~ OSTEOPATHIC MEDICAL student in A ~~an approved~~ college of osteopathic medicine ACCREDITED BY THE COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ADMINISTRATION OF MEMBERSHIP DUES

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) and CAGOS Subcommittee on AOA Constitution & Bylaws

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Bylaws (Article III – Dues and Assessments) identifies a specific schedule for billing and collection of membership dues procedure and a defined timeline at which members are suspended for nonpayment of dues; and

WHEREAS, the Board of Trustees should be provided with more flexibility in setting the appropriate schedule for administration of membership dues, while the House of Delegates should retain authority to set membership dues; now, therefore, be it

RESOLVED, that the AOA House of Delegates approves the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

Article III – Dues and Assessments

~~Section 1 – Payment of Dues~~

~~The annual dues of regular members of the Association shall be payable in advance on or before 1 June, the beginning of the fiscal year.~~

~~A member whose dues shall remain unpaid for three months shall become suspended. He may be reinstated upon payment of dues and assessment provide such payment are not received prior to the end of the current fiscal year or, if later, by applying as a new member.~~

Section 1~~2~~ – Dues ~~Rates~~

a. Members

The annual dues of all members of the Association (except for allied members discussed in section ~~2~~ 1c and student members discussed in section ~~2~~ 1d, below) shall be determined by the House of Delegates. THE BOARD OF TRUSTEES SHALL BE RESPONSIBLE FOR ADMINISTRATION OF DUES, INCLUDING DETERMINATION OF THE MEMBERSHIP YEAR, THE SCHEDULE FOR PAYMENT OF DUES, AND THE SUSPENSION OF MEMBERSHIP FOR NONPAYMENT OF DUES. A SUSPENDED MEMBER MAY BE REINSTATED UPON PAYMENT OF DUES AND ASSESSMENTS, PROVIDED SUCH PAYMENT IS RECEIVED PRIOR TO THE END OF THE MEMBERSHIP YEAR.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0
The intent of the resolution is to allow for the adjustment to the time of membership renewal and the related billing cycle, not to adjust membership dues, as such there would be no estimated fiscal impact.

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – NAME OF AOA JOURNAL
FIRST READ ONLY IN JULY 2021

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) and CAGOS Subcommittee on Constitution & Bylaws
(to be presented to 2021 House of Delegates for First Reading)

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the current procedure for amending the AOA's Constitution described in Article IX of the AOA Constitution calls for providing notice to members through publication in the on-line edition of *The Journal of the American Osteopathic Association*; and

WHEREAS, in January 2021, the AOA announced that it was changing the name of *The Journal of the American Osteopathic Association* to *the Journal of Osteopathic Medicine*; now, therefore, be it

RESOLVED, that the AOA House of Delegates approves the following amendments to the American Osteopathic Association Constitution:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article IX - Amendments
This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by US mail or electronic mail to each divisional and specialty society entitled to and voting representatives to the House of Delegates, posted on the AOA's website, and published in the on-line edition of *the Journal of OSTEOPATHIC MEDICINE* ~~*the American Osteopathic Association*~~ not less than two months nor more than four months prior to the meeting at which they are to be acted upon.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___FIRST READ____

DATE _____JULY 17, 2021_____

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – PROCEDURE FOR NOTICE OF PROPOSED CHANGES TO CONSTITUTION

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (presented to 2020 House of Delegates for First Reading)

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the current procedure for amending the AOA's Constitution calls for providing notice to members through publication in the JAOA (now called the Journal of Osteopathic Medicine) and notice to affiliated organizations represented in the House of Delegates by U.S. mail; and

WHEREAS, the JAOA is transitioning to on-line publication and notice by electronic mail is more efficient and cost-effective than notice by U.S. mail; and

WHEREAS, this resolution was presented to the 2020 House of Delegates for a first reading; now, therefore be it

RESOLVED, that the AOA House of Delegates approves the following amendments to the American Osteopathic Association Constitution:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article IX - Amendments

This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by US MAIL OR ELECTRONIC ~~first class mail~~ COMMUNICATION, ~~postage prepaid,~~ to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in the ON-LINE EDITION OF THE Journal of the American Osteopathic Association not less than two months nor more than four months prior to the meeting at which they are to be acted upon.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION – NAMES OF AOA DEPARTMENTS

SUBMITTED BY: Committee on AOA Governance & Organizational Structure

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Board of Trustees approved certain changes to AOA's governance structure at its 2020 Midyear meeting, including changes to the names of some of the AOA's Departments; and

WHEREAS, the Departments are specifically referenced in the AOA's Constitution in the section identifying the composition of the Executive Committee of the AOA Board of Trustees; and

WHEREAS, the following amendment was presented for first reading at the 2020 House of Delegates; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Constitution:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article VIII - Board of Trustees and Executive Committee

Section 2 - Executive Committee.
The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Relations, FINANCE ~~Business Affairs~~, EDUCATION ~~Educational Affairs~~, Governmental Affairs, MEMBERSHIP ~~Professional Affairs~~, and Research~~, Quality~~ and Public Health.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – NAME OF AOA JOURNAL

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) and CAGOS Subcommittee on AOA Constitution & Bylaws

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Bylaws in multiple locations refer to the AOA's official journal *as the Journal of the American Osteopathic Association*; and

WHEREAS, the AOA's official journal changed its name in January 2021 to *the Journal of Osteopathic Medicine;* now, therefore, be it

RESOLVED, that the AOA House of Delegates approves the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

1. Bylaws, Article IV (Code of Ethics), Section 2 (Amendments to Code):

"It shall be the duty of the Chief Executive Officer to have the proposed amendment . . . published in the *Journal of ~~the American~~ Osteopathic ~~Association~~ MEDICINE* not later than one month before the annual meeting at which the amendment is scheduled for consideration."

2. Bylaws, Article VIII (Duties of Officers), Section 8 (Editor), part a

"The Editor shall:

a. Have the editorial discretion, in accordance with the established policies of the Board of Trustees and House of Delegates, of the *Journal of ~~the American~~ Osteopathic ~~Association~~ MEDICINE*, other periodical publications of the Association …"

3. Bylaws, Article XI (Amendments), Section 1 (Bylaws):

"These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the

amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by US mail or electronic mail to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in the on-line edition of *The Journal of OSTEOPATHIC MEDICINE* ~~*the American Osteopathic Association*~~ at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting."

3. Bylaws, Article IX (Amendments), Section 2 (Articles of Incorporation)

"Written or printed notice shall include the printing of the amendment in the electronic and/or printed issue of *The Journal of* ~~*the American*~~ *Osteopathic MEDICINE* ~~*Association*~~ published not less than five days or more than 40 days before the date of the meeting."

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: DECREASING THE LIMITATIONS ON PRESCRIBING CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS IN PRIMARY CARE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, migraine headache is the sixth most prevalent cause of global burden; and

WHEREAS, an American seeks care in the ER for an acute migraine every ten seconds; and

WHEREAS, healthcare and productivity costs accounts for up to $36 billions dollars annually from associated migraines; and

WHEREAS, healthcare costs are 70% higher in a family with a migraine compared with a non-migraine affected family; and

WHEREAS, only 4% of migraine suffers seek medical care from a headache or pain specialist; and

WHEREAS, 25% of sufferers would benefit from preventative care, only 12% receive it; and

WHEREAS, there are about 500 certified headache specialists compared to 39 million migraine suffers in the United States in 2019; and

WHEREAS, calcitonin-gene related peptide (CGRP) inhibitors are a novel drug class for the treatment of chronic migraine with improvement in response by 50% each month for the first 3 months; and

WHEREAS, the treatment with CGRP inhibitors for chronic migraine demonstrated quality of life adjustment equivalent with episodic migraines;

WHEREAS, side effects of this drug class are minimal including injection site reaction, constipation, and possible upper respiratory infections; and

WHEREAS, insurance companies have been denying coverage for CGRP inhibitors to primary care providers due to reason that the provider is not a headache specialist; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) on behalf of its members urges ~~Ohio Medicaid, Medicare~~ **FEDERAL AND STATE** and private insurers to enhance the coverage of CGRP inhibitor agents prescribed by primary care physicians for the treatment and management of chronic migraine.

References:
1. Migraine Research Foundation. *migrainresearchfoundation.org*
2. World Health Organization. *https://www.who.int/news-room/fact-sheets/detail/headache-disorders*
3. American Headache Society

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _REFERRED (***Ohio Osteopathic Association***)__

DATE _____JULY 17, 2021_____

SUBJECT: ~~REQUIRING THE~~ **ADVOCATING FOR** COVERAGE OF ELEMENTAL PEDIATRIC FORMULA IN STATE, FEDERAL, AND PRIVATE INSURANCE PROGRAMS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, thousands of children are diagnosed annually with diseases that interfere with the digestion and absorption of nutrients (1); and

WHEREAS, without medically necessary nutrition, these patients would risk malnutrition, further morbidity, medical complications, and hospitalizations (2); and

WHEREAS, a delay in coverage can have significant medical consequences during a critical time of growth and development in an infant's life; and

WHEREAS, elemental formula is the standard of care in many diseases of absorption and digestion (3); and

WHEREAS, current states' insurance polic~~y~~**IES** varies on elemental formula, making it difficult for families to access sufficient nutrition for their affected children; and

WHEREAS, there exists legislation in 19 states with various requirements regarding the mandatory coverage of elemental formula including Washington, Oregon, Arizona, Colorado, Texas, Nebraska, Missouri, Minnesota, Illinois, Kentucky, Pennsylvania, Maryland, New York, New Jersey, Connecticut, Rhode Island, Massachusetts, New Hampshire, and Maine(4); and

WHEREAS, there is no federal legislation requiring the coverage of elemental formula through Medicaid or private insurance; now therefore, be it

RESOLVED, that the American Osteopathic Association supports legislation ~~requiring~~ **WHICH ADVOCATES FOR THE** coverage of medically necessary elemental pediatric formula under Medicaid and private insurance plans.

References:

1. "Text - S.3657 - 116th Congress (2019-2020): Medical Nutrition Equity Act of 2020." *Congress.gov*, 7 May 2020, www.congress.gov/bill/116th-congress/senate-bill/3657/text.
2. "State Insurance Mandates for Elemental Formula." *APFED*, 5 Feb. 2020, apfed.org/advocacy/state-insurance-mandates-for-elemental-formula/.
3. "A Resource Guide for Enteral Formula Coverage." *Complex Child*, 10 Nov. 2020, complexchild.org/articles/2014-articles/april/enteral-formula-coverage/.
4. Singhal, Sarita, et al. "Tube Feeding in Children." *Pediatrics in Review*, vol. 38, no. 1, 2017, pp. 23–34., doi:10.1542/pir.2016-0096.

5. Treatment of Disorders Identified Through Newborn Screening." National Coordinating Center, Nov. 2016.
6. "Enteral Nutrition: Access and Coverage." Healthcarenutrition.org, 2019.
7. "MCD." *National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2)*, www.cms.gov/medicare-coverage-database

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE ____JULY 17, 2021_____

SUBJECT: PRIOR AUTHORIZATION

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy
2 and principles statement on prior authorization; and will merge policies H343-A/13,
3 H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16, AND H602-
4 A/16.

Prior Authorization

Prior authorization (PA) requirements have been found to result in care delays that place patients at risk and increase provider burden[1]. In order to ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of PA by payers and pharmacy benefits managers and should abide by the following principles.

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.
- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.
- Payors should appropriately compensate providers for complying with utilization review.
- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.
- Prior authorizations should allow continuation of medications already being administered or prescribed when a patient changes health plans, and changes should not be allowed without discussion and approval of the ordering physician.
- Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.
- Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.
- Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved.
- There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians.

As part of its efforts to advocate for these principles and ensure incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers**, INCLUDING MANAGED CARE ORGANIZATIONS,** and pharmacy benefit managers to:

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[1] American Medical Association. "2018 AMA Prior Authorization (PA) Physician Survey".

- Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being.
- Consider a physician's attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment.
- **ALLOW PATIENTS TO ACCESS A MEDICAL SPECIALIST BY DIRECT REFERRAL FROM THE PRIMARY CARE PHYSICIAN WITHOUT PREAUTHORIZATION.**
- Include in contracts with healthcare providers "hold harmless" clauses that indemnify healthcare providers against financial loss due to injury to a patient as a result of the payor's failure or refusal to grant a prior authorization request in a timely manner.
- Provide appropriate notice to patients and physicians when formulary and benefit changes are made.
- Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including Electronic Medical Record (EMR) templates.
- Publish and make available to the public all requirements for prior authorization and follow those published policies.
- Provide sufficient knowledgeable staff to ensure that healthcare providers can contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes.
- Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests.
- Identify and hold accountable the payor's medical director/claim adjudicator for the results of their decisions.

Background Information: Provided by AOA Staff

Current AOA Policy:

The following are similar topics:

H343-A/13
H602-A/15
H640-A/16
H632-A/17
H635-A/19
H602-A/16

Prior HOD action on similar or same topic:

H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018)
H602-A/15 policy approved in 2015
H640-A/16 policy approved in 2016
H632-A/17 policy approved in 2017
H635-A/19 policy approved in 2019; adopted 2020
H602-A/16 approved in 2001 and reaffirmed in 2016.

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: AOA POLICY ON TELEHEALTH - H601-A/17

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Council on Economic and Regulatory Affairs recommends that the following policy be reaffirmed with amendment now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy compendium on Telehealth. (2012; revised 2017, **REVISED 2021**).

AOA POLICY TELEHEALTH

THE COVID-19 PUBLIC HEALTH EMERGENCY CAUSED BY THE HIGHLY CONTAGIOUS SARS-COV-2 VIRUS HAS DEMONSTRATED THE NEED TO BROADEN AND OPTIMIZE THE USE AND DELIVERY OF HEALTHCARE SERVICES THROUGH ~~telemedicine~~**TELEHEALTH TO PREVENT THE SPREAD OF THE OUTBREAK.** With the rapid pace of advancement in technology~~, telemedicine~~ **TELEHEALTH** is an evolving practice – both in the **TYPES OF SERVICES FURNISHED** ~~scope of practice that is covered~~, and **THE TOOLS USED TO EXPAND ACCESS TO MEDICAL CARE.** ~~in the overall meaning of the term "telemedicine." Telemedicine~~**TELEHEALTH** is a tool used not only to provide direct services to a patient via information technology, but also specialist and primary care consultations, the online storage and sharing of medical information, imaging services through digital transmissions and the interpretation of images, remote patient monitoring, and medical education.

The practice of medicine via electronic and technological means has been occurring for decades. As technology advances and the breadth of medical practice in this area expand, there is an increasing call to regulate patient care delivered through technological resources. Advocates for ~~telemedicine~~ **TELEHEALTH** argue that it provides improved access to medical care and services to patients in rural or ~~distant~~ **UNDERSERVED** areas. They also emphasize that it allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times, is also noted as a cause for increased patient demand for health care services through ~~telemedicine~~**TELEHEALTH**.

Despite its advantages, opponents raise concerns over the lack of regulation and oversight to control this practice. The primary issues involving ~~telemedicine~~ **TELEHEALTH** are: (1)**GEOGRAPHICAL AND SITE-OF-SERVICE RESTRICTIONS: (2)** licensure of out-of-state practitioners who use technology to treat patients in a state where they are not licensed to practice; (~~2~~**3**) technological problems and barriers; (~~3~~**4**) reimbursement issues regarding payment for services rendered; and (~~4~~ (**5**) quality of care. ~~Currently, thirty-nine states allow some type of reimbursement for telemedicine services under Medicaid. Additionally, eighteen states grant expedited telemedicine licenses and forty states[1] have specific statutes addressing the practice of medicine over technologic networks[2].~~

Access, EFFICIENCY and Quality

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) AND THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) HAVE IDENTIFIED SEVERAL BENEFITS OF TELEHEALTH. VIRTUAL SERVICES LIMIT PHYSICAL CONTACT AND EXPOSURE TO INFECTIOUS DISEASES, SHORTEN IN-OFFICE WAIT

TIMES, ELIMINATE COMMUTING TIME AND TRAVEL EXPENSES, REDUCE TIME OFF FROM WORK AND THE NEED FOR CHILDCARE, AND PROVIDE ACCESS TO MEDICAL CARE IN RURAL AND UNDERSERVED COMMUNITIES. ~~Many see telemedicine as a solution to the access to care issues currently facing many in rural and underserved communities. In an effort to improve access to care in rural areas, CMS, in July 2011, instituted a new rule easing the burden of hospital credentialing for providers offering services via telemedicine.3 This change allows rural critical access hospitals to obtain consultations from a subspecialty provider or facility without undertaking the administrative burden of credentialing each provider individually.~~

~~While mostly supportive, concerns about the quality of care being provided through telemedicine do exist.~~ **DESPITE THE ADVANCES IN TELECOMMUNICATION TECHNOLOGY, SOME STAKEHOLDERS ARE CONCERNED THAT A LACK OF REGULATION AND OVERSIGHT MAY UNDERMINE THE QUALITY OF CARE PROVIDED, OR CREATE AN OPPORTUNITY FOR FRAUD AND ABUSE.** Care deemed to be below the acceptable quality standard can be addressed either via the disciplinary action of a state medical board or via civil legal action (medical malpractice claims). Liability rules vary state by state and concerns exist over the determination of venue when a provider is utilizing ~~telemedicine~~ **TELEHEALTH** across state lines. Additionally, standard of care must be established and may vary between face-to-face encounters and ~~telemedicine~~ **TELEHEALTH** encounters; although, many providers argue against this variation.

Liability Concerns

One issue that arises under the discussion of advancing **TELEHEALTH** is the question of jurisdiction for liability cases. This includes cases of medical malpractice, where a physician licensed to practice in two or more states practices medicine over state lines through electronic means, and an adverse event occurs. Current state and federal statutes and case law provide a remedy to overcome this barrier. Patients are provided a pathway to legal recourse in the state where the accident occurred, if there is a reasonable expectation for that harm to have occurred there. If the patient can provide evidence confirming that location, (IP address, for example) and did not attempt to deceive the physician as to their location. Under this established system, any time a physician is choosing to perform ~~telemedicine~~**TELEHEALTH**, they should have the expectation that they are choosing to be held liable under another state's laws if an adverse event occurs.

Licensure

~~Telemedicine~~**TELEHEALTH** is a broad area and is not regulated by one specific board or oversight body. There is no standard for ~~telemedicine~~**TELEHEALTH** education and no certification in the provision of **TELEHEALTH**. Therefore, the burden of oversight currently falls on the state medical boards. Each board defines care that meets an acceptable quality somewhat differently. State licensure requirements also diverge with significant differences in ~~testing,~~ postgraduate education and continuing medical education requirements. Additionally, scopes of practice varies by state with no overall standard in regards to prescription authority or practice rights. Finally, uniformity fails to exist in what constitutes a visit (establishment of the "physician-patient relationship"), with some states requiring a face-to-face visit before a ~~telemedicine~~**TELEHEALTH** relationship can be established. Due to these differences, some advocates have promoted the concept of national licensure. They believe that a national license for the practice of medicine would eliminate barriers that prevent widespread use of ~~telemedicine~~**TELEHEALTH**.

The AOA supports state-based licensure and discipline oversight, believing that states should have the right to directly regulate and provide oversight for services being provided to their citizens. Concerns have been expressed about who would assume responsibility for disciplinary action against providers if a national medical license was initiated. Currently, protection of the residents of the state is a top function and core value of the state licensing boards.

~~The American Telemedicine Association (ATA) argues that state-by-state licensing, as it currently exists, restricts consumer choice and the free flow of services, protecting some markets from healthy economic competition.4 New Mexico, a state where 91% of the counties qualify as medically underserved, views telemedicine as a lifesaving mechanism to provide primary patient care and specialty consultation services. Senator Tom Udall (D-NM) believes national medical licensure for telemedicine will improve access to health care. Senator Udall has announced plans to allow physicians to provide care using telemedicine and in some instances, travel more freely across state lines to more remote rural areas by establishing a national licensure system.~~

Conclusion

The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who may not have access to medical care.

The AOA further recognizes the need to provide a broad framework that establishes **PAYMENT AND POLICY** recommendations to ~~address~~ **EFFECTIVELY ADVOCATE FOR** ~~telemedicine~~ **TELEHEALTH** at the national level, while providing enough flexibility to allow each state to incorporate policies that meet the health care needs of their citizens.

The AOA supports that a physician is practicing medicine, in the absence of physical interaction, when medical services are being provided through simultaneous two-way communication, recognizing that some services may require appropriate and corresponding delays in said communication.

The AOA supports that the utilization of technology in patient care should be used to increase access to care, and must not be used in a way that would diminish patient centered comprehensive personal medical care or the quality of care being provided to the patient. To this end, the AOA supports the concept of ~~telemedicine~~**TELEHEALTH** and advocates that public and private payers adopt payment systems that are inclusive of ~~telemedicine~~ **TELEHEALTH, AND PAYMENT PARITY FOR PROFESSIONAL ADVICE, CONSULTATION AND DEVELOPMENT OF PATIENT TREATMENT PLANS PROVIDED TO PATIENTS, FAMILY MEMBERS OR DESIGNEE VIA TELEHEALTH.**

The AOA supports that the standard of care provided through the use of technology should be equivalent to that of care provided when the physician and patient are within close physical proximity.

The AOA supports that the technological network being used to deliver patient care must have protocols in place that ensure the stability and security of that network to comply with applicable state and federal laws regarding patient privacy ~~issues~~**PROTECTIONS**.

The AOA supports that the scope of care being delivered by the physician and other health care providers through ~~telemedicine~~ **TELEHEALTH** should not exceed education training and applicable state and federal law.

The AOA supports that the state-based licensure and ability of states to govern activities within their borders is paramount and would oppose any national licensure or efforts to preempt state statutes.

The AOA supports that malpractice claims that arise from care provided through technological means, when the physician and patient in separate jurisdictions, should be adjudicated under the process currently utilized by the judicial system; whereby, the plaintiff has the ability to determine the venue where the case is filed, within the constraints of that system.

The AOA supports physicians must provide complete transparency to their patients regarding their location,

jurisdiction of licensure and any limitations of the technology used to deliver care.

The AOA supports that as physicians provide care in a variety of new ways, including ~~telemedicine~~**TELEHEALTH**, advanced technology can be used to improve patient care. The AOA further supports that **TELEHEALTH** policies directly tie into the Patient-Centered Medical Home (PCMH) model for care **AND OTHER VALUE-BASED CARE ARRANGEMENTS**, and recognizes that we must simultaneously implement advancements in ~~telemedicine~~ **TELEHEALTH** in order to be successful in ~~that~~ new **ALTERNATIVE PAYMENT** model**S**.

THE AOA SUPPORTS COLLABORATION WITH THE AMERICAN MEDICAL ASSOCIATION AND OTHER STAKEHOLDERS TO ADVOCATE FOR LEGISLATION OR AN EXECUTIVE ORDER TO MANDATE THAT ALL HEALTH INSURANCE PLANS, INCLUDING THOSE ISSUED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ENTITIES COVERED UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) LAW CONTINUE TO REIMBURSE FOR TELEHEALTH SERVICES AT A LEVEL THAT IS COMMENSURATE WITH A FACE-TO-FACE VISIT.

THE AOA SUPPORTS EFFORTS TO ADDRESS EDUCATIONAL AND OPERATIONAL BARRIERS THAT INTERFERE WITH IMPLEMENTATION OF TELEHEALTH IN PHYSICIAN OFFICES, AND BELIEVES THAT EVERY EFFORT SHOULD BE MADE TO ALLOW TELEHEALTH SERVICES TO BE PROVIDED BY THE PATIENT'S ATTENDING PHYSICIAN, RATHER THAN BY PHYSICIANS OR CLINICIANS THE PATIENT IS UNAFFILIATED WITH OR IS NOT REFERRED BY THE PATIENT'S PRIMARY CARE PHYSICIAN.

The AOA will monitor developments in ~~telemedicine~~ **TELEHEALTH** on an ongoing basis and update this policy as needed.

~~1 *50 State Medicaid Statute Survey*, Center for Telehealth & e-Health Law, February 2011, available at http://www.ctel.org/expertise/reimbursement/medicaid-reimbursement/~~
~~2 Humayun J. Chaudhry, *Setting Expectations for Professional Behavior: MOL and Ongoing Clinical Competence*, Federation of State Medical Boards, January 15, 2011, *available at http://www.osteopathic.org/inside-aoa/events/Documents/ome2011-chaudhry-setting.pdf*~~
~~3 Federal Register Volume 76, Number 87, May 5, 2011, *available at* http://www.gpo.gov/fdsys/pkg/FR-2011-05-05/html/2011-10875.htm~~
~~4 American Telemedicine Association, Medical Licensure and Practice Requirements, June 2011~~

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: PATIENT ACCESS TO HOME HEALTH SERVICES

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, alternative solutions to hospitalizations are being sought after due to unsustainable growth in healthcare expenditures, and increased, hospital admissions. (10, 18); and

WHEREAS, the results of a 2019 study that evaluated readmission rates and cost for patients receiving home health directly after an emergency room visit verses undergoing a hospital admission showed that both the total 90 day and readmissions COSTS were lower in the home health group (10); and

WHEREAS, studies evaluating the quality and cost of home healthcare demonstrated that post-acute home healthcare services promoted better patient outcomes and reduced costs compared to alternative post-acute care options such as skilled nursing facilities and inpatient rehabilitation facilities (3, 7, 9, 10); and

WHEREAS, despite these observations, patient access to home health services continues to be limited by a range of factors that include inconsistent Medicare Advantage (MA) insurance coverage, limited MA plan networks (21), and limited home healthcare providers in rural areas (20); and

WHEREAS, there is a shortage of Home Health Agencies (HHAs) in rural areas, with 84% of HHAs located in urban areas (20) now; therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports policies that will improve patient access **AND COVERAGE** to home healthcare services while prioritizing patient safety; **AND PROMOTE QUALITY FOR HOME HEALTH SERVICES**. ~~and be it further~~

~~RESOLVED, that the AOA advocates for policies that (1) support appropriate Medicare payments to home healthcare agencies (2) SUPPORT incentivized Medicare Advantage Plan (MA) coverage for beneficiaries with complex home health needs through improved plan networks, AND (3) promote quality for home health services in rural areas.~~

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: DISASTER RELIEF VOLUNTEERS - SOURCE: H313-A/16

SUBMITTED BY: Council on State Health Affairs/Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Council on State Health Affairs and the Bureau of Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED as amended.

~~RESOLVED, that the following change are made to the policy statement~~.

As part of volunteer service, the American Osteopathic Association: (1) encourage ~~that all~~ osteopathic physicians seek appropriate training in disaster response ~~such as the National Incident Management System (NIMS), Community Emergency Response Teams (CERT), Simple Triage and Rapid Treatment (START), etc.,~~ (2) encourages all osteopathic physicians to enroll ~~as a~~ volunteers to provide medical care during disasters before the next disaster strikes; (3) encourages all DOs to consider joining the U.S. Surgeon General's Medical Reserve Corps or registering with their state or local Emergency System for Advanced Registration of Volunteer Health Profession Program (ESAR-VHP); (4) encourages osteopathic physicians who wish to volunteer to provide domestic or international emergency medical assistance to contact ~~the~~ humanitarian organizations, ~~for example Heart to Heart and DO CARE International~~; and (5) encourages the federal AND STATE GOVERNMENTS to work with MEDICAL LICENSING BOARDS ~~the Federation of State Medical Boards (FSMB) in their "All Licensed Physicians Project"~~ to produce pathways and data resources that can hasten licensed medical aid to disaster victims during public health emergencies.

Background Information: Provided by AOA Staff

Current AOA Policy:
2006; 2011 Reaffirmed as amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN _____ADOPTED AS AMENDED__

DATE _____JULY 17, 2021_____

SUBJECT: ELECTRONIC MEDICAL/HEALTH RECORD EXEMPTION WITHOUT PENALTY - SOURCE: H326-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association supports an exemption to financial penalties to solo
7 and small group practices that do not implement electronic medical records.

Background Information: Provided by AOA Staff

Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: PHYSICIAN ADMINISTERED OMT - SOURCE: H601-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association actively opposes the use of Osteopathic Manipulative
7 Treatment (OMT) / Current Procedural Terminology (CPT) codes by groups other than fully-
8 licensed osteopathic and allopathic physicians and will work diligently to reverse such policies,
9 wherever they exist, that allow non-physicians to utilize OMT/CPT codes for reimbursement.

Background Information: Provided by AOA Staff

Current AOA Policy:
1994; 1999 Reaffirmed as Amended; 2004 Reaffirmed; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: MANDATORY PARTICIPATION IN INSURANCE PLANS – SOURCE: H617-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association opposes any public policy that requires mandatory
7 participation of physicians in any insurance plan, including Medicare or Medicaid and private
8 insurance plans.

Background Information: Provided by AOA Staff

Current AOA Policy:
1994; 1996 Reaffirmed as Amended, 2001; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: MEDICARE CLAIMS CODING – CENTERS FOR MEDICARE AND MEDICAID SERVICES COMMUNICATIONS WITH PHYSICIANS -SOURCE: H620-A/16

SUBMITTED BY: Council on Economic Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic Regulatory Affairs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association urges the Centers for Medicare and Medicaid Services
7 officials to require its Medicare administrative contractors provide thorough, current, written
8 information on the preparation and coding of Medicare claims to all physicians prior to the
9 implementation of any new policies or programs.

Background Information: Provided by AOA Staff

Current AOA Policy:
1999; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: PHYSICIAN NEGOTIATION RIGHTS - SOURCE: H622-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the ~~following changes are made to the policy statement~~. **Council on**
5 **Economic and Regulatory Affairs and recommends that it be REAFFIRMED**
6 **with amendments.**

7 The American Osteopathic Association will support public policies that allow physicians to jointly
8 negotiate with **INSURERS** ~~third party payers~~ thereby creating an equitable basis for negotiations
9 between these parties.

Background Information: Provided by AOA Staff

Current AOA Policy:
2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: READMISSION RATES BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS A CRITERION FOR RANKING – OPPOSITION TO USE OF - SOURCE: H626-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association is opposed to the use of readmission rates as a criterion
7 for deciding payment for physicians and the use of readmission rates as a criterion for ranking
8 the quality of care provided by physicians.

Background Information: Provided by AOA Staff

Current AOA Policy:
2011; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES – BLENDING RATES - SOURCE: H629-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association is opposed to blending of payment rates by ~~insurance~~
7 ~~companies~~ **INSURERS** for ~~Evaluation and Management~~ **CPT** codes.

Background Information: Provided by AOA Staff

Current AOA Policy:
2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

SUBJECT: HEALTH INSURANCE EXCHANGES - SOURCE: H633-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; now,
3 therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the
5 following policy be REAFFIRMED.

6 The American Osteopathic Association adopts the following "Principles for State Health
7 Insurance Exchanges" to assist states in the formation of health insurance exchanges and will
8 communicate these principles to the Department of Health and Human Services (HHS), the
9 Centers for Medicare and Medicaid Services (CMS), governors and state legislatures.

Background Information: Provided by AOA Staff

Current AOA Policy:
2011; 2016 Reaffirmed as Amended

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $

ACTION TAKEN ADOPTED

DATE JULY 17, 2021

SUBJECT: ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE - SOURCE: H635-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs/Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Council on Economic and Regulatory Affairs/Council on State Health Affairs
3 has reviewed the policy; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs/Council on State Health
5 Affairs recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association: (1) will advocate for public and private payors ensuring
7 plan coverage for all medically necessary services, regardless of availability within the service
8 area of its beneficiaries and supporting state regulators as the primary enforcer of network
9 adequacy requirements; (2) supports requiring provider terminations without cause be done
10 prior to the enrollment period, allowing physicians to be added to the network at any time, and
11 requiring health insurers to submit and make publicly available, at least quarterly, reports to
12 state regulators that provide data on several measures of network adequacy; (3) supports
13 requiring health insurers to indemnify patients for any covered medical expenses provided by
14 out-of-network providers incurred over the co-payments and deductibles that would apply to
15 in-network providers, in the case that a provider network is deemed inadequate by the health
16 plan or appropriate regulatory authorities; (4) will advocate for public policies to require out-of-
17 network expenses count toward a participant's annual deductibles and out-of-pocket maximums
18 when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-
19 network due to network inadequacies; (5) supports fair and equitable compensation to out-of-
20 network providers in the event that a provider network is deemed inadequate by the health plan
21 or appropriate regulatory authorities; and, that physician and patients have access to adequate
22 and fair appeals processes in the event that they are harmed by inadequate networks; (6)
23 supports the development of a mechanism by which health insurance enrollees are able to file
24 formal complaints about network adequacy with appropriate regulatory authorities, and will
25 advocate for laws that prohibit health insurers from falsely advertising that enrollees in their
26 plans have access to physicians of their choosing if the health insurer's network is limited; and
27 (7) will advocate that health plans be required to document to regulators that they have met
28 requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology,
29 pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities

Background Information: Provided by AOA Staff
Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: THIRD PARTY ~~PAYOR~~ **INSURER** COVERAGE PROCESS REFORM – SOURCE: H637-A/16

SUBMITTED BY: Council on Economic Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Council on Economic Regulatory Affairs has reviewed the policy; now, therefore be it

RESOLVED, that the Council on Economic Regulatory Affairs recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports the development of model legislation and/or regulations to require that Medicare, commercial insurance companies, state Medicaid agencies, or other third-party ~~payors~~ **INSURER** utilize transparent and accountable processes for developing and implementing coverage decisions and policies.

The AOA will advocate that public and ~~payors~~ **INSURER** and benefit management companies develop transparent clinical protocols as well as formal processes to write/revise them; that those processes should seek input from the relevant physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites.

The AOA will advocate that when public and private ~~payors~~ **INSURER** and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect; and, through legislative and/or regulatory efforts the AOA will advocate that when Medicare Administrative Contractors (MAC) propose new or revised Local Coverage Determinations (LCD), said Contractors must: 1. Conduct Carrier Advisory Committee meetings in public, with minutes recorded and posted to the Contractor's website; and 2. Disclose the rationale for the LCD, including the evidentiary standard upon which it is based when releasing an approved LCD. Through legislative and/or regulatory efforts the AOA will advocate that CMS adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party empowered to make recommendations to affirm, withdraw or revised said policies to the Secretary of HHS; and that that MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

Background Information: Provided by AOA Staff

Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED___

DATE _____JULY 17, 2021_____

SUBJECT: MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) & ALTERNATIVE PAYMENT MODELS (APMS) - SOURCE: H638-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will educate osteopathic physicians on the
7 Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of
8 2015 (MACRA) and the newly emerging payment models, including Merit Based Incentive
9 Payment System (MIPS) AND Alternative Payment Models (APMS), resulting from the act and
10 how these payment models might affect practicing physicians by developing and disseminating
11 broadly available educational materials on Medicare Access and Children's Health Insurance
12 Program (CHIP) Reauthorization Act (MACRA) and resulting payment models.

Background Information: Provided by AOA Staff

Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ____ADOPTED_____

DATE _____JULY 17, 2021_____

SUBJECT: HEALTH INSURER CONSOLIDATION - SOURCE: H643-A/16

SUBMITTED BY: Council on Economic and Regulatory Affairs/Council on State Health Affairs/Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be sunset reviewed; and

WHEREAS, the Council on Economic and Regulatory Affairs/Council on State Health Affairs/Bureau on Federal Health Programs has reviewed the policy; now, therefore be it

RESOLVED, that the following changes are made to the policy statement.

The American Osteopathic Association (AOA) supports the application of strict and necessary scrutiny by appropriate governmental agencies, including but not limited to the Department of Justice State Attorneys General, Federal Trade Commission, and State Insurance Commissioners, to any consolidation of health insurers and that each health insurer consolidation should be evaluated on protecting the interests and needs of the health care consumer, including patient access**, AND CHOICE AMONG MULTIPLE INSURERS**. The necessity of any merger within the health insurance industry must demonstrate a benefit to patients by **IMPROVING PATIENT ACCES AND BY** meeting the ~~**INSTITUTE FOR HEALTHCARE IMPROVEMENT'S** triple~~**QUADRUPLE-**aim of ENHANCING PATIENT EXPERIENCE, IMPROVING POPULATION HEALTH, REDUCING COSTS, AND IMPROVING THE WORK LIFE OF HEALTH CARE PROVIDERS, INCLUDING CLINICIANS AND STAFF. ~~access, improved health outcomes, **IMPROVED CLINICAL EXPERIENCE, REDUCED ADMINISTRATIVE BURDEN** and reduced costs.~~

Background Information: Provided by AOA Staff
Current AOA Policy:
2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: MEDICARE MEDICAL NECESSITY CERTIFICATION REQUIREMENTS - SOURCE: H645-A/16

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; now, therefore
3 be it

4 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
5 policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports reasonable efforts to prevent Medicare
7 waste, fraud, and abuse, ~~and calls~~ THERE BY CALLING on the Center for Medicare and
8 Medicaid Services (CMS) to evaluate its medical necessity certification requirements, including
9 the amount of waste fraud and abuse detected and prevented by such measures, the
10 administrative burden imposed on physician practices, and the rate of denial of legitimate
11 medical supplies and equipment. The AOA encourages CMS to develop a more efficient and
12 less burdensome approach to medical necessity certification.

Background Information: Provided by AOA Staff

Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ADOPTED AS AMENDED

DATE JULY 17, 2021

SUBJECT: EXPANDING GENDER IDENTITY OPTIONS ON PHYSICIAN INTAKE FORMS - SOURCE: H647-A/16

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be sunset reviewed; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy;
3 now, therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends
5 REAFFIRMED with amendments.

6 The American Osteopathic Association (AOA) supports the inclusion of a two-part
7 demographic inquiry on patient intake forms, requesting patients indicate both their
8 **ASSIGNED** sex at birth (male, female, intersex) and gender identity (male, female, transgender
9 **MALE, TRANSGENDER FEMALE, ~~GENDERQUEER~~ NONBINARY,** additional
10 category **(WITH BLANK FOR PATIENT TO COMPLETE)**.

Background Information: Provided by AOA Staff

Current AOA Policy: 2016

Prior HOD action on similar or same topic: N/A

FISCAL IMPACT: $0

ACTION TAKEN ___ADOPTED AS AMENDED____

DATE _____JULY 17, 2021_____

AMERICAN OSTEOPATHIC ASSOCIATION

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SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
EDUCATIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Educational Affairs (200 series)
  This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Action
H200	Graduate Medical Education – Training of US Medical School Graduates (H213-A/15)	BOE	ADOPTED
H201	Rural Sites – Osteopathic Education in (H214-A/15)	BOE	ADOPTED
H202	Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs (H216-A/15)	BOE	ADOPTED as AMENDED
H203	Autopsies (H217-A/15)	BOE	ADOPTED
H204	Clarity Regarding Matching Service Listing of AOA Residencies with ACGME Pre-Accreditation Status (H219-A/15)	BOE	ADOPTED *(for sunset)*
H205	Blue Ribbon Commission Report (H223-A/15)	BOE	ADOPTED
H206	AOA to Support Education and Advocate for Policies Relating to Climate Change	MOA	NOT ADOPTED
H207	Adoption of Specific Informed Consent Guideline for Sensitive Exams Under Anesthesia for Education Purposes	SOMA	REFERRED
H208	Incorporating Continuing Medical Education Opportunities on Human Trafficking	SOMA	REFERRED
H209	Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities	SOMA	ADOPTED as AMENDED
H210	Recommendation of Buprenorphine Waiver Training in Osteopathic Medical Schools	BSAPH	NOT ADOPTED
H211	Referred Res. No H-224 – A/2019 AOA Board Certification Terminology	BOS	NOT ADOPTED
H212	Residency Redistribution of Center for Medicare/Medicaid Services Funding Following Single Accreditation Systems (SAS)	OPSC	NOT ADOPTED
H213	Training High Quality Physicians in a Healthy and Safe Environment	MAOP	NOT ADOPTED
H214	Audition Rotations for Osteopathic Medical Students	IOMA	ADOPTED as AMENDED

SUBJECT: H213-A/15 GRADUATE MEDICAL EDUCATION – TRAINING OF US MEDICAL SCHOOL GRADUATES

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H213-A/15 GRADUATE MEDICAL EDUCATION – TRAINING OF US**
5 **MEDICAL SCHOOL GRADUATES**
6 The American Osteopathic Association advocates for the elimination of limitations on the
7 number of funded graduate medical education positions to accommodate increases in US
8 medical school enrollment; places great emphasis on establishing graduate medical education
9 opportunities for osteopathic medical school graduates in geographic areas that lack adequate
10 training capacity and as needed to meet future workforce needs. 2009; referred 2014; approved
11 as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H214-A/15 RURAL SITES – OSTEOPATHIC EDUCATION IN

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H214-A/15 RURAL SITES – OSTEOPATHIC EDUCATION IN**
5 The American Osteopathic Association encourages clinical rotations in rural settings by
6 osteopathic medical students and graduates during their respective predoctoral and postdoctoral
7 education programs. 1990; revised 1995, 2000, 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H216-A/15 DIRECTORS OF MEDICAL EDUCATION OVERSEEING OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 RESOLVED, that the Bureau of Osteopathic Education recommends ~~that~~ the following policy
2 be ~~SUNSET~~ **REAFFIRMED as AMENDED**.

3 (Old language is crossed out and new language is in CAPS)

4 **H216-A/15 ~~DIRECTORS OF~~ MEDICAL ~~EDUCATION OVERSEEING~~**
5 **~~OSTEOPATHIC~~ POSTDOCTORAL TRAINING PROGRAMS**
6 The American Osteopathic Association will ~~continue the present requirement that the Director~~
7 ~~of Medical Education overseeing osteopathic postdoctoral training programs must be an~~
8 ~~osteopathic physician~~ **ENCOURAGE~~NSURE~~** THE CONTINUED TEACHING OF
9 OSTEOPATHIC PRINCIPLES AND PRACTICES **THROUGH BUT NOT LIMITED**
10 **TO OSTEOPATHIC RECOGNITION** IN GRADUATE MEDICAL EDUCATION
11 PROGRAMS AND ENCOURAGES OSTEOPATHIC PHYSICIANS TO SEEK FACULTY
12 AND ADMINISTRATIVE POSITIONS IN GRADUATE MEDICAL EDUCATION
13 PROGRAMS. 2010, reaffirmed 2015.

Explanatory Statement: Submitted by Author
The BOE recommends this policy be sunset because Directors of Medical Education are not required by the ACGME.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H217-A/15 AUTOPSIES

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H217-A/15 AUTOPSIES**
5 The American Osteopathic Association encourages medical schools, private hospital systems
6 and public medical facilities to allow the viewing of autopsies by medical students and residents
7 for teaching purposes. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H219-A/15 CLARITY REGARDING MATCHING SERVICE LISTING OF AOA RESIDENCIES WITH ACGME PRE-ACCREDITATION STATUS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H219-A/15 CLARITY REGARDING MATCHING SERVICE LISTING OF AOA**
5 **RESIDENCIES WITH ACGME PRE-ACCREDITATION STATUS**
6 The American Osteopathic Association (AOA) will provide guidance to the osteopathic student
7 body regarding the timelines of residency program transition between the NRMP and NMS
8 matching services. The AOA will openly distribute information regarding the match transition
9 and its implications to osteopathic medical students applying to those residency programs,
10 starting in the period leading up to the pre-accreditation eligibility of AOA residency programs.
11 2015

Explanatory Statement: Submitted by Author
The BOE recommends this policy be sunset because the AOA no longer offers a separate AOA Match.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H223-A/15 BLUE RIBBON COMMISSION REPORT

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H223-A/15 BLUE RIBBON COMMISSION REPORT**
5 The American Osteopathic Association (AOA) encourages colleges of osteopathic medicine to
6 collaborate with appropriate regulatory authorities, licensing boards, certifying boards, the
7 National Board of Osteopathic Medical Examiners, and other stakeholders in their pursuit of
8 innovative pilot studies to produce primary care, competency-based physician team leaders and
9 the AOA will monitor the outcomes of these pilot programs and the route to board
10 certification. 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: HOD Reference Committee
The Committee heard singular testimony advocating sunset due to perceived lack of action, while others felt there remains ongoing value in the collaboration embodied in the resolution. The resolution directs the AOA to monitor the Blue Ribbon Commission pilot studies and the Committee respectfully recommends a summary report be provided by the AOA as an informational item for the 2021 House of Delegates.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA TO SUPPORT EDUCATION AND ADVOCATE FOR POLICIES RELATING TO CLIMATE CHANGE

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, there is agreement within the scientific community that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant; and

WHEREAS, these climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the economically disadvantaged; and

WHEREAS, the American Osteopathic Association (AOA) has encouraged efforts to promote standards which will prevent human suffering and death from environmental threats and hazards; and supported efforts to eradicate environmentally related health risks since 1970; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports educating the medical community on the potential adverse public health effects of global climate change; and, be it further

RESOLVED, that AOA encourages American Association of Colleges of Osteopathic Medicine (AACOM) to advocate for their member osteopathic medical schools to incorporate the health implications of climate change into their curricula, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies and, be it further

RESOLVED, that AOA advocates for and support epidemiological, translational, clinical and basic science research, in order that global climate change policy decisions related to health care and treatment have an appropriate evidence base and, be it further

RESOLVED, that AOA encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

Explanatory Statement: Submitted by Author

Resolved 3 refers to H402-A/18 ENVIRONMENTAL HEALTH. Passed in 1970; revised 1978; reaffirmed 1983; revised 1988; reaffirmed 1993; revised 1998, 2003; reaffirmed 2008; reaffirmed 2013; 2018.

Explanatory Statement: Reference Committee

The Committee heard testimony mostly against the resolution. Advocates commented that environmental health is a public health issue. The Committee believes that the current policy, H402-A/18 demonstrates the AOA's commitment to Environmental Health. In H402-A/18, the AOA strongly encourages the federal government to increase its efforts to promote standards which will

prevent human suffering and death from environmental threats and hazards; and reaffirms its commitment to support governmental agencies' efforts in eradicating environmentally related health risks. Regarding this resolution's call for incorporating health implications of climate change into osteopathic medical school curricula, the Committee believes that osteopathic medical schools should have the autonomy to choose their curricula based on the COCA requirements, their curriculum committee, and their mission statement, and that this was beyond the scope and authority of the AOA.

Background Information: Provided by AOA Staff
Current AOA Policy: H402-A/18 ENVIRONMENTAL HEALTH

Prior HOD action on similar or same topic: Policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: ADOPTION OF SPECIFIC INFORMED CONSENT GUIDELINE FOR SENSITIVE EXAMS UNDER ANESTHESIA FOR EDUCATION PURPOSES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, patient consent is critical to patient care; and

WHEREAS, physicians, residents, and medical students have a duty to respect the autonomy of patients; and

WHEREAS, sensitive exams are defined as pelvic exams, rectal exam, clinical breast exam, urogenital exams[1]; and

WHEREAS, the performance of sensitive exams under general anesthesia without specific informed consent can lead to severe psychological stress for the patient, damage to the patient provider relationship, and a distressing experience for the medical student or resident[2]; and

WHEREAS, thirty-nine states have no law explicitly banning the practice of performing pelvic exams on general anesthetized patients without their specific consent[3]; and

WHEREAS, in a study conducted in 2003, 90% of students surveyed had completed a pelvic exam on general anesthetized patient who had not given informed consent[4]; and

WHEREAS, If asked for specific consent prior to surgery, 62% of women claimed they would consent to a medical student performing a pelvic exam while under general anesthesia for educational purposes, showing that asking does not significantly impact learning opportunities[5]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopt guidelines that require the practicing physician or resident to obtain specific informed consent before the resident or medical student performs a sensitive exam for education purposes on a patient who is under general anesthesia.

Explanatory Statement: Submitted by Author

Performing sensitive exams on unconscious patients for educational purposes is not a new practice[5]. Public awareness in the 1990's saw the introduction of limited state legislation against the practice[2]. Today there are 11 states that have banned the performance of sensitive exams under anesthesia without specific consent[3]; Wisconsin and Florida have proposed bills under consideration[6,7]. It is difficult to predict the number of educational pelvic exams under anesthesia without specific consent being performed today but recent lawsuits as well as reports from patients and medical students indicate the practice is still occurring nationally[2,3,6,7].

References

1. University Health Service. (n.d.). *University of Michigan*. Retrieved February 21, 2020, from https://www.uhs.umich.edu/sensitive-exams
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3. Goldberg, E. (2020, February 17). She Didn't Want a Pelvic Exam. She Received One Anyway. *New York Times*. Retrieved February 21, 2020, from https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html
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5. Cundall, H., MacPhedran, S., & Arora, K. (2019, December). Consent for Pelvic Examinations Under Anesthesia by Medical...: *Obstetrics & Gynecology*. Retrieved February 21,2020, fromhttps://journals.lww.com/greenjournal/Fulltext/2019/12000/Consent_for_Pelvic_Examinations_Under_Anesthesia.23.aspx?casa_token=oPri3J4ogx8AAAAA:k-v1Z0A8izkAtAX3vcyWc_0MTL7uUDLFIPKzbSVUxGlVULCEd7SQcmEtOi4bM48xh-nbgFr312d8Yk6VhtT9z5X_
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Explanatory Statement: Reference Committee

The Committee respectfully recommends this resolution be referred back to its authors, the Student Osteopathic Medical Association (SOMA). The Committee was supportive of the resolution's intent but felt that current policy, H223-A/19, is broad enough to include the encounters such as that referred to in the resolution. The Committee recommends that the SOMA study current AOA policy H223-A/19 and consider resubmitting a resolution for a future HOD that amends H223-A/19, should the SOMA believe there is a need to include specific informed consent for sensitive exams under anesthesia in the current AOA policy. In addition, the Committee also recommends the authors consider defining sensitive exams in a Resolved statement so that its definition will be included in the AOA policy compendium.

Background Information: Provided by AOA Staff

Current AOA Policy: H223-A/19 EDUCATION OF STUDENTS AND FACULTY ON OBTAINING PERMISSION BEFORE ALL STUDENT AND PATIENT ENCOUNTERS

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ~~**INCORPORATING**~~ **ENCOURAGING** CONTINUING MEDICAL EDUCATION OPPORTUNITIES ON HUMAN TRAFFICKING

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, human trafficking is defined as ~~**the use of force, fraud, or coercion to obtain some type of labor or commercial sex act**~~ **COMPLEX CRIME INVOLVING THE EXPLOITATION OF SOMEONE FOR THE PURPOSES OF COMPELLED LABOR OR A COMMERCIAL SEX ACT, THROUGH THE USE OF FORCE, FRAUD, OR COERCION. WHEN A PERSON UNDER 18 IS USED TO PERFORM A COMMERCIAL SEX ACT, IT IS HUMAN TRAFFICKING WHETHER OR NOT THERE IS ANY FORCE, FRAUD, OR COERCION** [1]; and

WHEREAS, an estimated 40.3 million people are victims of human trafficking globally, 4.8 million of which are in forced sexual exploitation for profits of an estimated $99 Billion US dollars per year[2]; and

WHEREAS, 1 million children are victims of sex trafficking globally[3]; and

~~**WHEREAS, 14,500 to 17,500 people are trafficked into the United States each year[4]; and**~~

WHEREAS, 1 in 6 reported runaways in the United States are presumed to be victims of child sex trafficking[5]; and

WHEREAS, trafficking victims experience higher rates of the following healthcare concerns: STI's, pregnancy, unsafe abortion, malnourishment, illness from unsanitary conditions, and physical and mental abuse manifestations such as PTSD and depression[6]; and

WHEREAS, studies have shown that 28-88% of trafficking victims have come into contact with the healthcare system while being trafficked [6, 7]; and

WHEREAS, the American College of Osteopathic Emergency Physicians reports that only 10% of physicians recognize human trafficking victims and 3% of emergency physicians receive training on human trafficking[8]; and

WHEREAS, only three medical schools in the United States have formal case based simulation training in identifying victims of human trafficking during the first three years of medical education, none of which are osteopathic medical schools[9,10]; and

WHEREAS, "Educating healthcare professionals on the topic cannot be limited to one subspecialty as trafficking victims have a wide variety of physical symptoms… To reach the widest range of subspecialties, education must occur during undergraduate medical education and focus on practical aspects of providing care for trafficked persons as well as identifying elements of trafficking"[10]; and

WHEREAS, a multitude of organizations, including the World Health Organization, have released statements regarding the need for awareness of the signs of human trafficking in healthcare professionals[8,11,12,13]; and

WHEREAS, it is recommended that medical school and emergency medicine residency curricula should include training in recognizing and intervening for patients surviving human trafficking[8]; and

WHEREAS, American Osteopathic Association policy H401-A/14 Human Trafficking—Awareness as a Global Health Problem acknowledges human trafficking as a global public health problem and encourages awareness among osteopathic physicians[14]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~**incorporate**~~ **ENCOURAGE** continuing medical education opportunities on recognizing the signs and risk factors of human trafficking.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

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2. Worldwide Human trafficking prevalance: International Labor Organization. (2017, September 19). Forced labour, modern slavery and human trafficking. Retrieved from https://www.ilo.org/global/topics/forced-labour/lang--en/index.h
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Explanatory Statement: Reference Committee

The Committee recommends amendments to correct terminology and statistics and to reduce the perceived fiscal impact on the AOA as well as encourage all CME sponsors to consider providing educational offerings on this topic. Further, the Committee was informed that a number of State licensing boards already include this topic among those required.

Background Information: Provided by AOA Staff

Current AOA Policy: H401-A/19 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

Prior HOD action on similar or same topic: Policy reaffirmed in 2019.

FISCAL IMPACT: Up to approximately $130,000 in additional expense.

The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **REFERRED** *(to Bureau of Osteopathic Education with proposed amendments)*

DATE: **October 14, 2020**

SUBJECT: ~~**INCORPORATING**~~ **ENCOURAGING** CONTINUED MEDICAL EDUCATION REGARDING INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, "developmental disabilities" are defined as a group of lifelong conditions due to an impairment in physical, learning, language, behavioral areas, or self-care before the age of 22[1]; and

WHEREAS, people with disabilities make up the largest legally protected group in the country since the passage of the ADA in 1990[1]; and

WHEREAS, over a billion people live with a disability, including 54 million Americans according to the World Report on Disability[2]; and

WHEREAS, the life expectancy of people with intellectual disabilities has increased by 200% over the past 80 years, while the life expectancy of the general population has increased by approximately 30%[3]; and

WHEREAS, for the first time in the course of human history, there are now more adults living with intellectual and developmental disabilities (I/DD) than children[3]; and

WHEREAS, it has been shown that people with disabilities report seeking more healthcare than people without disabilities and have greater unmet needs[4]; and

WHEREAS, Patients with intellectual disabilities also encounter additional challenges in accessing healthcare compared to the general population[4]; and

WHEREAS, health promotion and preventative medical care rarely target people with disabilities; examples range from a lower rate of cervical and breast screenings for patients to unmonitored weight for patients with I/DD compared to patients without I/DD[4]; and

WHEREAS, communication barriers and complexity of social/medical situations for this particular population were the main reasons clinicians felt like they were not able to deliver adequate care[5]; and

WHEREAS, barriers to receiving healthcare are not only physical, but also perhaps more importantly related to the knowledge and attitudes of healthcare providers[5] ; and

WHEREAS, people with disabilities have cited negative attitudes and behaviors of healthcare providers as the most formidable barriers to accessing healthcare services[5]; and

WHEREAS, medical students, residents, and practicing physicians have demonstrated deficiencies in the most basic patient care towards common forms of disability, such as cerebral palsy and learning disabilities[5] ; and

WHEREAS, given the range in exposure to clinical populations, there is no guarantee that medical students will interact with patients with disabilities in medical school[6]; and

WHEREAS, providers have reported feeling inadequate in addressing this population's healthcare needs due to lack of education received in prior years of schooling,[4] and illnesses that are readily apparent in persons without disabilities may remain undiagnosed in individuals with I/DD[5]; and

WHEREAS, 40% of internal medicine physicians do not feel comfortable caring for patients with chronic disease of childhood-onset secondary to lack of familiarity with the literature, lack of training with this population, and lack of coordination among specialists[8]; and

WHEREAS, Section 5307 of the Patient Protection and Affordable Care Act states that a model disability curriculum should be developed that addresses "cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities";[2] however, only a few healthcare programs have included disability topics within their curriculum[2]; and

WHEREAS, a multitude of medical schools have incorporated education tools within their curriculum to improve medical students' preparedness for communicating with persons with disabilities that led students to report feeling more prepared and knowledgeable about properly caring for this community[6]; and

WHEREAS, a study of pre-clinical medical school curriculum focused on healthcare disparities of and biases towards disabled communities in an effort to change the current attitudes of healthcare providers towards persons with disabilities led to the majority of medical students involved in this curriculum development course responding positively and believing community involvement with patients would be helpful for future clinical work[2]; and

WHEREAS, results from physician education seminars for a clinical improvement program in the treatment of the intellectual and developmental disabilities population reveal statistically significant improvements in self-assessed competence and clinician knowledge[9]; and

WHEREAS, in order to improve the quality of healthcare for people with I/DD, individual providers must expand their knowledge base and skill set via professional education to be integrated with didactic and clinical training that include: direct interactions with these patients, history taking, cultural practices, diagnostic treatment, as well as counseling and supporting individuals[7]; and

WHEREAS, AOA sponsored conferences since January 1, 2019 did not discuss specific topics regarding the care and treatment of the adult intellectual and developmental disabilities population[9]; and

WHEREAS, AOA Resolution H211-A/18 "encourages osteopathic medical schools to develop and implement curricula on the care of people with developmental disabilities[10]"; and

WHEREAS, by instilling earlier education into the medical curriculum, along with continuing education for all levels of practice, improvements may be seen in the degree of comfort and quality of care that is delivered[10]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~**incorporates**~~ **ENCOURAGES CONTINUING MEDICAL EDUCATION OPPORTUNITIES** ~~**content**~~ regarding intellectual and developmental disability care for adults~~ **during AOA-sponsored conferences**~~.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

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DEVELOPMENTAL-DISABILITIES-CURRICULUM-ON-THE-CARE-OF-PEOPLE.pdf

Explanatory Statement: Reference Committee
The Committee heard mixed testimony on this resolution. Advocates wished to highlight the topic of disability through inclusion during AOA conferences. Those in opposition cited the potential fiscal note. The Committee believes the AOA House of Delegates should not mandate specific CME content at AOA-sponsored conferences. Decisions on CME content should be based on the CME sponsor's practice gap analysis of its intended audience, which may include sessions regarding the care of disabled patients.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to approximately $130,000 in additional expense.
The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: RECOMMENDATION OF BUPRENORPHINE WAIVER TRAINING IN OSTEOPATHIC MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Educational Affairs

WHEREAS, opioid overdose has become a leading cause of death in the United States[1]; and

WHEREAS medication-assisted treatment (MAT), including buprenorphine formulations and other opioid receptor agonists and antagonists, is an effective, evidence-based treatment for opioid use disorder (OUD) and is an integral part of guidelines promoted by the National Institute on Drug Abuse and the American Society of Addiction Medicine[2]; and

WHEREAS the Drug Addiction Treatment Act of 2000 (DATA 2000) requires prescribers to undergo a training regimen designed by the US Drug Enforcement Agency (DEA) before receiving authorization to prescribe MAT[3]; and

WHEREAS the American Osteopathic Association and its member institutions are committed to fully equipping osteopathic medical students with the evidence-based tools needed to meet the most pressing needs of 21st century medicine[4]; now, therefore be it

RESOLVED, the American Osteopathic Association recommends that osteopathic medical schools will adopt and incorporate an approved DATA 2000 waiver training program into their core curricula, with implementation no later than the matriculating class of 2022.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

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Explanatory Statement: Reference Committee

The Committee believes the policy as written is inappropriate because the AOA lacks sufficient authority over educational curricula, as that rests with the COCA. Curricular initiatives addressing the treatment of pain and opioid use disorder already currently exist at many osteopathic medical schools. In addition, the Committee believes that waiver training in osteopathic medical school may be too early since osteopathic medical students do not have DEA certificates and would be more appropriate training during residency, temporally closer to the time when they would prescribe medications for opioid use disorder.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: REFERRED RES. NO H-224 – A/2019 AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Committee on Educational Affairs

1 RESOLVED, THAT THE TERMINOLOGY FOR AMERICAN OSTEOPATHIC
2 ASSOCIATION ISSUED BOARD CERTIFICATIONS SHOULD STATE THAT A
3 CERTIFICATE HOLDER IS "BOARD CERTIFIED IN THE PRINCIPLES AND
4 PRACTICE OF OSTEOPATHIC "SPECIALTY"

Explanatory Statement: Submitted by Author:
The BOS believes that adding Osteopathic in front of the specialty name is redundant and unnecessary. The certification is an osteopathic certification because it comes from the American Osteopathic Association, and therefore, the inclusion of Osteopathic Principles and Practices is strongly implied. There is no doubt that the certification is osteopathic as the word osteopathic appears on each certificate a minimum of five (5) times.

Explanatory Statement: Reference Committee
At the 2019 House of Delegates, the House referred Resolution H224-A/19 to the Bureau of Osteopathic Specialists (BOS) for review and recommendation. Resolution H211, submitted by BOS, does not respond to the 2019 House of Delegates request, and therefore, Resolution H224-A/19 still requires final action by the House of Delegates. The Committee presents Substitution Resolution H211, which is the resolved statement from H224-A/19. The testimony heard by the Committee was in opposition to this language, and generally supportive of the current terminology included on AOA board certificates. The Committee supports the BOS and its member certifying boards, believing that the BOS and its member certifying boards must have the authority to determine the terminology used on AOA board certificates. Current AOA board certificates state the word, "Osteopathic" a minimum of five (5) times and the Committee believes this to be sufficient.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

1 WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to
2 "advance the distinctive philosophy and practice of osteopathic medicine"; and

3 WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that
4 "the BOS is the certifying body for the approved specialty boards of the AOA and is
5 dedicated to establishing the high standards for certification of osteopathic physicians";
6 and

7 WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that
8 "There are more than 100,000 DOs in the US, practicing their distinct philosophy in
9 every medical specialty. We have additional training in OMT and use this tool to help
10 diagnose, treat and prevent illness and injury"; and

11 WHEREAS, www.doctorsthatdo.org also claims that "by combining the latest advances in
12 medical technology with OMT, Doctors of Osteopathic Medicine offer their patients
13 the most comprehensive care available in medicine today"; and

14 WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic
15 Principles and Practice (OPP) and OMT via minimal standards established by ECOP,
16 including over 200 hours of training in OMT, with practical exams, OSCE, and
17 COMLEX exams"; and

18 WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across
19 the USA, shows that 88% of respondents agree that osteopathic certification
20 terminology should clearly state a holder is certified in osteopathic principles and
21 practice; and

22 WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for
23 certification already approved that states, "General certification represents a distinct and
24 well defined field of osteopathic medical practice; now, therefore be it

25 RESOLVED, that the terminology for American Osteopathic Association issued board
26 certifications should state that a certificate holder is "Board certified in the Principles
27 and Practice of Osteopathic "Specialty".

Reference Committee Explanatory Statement:

Specific terminology on certificates is determined by the BOS and the individual certifying boards. The Committee requests the BOS report back to the 2020 House of Delegates on this issue.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019**

ACTION TAKEN: **NOT ADOPTED by action of substitute resolution H211 – Oct. 13 2020**

DATE: **October 14, 2020**

SUBJECT: RESIDENCY REDISTRIBUTION OF CENTER FOR MEDICARE/MEDICAID SERVICES FUNDING FOLLOWING SINGLE ACCREDITATION SYSTEMS (SAS)

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Accreditation Council of Graduate Medical Education (ACGME) ratified the Memorandum of Understanding (MOU) for the Single Accreditation Systems (SAS) with the American Osteopathic Association (AOA) and American Association of Colleges of Osteopathic Medicine (AACOM) in 2014 for the transition of AOA accredited residencies into ACGME accredited programs starting in 2015; and

WHEREAS, the majority of Graduate Medical Education (GME) residency funding is by Centers of Medicare Medicaid Services (CMS) through direct graduate medical education (DGME) funding and indirect funding (IME); and

WHEREAS, the vast majority of those AOA accredited residencies that applied under SAS successfully achieved ACGME accreditation but without an increase in the total CMS funded GME residency positions; and

WHEREAS, a percentage of AOA accredited programs did not apply for ACGME accreditation and will close after the July 2020 date with a loss of CMS funded GME positions during a time when more funded ACGME positions are needed; and

WHEREAS, the consequence of many the AOA accredited programs not applying for transition from AOA accreditation to ACGME accreditation will be the loss of CMS funded positions and will significantly affect those communities that had GME positions prior to July 1, 2020 and are in need for medical care; and

WHEREAS, CMS may redistribute some or all the GME funded but closed residency training positions to other ACGME residencies; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate and work in conjunction with the Accreditation Council of Graduate Medical Education (ACGME) to advocate for the continued development and Centers of Medicare Medicaid Services (CMS) funding of ACGME accredited residency training programs in rural and underserved areas affected by Graduate Medical Education (GME) residency position losses; and, be it further

RESOLVED, that the AOA advocates that CMS prioritizes funding new residency positions, and that these funds are not used to offset non-CMS funded residency positions.

Explanatory Statement: Submitted by Author

None provided.

Explanatory Statement: Reference Committee
The Committee received testimony that was mostly against the adoption of this resolution, including a desire by the authors to withdraw the resolution. The Committee believes that the current policies, H213-A/15, H329-A/16, and H201-A/19 satisfactorily address the concepts proposed within this resolution.

Background Information: Provided by AOA Staff
Current AOA Policy:
H329-A/16 GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES
H201-A/19 GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES

Prior HOD action on similar or same topic: H320-A/16 policy approved in 2016; H201-A/19 reaffirmed in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: TRAINING HIGH QUALITY PHYSICIANS IN A HEALTHY AND SAFE ENVIRONMENT

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, the goal of osteopathic medical schools is to train competent, caring physicians who will be comfortable caring for people in all clinical care settings, and

WHEREAS, all osteopathic medical schools have developed their own method of assessment designed to assure that students acquire and demonstrate core clinical skills, and

WHEREAS, the COVID-19 pandemic has created challenges and risks to students who have to travel to national standardized examinations administered by the National Board of Osteopathic Medical Examiners (NBOME) to one of two standardized testing centers run by the NBOME, and

WHEREAS, the COVID-19 pandemic has created challenges and risks to students by exposing students to standardized patients, and

WHEREAS, the NBOME is still striving to schedule and administer a standardized clinical skills/performance evaluation examination to all current osteopathic medical students in a safe manner, and

WHEREAS, the NBOME has provided conflicting information on scheduling dates for this examination to osteopathic medical students which has necessitated multiple rescheduled examinations, and

WHEREAS, communication from the NBOME on plans to make the performance evaluation/clinical skills exam safe for students and with key stakeholders needs to be done in a timely manner, and

WHEREAS, the time and resources required of students to take the clinical skills/performance evaluation removes students from the learning environment with required travel for longer than other alternatives, and

WHEREAS, all osteopathic medical schools have clinical skills training sites at each college of osteopathic medicine, and

WHEREAS, technology has provided us with new efficient and safe ways to assess the same skills; now therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) work with key stakeholders to provide safe and remote clinical skills testing without granting a monopoly to any one business entity; and be it further

RESOLVED, that clinical skills testing in a standardized, safe and effective format be provided in the safest manner possible even if that means that the tests be provided through the Colleges of Osteopathic Medicine or other entities such as state or specialty societies, and be it further

RESOLVED, that American Association of Colleges of Osteopathic Medicine (AACOM) and the AOA work to create a feedback system for the National Board of Osteopathic Medical Examiners' (NBOME) performance regarding communication with students and key stakeholders, and attention to safety and industry standards in scheduling test administration to see how the NBOME performs and where an increased focus might be necessary to meet the standards expected.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee heard mixed testimony, but mostly against the adoption of this resolution. The Committee believes that the resolution is not within the AOA's authority. The AOA does not mandate the work of AACOM, NBOME, or Colleges of Osteopathic Medicine. The intent of the resolution is wholly supported, and the Committee is hopeful that the clinical skills testing will be given in a standardized, safe and effective format.

Background Information: Provided by AOA Staff
Current AOA Policy: H206-A/16 COMLEX-USA LEVEL 2-PE

Prior HOD action on similar or same topic: Policy reaffirmed in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AUDITION ROTATIONS FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Single Accreditation System (SAS) was fully implemented on July 1, 2020; and

WHEREAS, most FOURTH-YEAR medical students ~~must~~ CHOOSE TO schedule VISITING STUDENT OR "audition" rotations at ~~hospitals~~ INSTITUTIONS, OTHER THAN THOSE AFFILIATED WITH THEIR OWN MEDICAL SCHOOL ~~which~~ THAT sponsor residencies into which the student desires to match; and

WHEREAS, some ~~hospitals~~ INSTITUTIONS charge FOURTH-YEAR medical students a fee for ~~participating in audition~~ VISITING STUDENT rotations; and

WHEREAS, in some ~~hospitals~~ INSTITUTIONS, FOURTH-YEAR osteopathic medical students are required to pay substantially higher fees than allopathic students ~~are required to pay~~ or are being refused the opportunity to participate in ~~audition~~ VISITING STUDENT rotations solely because they are enrolled in an osteopathic medical college[1]; ~~and~~

~~WHEREAS, this places osteopathic medical students at a significant disadvantage in matching into their desired residency program and causes them to incur significantly higher expenses compared to allopathic medical students;~~ now therefore be it,

RESOLVED, that the American Osteopathic Association (AOA), ~~through its representatives to the Accreditation Council in Graduate Medical Education (ACGME)~~ PARTNER WITH INTERESTED STAKEHOLDERS INCLUDING, BUT NOT LIMITED TO, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES(AAMC) AND AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE (AACOM) TO ADDRESS ~~seek changes to the institutional accreditation standards to prohibit~~ the discriminatory practice of **PROHIBITING MEDICAL STUDENTS FROM VISITING STUDENT ROTATIONS OR CHARGING DIFFERENT FEES TO MEDICAL STUDENTS BASED SOLEY ON THEIR OSTEOPATHIC TRAINING** ~~charging osteopathic medical students a fee different than FROM THAT is charged to allopathic students for audition VISITING STUDENT rotations (E.G. AUDITION ROTATIONS)~~; and, be it further

RESOLVED, that the AOA WORK WITH ANY AND ALL RELEVANT ORGANIZATIONS TO ~~also~~ seek ~~any other~~ necessary changes in institutional or residency ~~standards~~ **POLICIES AND/OR** PRACTICES **THAT PROHIBIT VISITING STUDENT ROTATIONS OR CHARGE INEQUITABLE FEES TO MEDICAL STUDENTS BASED SOLELY ON THEIR OSTEOPATHIC TRAINING** ~~to prevent any ACGME accredited institution or program from discriminating THAT MAY ALLOW FOR BIAS~~ against osteopathic medical students or residents ~~in any way~~; and, be it further

RESOLVED, that ~~when~~ the AOA WILL CONTINUE TO ADVOCATE FOR OSTEOPATHIC MEDICAL STUDENTS AND RESIDENTS WITH INSTITUTIONS, PROGRAMS, AND OTHER RELEVANT STAKEHOLDERS WHEN THE AOA becomes aware of any instance of discrimination~~ against osteopathic medical students, it shall advocate on behalf of the students with the institution~~.

Explanatory Statement: Submitted by Author

1. See the following example:

"The University of Iowa Carver College of Medicine annually accepts applications from visiting fourth year medical students from LCME accredited schools. (We *cannot* accept applications from D.O. students in Osteopathic programs)"

"Visiting Student Information and Application", *University of Iowa, Carver School of Medicine*, https://medicine.uiowa.edu/md/student-support/visiting-student-information-and-application, accessed June 10, 2020

"A nonrefundable application fee of $150 for MD students is due on receipt of an offer for externship. DO and International medical students are required to pay a nonrefundable fee of $4,150 on receipt of an offer for externship."

"Visiting Students for Academic Year 2020-2021", University of Colorado School of Medicine, http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/extern/Pages/default.aspx, accessed June 10, 2020

"2. APPLICATION FEE – NOT REQUIRED FOR LCME-APPROVED OR DOMESTIC MEDICAL SCHOOLS.

Osteopathic Students: $50 payable to "UIC" in the form of a money order, traveler's check or cashier's check.
Fee waived (LCME/domestic)"

"Checklist for non-UIC medical students applying for electives and sub-internships at the university of Illinois college of medicine", *University of Illinois, College of Medicine,* http://chicago.medicine.uic.edu/wp-content/uploads/sites/6/2017/08/Medical-students-Visiting-Complete-packet_032917-1.pdf, accessed June 10, 2020

Explanatory Statement: Reference Committee

The committee heard mixed testimony but general support for the premise of the initial resolution. It was noted that the ACGME does not have purview over medical students or any fees charged to them for visiting, or "audition", rotations. The committee believes that the proposed amended resolution captures the spirit of the initial resolution and addresses the responsible stakeholder organizations.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

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SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Action
H300	Intractable and/or Chronic Pain (Not Associated with End of Life Care) (H327-A/15)	BSGA	REFERRED
H301	Retail-Based Health Clinics and Urgent Care Centers (H303-A/15)	BSAPH	ADOPTED as AMENDED
H302	Protecting American Students from Profit-Driven Foreign Medical Schools (H304-A/15)	BFHP	ADOPTED
H303	Remove FDA Ban on Anonymous Sperm Donation from Men Who Have Sex with Men (H305-A/15)	BFHP / BSAPH	ADOPTED
H304	Improving Competitive Edge for Membership in the AOA (H308-A/15)	BOM	ADOPTED
H305	Tax Credit for Precepting (H312-A/15)	BSGA	ADOPTED as AMENDED
H306	Site Neutral Reimbursement (H396-A/15)	BFHP	ADOPTED as AMENDED
H307	Supporting the Use of OMM in the VA (H311-A/15)	BHFP	ADOPTED
H308	Practice Rights of Osteopathic Physicians (H313-A/15)	BSGA	ADOPTED as AMENDED
H309	Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products (H314-A/15)	BSAPH	ADOPTED as AMENDED
H310	Osteopath and Osteopathy - Use of the Term (H315-A/15)	BIOM	ADOPTED
H311	Patient Access in Rural Areas (H317-A/15)	BSGA	ADOPTED *(for sunset)*
H312	Physician Office Laboratories (H318-A/15)	BFHP	ADOPTED
H313	Postgraduate Compensation (H319A/15)	BOE	ADOPTED as AMENDED
H314	Second Opinion, Surgical Cases (H320-A/15)	BSA	ADOPTED
H315	Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services (H322-A/15)	BFHP	ADOPTED as AMENDED
H316	Emergency Medical Services for Children, Support of (H323-A/15)	BFHP	ADOPTED as AMENDED

AMERICAN OSTEOPATHIC ASSOCIATION

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SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H317	Physician Incentives to Underserved Areas (H324-A/15)	BSGA	ADOPTED
H318	Vaccines Shortages (H326-A/15)	BFHP	ADOPTED as AMENDED
H319	Medicare Balance Billing (H329-A/15)	BFHP	ADOPTED as AMENDED
H320	Electronic Prescribing of Controlled Substances (H332-A/15)	BSA	ADOPTED *(for sunset)*
H321	Professional Organization -- Physicians Choosing to Which They Belong (H334-A/15)	BOM	NOT ADOPTED
H322	Prescription Drug Diversion and Abuse – Education, Research, and Advocacy (H335-A/15)	BSGA	ADOPTED
H323	Buprenorphine Maintenance Treatment Insurance Coverage (H336-A/15)	BSA	ADOPTED
H324	Violence Against Healthcare Staff (H337-A/15)	BSGA	ADOPTED as AMENDED
H325	Low Back Pain Clinical Practice Guidelines, Revision of (H338-A/15)	BOCER	ADOPTED as AMENDED
H326	Addressing the Effects of Climate on National Health	SOMA	REFERRED
H327	Adverse Childhood Experiences Screening	SOMA	ADOPTED as AMENDED
H328	Inclusion of Patient Education on Organ Donation as a Component of a Primary Care Visit	SOMA	NOT ADOPTED
H329	Inequalities in Medicaid Funding Affecting U.S. Territories	SOMA	ADOPTED as AMENDED
H330	Improving Insulin Affordability	SOMA	REFERRED
H331	Medication for Opioid Use Disorder Insurance Coverage	AOAAM	NOT ADOPTED
H332	Recruitment and Retention of Native Americans in Medicine	SOMA	NOT ADOPTED
H333	WITHDRAWN	SOMA	WITHDRAWN
H334	Sustainability at AOA Events	MOA	NOT ADOPTED
H335	H357-A/19 Nutrition and Leading By Example	OPSC	NOT ADOPTED
H336	REFERRED RESOLUTION: H324-A/14 Use of the Term "Physician" "Doctor" and "Provider"	BSGA	ADOPTED

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OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H337	CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016	IOMA	ADOPTED as AMENDED

SUBJECT: H327-A/15 INTRACTABLE AND / OR CHRONIC PAIN (NOT ASSOCIATED WITH END OF LIFE CARE)

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H327-A/15 INTRACTABLE AND/OR CHRONIC PAIN (NOT ASSOCIATED WITH END OF LIFE CARE)

The American Osteopathic Association supports the enactment of legislation concerning the administration of controlled substances to persons experiencing intractable and/or chronic non-malignant pain substantially conforming to the attached definitions and requirements; and will advocate and promote to students, residents, fellows and practicing physicians educational resources regarding addictive disorders, diversion awareness and monitoring and appropriate referral resources, as well as the prevention and treatment of pain disorders.

Definitions:

A. Intractable ~~and/or chronic~~ pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, a face to face evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION DEFINES CHRONIC PAIN AS "PAIN THAT TYPICALLY LASTS >3 MONTHS OR PAST THE TIME OF NORMAL TISSUE HEALING. CHRONIC PAIN CAN BE THE RESULT OF AN UNDERLYING MEDICAL DISEASE OR CONDITION, INJURY, MEDICAL TREATMENT, INFLAMMATION, OR AN UNKNOWN CAUSE."[1]

~~Requirement~~GUIDELINES:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's treatment of the person for a diagnosed condition causing intractable and/or chronic pain. This includes patients with chemical dependency and/or substance abuse history if chronic pain exists

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[1] Dowell, Deborah; Haegerich, Tamara; Chou, Roger. "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016." *Recommendations and Reports*, March 18, 2016 / 65(1);1–49. *See* https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.

and controlled substance management is indicated. Physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

B. No physician shall be subject to ~~disciplinary~~ ADVERSE action (by the state medical board, EMPLOYERS, INSURERS, ETC.) for appropriately prescribing or administering controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

C. No physician shall be subject to criminal prosecution (by state or federal agencies) for appropriately prescribing or administering medically necessary controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

D. This section shall not authorize a physician to prescribe or administer controlled substances to a person the physician knows to be using drugs or substances for non-therapeutic purposes.

E. This section ~~does not affect~~ IS NOT INTENDED TO INTERFERE WITH the power (of the state medical board) to deny, revoke, or suspend the license of any physician who fails to keep accurate records of purchases and disposal of controlled substances, writes false or fictitious prescriptions for controlled substances, or prescribes, administers, or dispenses in violation of state controlled substances actS.

~~Recent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medically necessary pain management needs to be revisited. Furthermore, the term intractable pain is ambiguous as to the source. A policy on hospice related pain exists and is supportive of palliative care, including opiate and/or controlled substance management for terminally ill patients. This defines intractable pain in the terminally ill, but further clarification is necessary for chronic pain. Chronic pain might also necessitate opiate and/or controlled substance management for patients when other interventions have been inadequate. Opiate and/or controlled substance management in treating chronic pain patients in those with substance abuse disease issues is now supported as a standard of care by the medical literature. Such patients require physician hypervigilance as part of this standard of care.~~ (2005, revised 2010)

Explanatory Statement: Submitted by Author

The final paragraph was deleted because according to Suffolk University's *Journal of Health & Biomedical Law*, "only about 15 appellate cases of criminal medical malpractice" occurred between 1809 and 1981, and there have only been a handful of criminal cases since. This data does not support the statements that "[r]ecent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medical necessary pain management needs to be revisited."

H438-A/17 END OF LIFE CARE – POLICY STATEMENT ON is the current AOA policy referenced in lines 28-29 on page 2. This policy is supportive of palliative care and physicians' ability to prescribe appropriate analgesics for pain without fear of repercussions, but it does not define "intractable pain" or specifically mention opioids; therefore, those lines have been deleted.

Explanatory Statement: Reference Committee
It is unclear if this is to be a guideline as suggested by the change from "Requirement" to "Guidelines" in page 1, line 27, or if it is to be model legislation as suggested by the language in section B or C of the "Guidelines". Recommend language be clarified to be consistent with model legislation since there is a lack of evidence-based literature referenced. Also recommend title of resolution be updated to match language change proposed on page 1, line 13.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on State Health Affairs)*

DATE: **October 14, 2020**

SUBJECT: H303-A/15 RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H303-A/15 RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS

The American Osteopathic Association recommends that retail-based health clinics and urgent care centers adhere to the following principles and standards to guide their establishment and operation (2006; reaffirmed as amended 2011; revised 2015)

1. Retail-based health clinics and urgent care centers must establish arrangements by which their health care practitioners have direct access to and supervision by physicians at levels that meet or exceed respective state laws.
2. Retail-based health clinics and urgent care centers must encourage patients to establish care with a primary care physician to ensure continuity of care. If a patient's conditions or symptoms are beyond the scope of services provided by the clinic, that patient must immediately be referred to an appropriate physician or emergency facility. Also, retail-based health clinics urgent care centers should be encouraged to use electronic health records as a means of communicating information with the patient's primary physician and facilitating continuity of care.
3. Whether by electronic communication, or some other acceptable means, retail-based health clinics urgent care centers must send detailed information on services provided to the patient's primary care physician in a timely manner to ensure continuity of care.
4. The clinic must have a well-defined and limited scope of clinical services. These services must not exceed the on-site health provider's scope of practice, as determined by state law.
5. Retail-based health clinics AND urgent care centers ~~urgent care centers~~ must use standardized medical protocols developed from evidence-based practice guidelines for non-physician practitioners.
6. Retail-based healthcare clinics AND urgent care centers must comply with all applicable standards of state and federal regulations expected of physician offices.
7. Retail-based healthcare clinics and urgent care centers must not expand into programs offering patient care for the management of chronic and complex conditions.

Retail-based healthcare clinics located in or affiliated with a pharmacy must inform patients that any medication prescribed or recommended may be purchased at the patient's pharmacy of choice.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H304-A/15 PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN FOREIGN MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H304-A/15 PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN**
5 **FOREIGN MEDICAL SCHOOLS**
6 The American Osteopathic Association will officially adopt and advocate for the position that
7 federal student loans shall be restricted from medical schools not subject to the accreditation
8 standards of the Commission on Osteopathic College Accreditation or the Liaison Committee
9 on Medical Education. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H305-A/15 REMOVE FDA BAN ON ANONYMOUS SPERM DONATION FROM MEN WHO HAVE SEX WITH MEN

SUBMITTED BY: Bureau on Federal Health Programs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs and the Bureau on Scientific Affairs
2 and Public Health recommend that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H305-A/15 REMOVE FDA BAN ON ANONYMOUS SPERM DONATION FROM**
5 **MEN WHO HAVE SEX WITH MEN**
6 The American Osteopathic Association (AOA) will call for an end to the five-year deferment
7 period for anonymous sperm donation for men who have sex with men, and modify the
8 exclusion criteria for men who have sex with men to be consistent with deferrals for those to be
9 judged at an increased risk of infection. The AOA supports lobbying measures with the
10 intention of amending this policy. 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The FDA five-year deferment period for anonymous sperm donation for men who have sex with men has been in place since 2005.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H308-A/15 IMPROVING COMPETITIVE EDGE FOR MEMBERSHIP IN THE AOA

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H308-A/15 IMPROVING COMPETITIVE EDGE FOR MEMBERSHIP IN THE**
5 **AOA**
6 The American Osteopathic Association will review all membership dues, fees, and duration of
7 certification to become more cost competitive with allopathic organizations to help build and
8 maintain membership. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H312-A/15 TAX CREDIT FOR PRECEPTING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H312-A/15 TAX CREDIT FOR PRECEPTING**
5 The American Osteopathic Association (AOA) will SUPPORT ~~develop a template for model~~
6 ~~**STATE**~~ legislation ~~and a toolkit with strategies~~ to implement precepting tax credit**S** ~~legislation~~.
7 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Tax credits could be either state or federal.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H309-A/15 SITE NEUTRAL REIMBURSEMENT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H309-A/15 SITE NEUTRAL ~~REIMBURSEMENT~~ PAYMENT

The American Osteopathic Association (AOA) **SUPPORTS** that payments from all payers should reflect the resources required to provide patient care in each setting, ~~**and therefore, may vary to the extent that documented resource differences may vary**~~.

The AOA ~~**believes**~~ **SUPPORTS** that payments for all sites of care should account for costs incurred in that setting, and should take into account the nature of the patient population served by each type of provider and other factors, such as, but not limited to, the provision of care coordination, access to after-hours care, emergency care, quality activities, and regulatory compliance costs.

The AOA ~~**believes**~~ **SUPPORTS** that efforts should be made to collect comprehensive and reliable data regarding the extent of actual cost differences among sites of service, the impact of current site of service differentials on patient access; the extent to which recent site of service shifts are attributable to payment differentials; and the potential impact of the elimination or reduction of such differentials on providers' ability to cover their reasonable costs.

The AOA ~~**believes**~~ **SUPPORTS** that pending collection of such data, private and public payers should avoid reductions in payment that create or aggravate existing site of service differentials for services that are demonstrably similar in terms of nature, scope, and patient population.

The AOA ~~**believes**~~ **SUPPORTS** that Medicare patients should be provided access to data regarding differences in copayment requirements among various sites of service. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H311-A/15 SUPPORTING THE USE OF OMM IN THE VA

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H311-A/15 SUPPORTING THE USE OF OSTEOPATHIC MANIPULATIVE**
5 **MEDICINE (OMM) IN THE VETERANS ADMINISTRATION (VA)**
6 The American Osteopathic Association (AOA) will work with the Veterans Administration
7 (VA) to: 1) establish the position of National Osteopathic Manipulative Medicine (OMM)
8 Director within the Veterans Administration System; 2) create National VA Regulation
9 promoting the use of Osteopathic Manipulative Medicine; 3) create Manual Medicine Clinics; 4)
10 to hire physicians trained in Osteopathic Manipulative Medicine, to staff manual medicine
11 clinics within the department of Physical Medicine and Rehabilitation (PMR); 5) assist the
12 National OMM Director in coordinating support for manual medicine clinics by encouraging
13 Osteopathic Schools to sign Memorandum Of Understandings that allow osteopathic students
14 and residents to rotate through the manual medicine clinics and eventually apply for jobs in
15 these clinics on an equal opportunity basis; 6) and the AOA will work with Congress to pass
16 any legislation required to put forth the promotion of OMM in the VA (see policy background
17 in VHA Directive 2009-059 supporting Chiropractic Care. The AOA will continue to educate
18 the VA on the benefit of OMM to patient care. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H313-A/15 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRM AS AMENDED.

(Old language is crossed out and new language is in CAPS)

H313-A/15 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

The American Osteopathic Association and its component societies ~~be~~ **ARE** encouraged to ~~promote~~ SUPPORT OSTEOPATHIC PHYSICIANS AND THEIR PRACTICES ~~unity and the practice rights of osteopathic physicians,~~ by ~~establishing a specific Practice Rights agenda and support the development of seminars or other vehicles to carry out the following objectives~~: (1) WORKING WITH THE AMERICAN OSTEOPATHIC INFORMATION ASSOCATION TO educate physicians as to the importance of compliance, risk management, ~~at~~ AND risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues. (2). IdentifyING supportive STATE AND FEDERAL agencies, PROFESSIONAL liability INSURANCE companies, and physicians with expertise ~~in~~ **ON** these issues. (3) **ENCOURAGING** ~~EncourageING government AGENCIES and insurance agencies COMPANIES to utilize only expert witnesses~~ **GOVERNMENT AGENCIES AND INSURANCE COMPANIES TO UTILIZE ONLY EXPERT WITNESSES WHO ARE OSTEOPATHIC PHYSICIANS IN PEER REVIEW, FRAUD AND ABUSE, CIVIL AND CRIMINAL CASES INVOLVING OSTEOPATHIC PHYSICIANS AND BOARDS WITH "LIKE OSTEOPATHIC SPECIALTY". (4)** ~~who are osteopathic physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic physicians and boards with "like osteopathic specialty". (4)~~ ~~DevelopING and a~~Advis**E**~~eING the~~ AOA AND STATE SOCIETY leadership ~~and state societies~~ of ~~the~~ ANY needs, trends~~,~~ ~~and~~ OR issues of concern RELATED TO THE ABOVE**,** which will ~~encourage unity, and~~ enhance the RIGHTS AND practiceS ~~rights~~ of our fellow OSTEOPATHIC physicians. ~~The AOA will take steps to address the above listed issues at the national level.~~ 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____

DATE _____

SUBJECT: H314-A/15 RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H314-A/15 RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO,**
5 **NICOTINE OR VAPING PRODUCTS**
6 The American Osteopathic Association discourages the placement of medical practices AND
7 LIMITED SERVICE CLINICS in retail settings ~~and limited service health clinics~~ that promote
8 and sell tobacco because it is contrary to the efforts and standards of the health care community
9 at large. 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H315-A/15 OSTEOPATH AND OSTEOPATHY - USE OF THE TERM

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H315-A/15 OSTEOPATH AND OSTEOPATHY - USE OF THE TERM**
5 The American Osteopathic Association policy both officially in our publications and
6 individually on a conversational basis, is to preferentially use the term "osteopathic physician"
7 in place of the word "osteopath" and the term "osteopathic medicine" in place of the word
8 "osteopathy;" and that the words "osteopath" and "osteopathy" be reserved in the United
9 States for the following purposes: (1) previously named entities within the osteopathic medical
10 profession; (2) historical, sentimental and informal discussions; and (3) osteopaths with a
11 limited scope of practice. 1994; reaffirmed 2000; revised 2005; revised 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H317-A/15 PATIENT ACCESS IN RURAL AREAS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H317-A/15 PATIENT ACCESS IN RURAL AREAS**
5 The American Osteopathic Association supports policy on the state and federal levels that
6 would require all managed care health plans to have reasonably placed network physicians and
7 hospital access; if the distance is unreasonable, the plans should pay for out of network
8 services at no additional cost to the patient. 1995; revised 2000, 2005, 2010; revised 2015

Explanatory Statement: Submitted by Author
Submitted a new resolution for consideration by 2020 HOD that combines this policy with H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE.

Background Information: Provided by AOA Staff
Current AOA Policy: H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE.

Prior HOD action on similar or same topic: Policy approved in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H318-A/15 PHYSICIAN OFFICE LABORATORIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H318-A/15 PHYSICIAN OFFICE LABORATORIES**
5 The American Osteopathic Association supports the development and expansion of Waived
6 Physician Office Laboratory testing and will work to ensure that physician office laboratory
7 certification be as non-intrusive into the practice of medicine as possible; and will seek
8 assurances that access to any laboratory tests deemed medically necessary by the physician, not
9 be limited by unnecessary regulations. 1990; revised 1995, 2000, 2005, 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H319-A/15 POSTGRADUATE COMPENSATION

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H319-A/15 POSTGRADUATE COMPENSATION**
5 The American Osteopathic Association affirms its support for ~~maintaining and~~ enhancing the
6 quality of teaching programs, and urges Congress to provide more equitable graduate medical
7 education funding so hospitals and other healthcare delivery systems can provide competitive
8 compensation for postgraduate training. 1990; revised 1995; reaffirmed 2000, revised 2005,
9 reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Maintaining and enhancing are two separate actions which are mutually exclusive of one another.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H320-A/15 SECOND OPINION, SURGICAL CASES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H320-A/15 SECOND OPINION, SURGICAL CASES**
5 The American Osteopathic Association believes that AOA members who are board certified, or
6 board eligible and qualified by their training and experience to render a second surgical opinion
7 in any given case, be recognized and utilized as qualified and reimbursed by entities
8 underwriting such opinions and that this policy statement in no way advocates the institution of
9 any mandatory second surgical opinion programs, by any entity. 1980; revised 1985, 1990;
10 reaffirmed 1995; revised 2000, 2005, revised 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H322-A/15 UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H322-A/15 UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS**
5 **SERVING IN THE UNIFORMED SERVICES**
6 The American Osteopathic Association(AOA) will continue to assist the Surgeons General of
7 the uniformed services and the American public in maintaining and assuring the highest quality
8 of healthcare by its representatives in the uniformed services and recognizes the ~~55th~~ **ANNUAL**
9 anniversary of osteopathic physicians being commissioned in the military. 1985; revised 1990,
10 1995; 2000, 2005; revised 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H323-A/15 EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H323-A/15 EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

The American Osteopathic Association (AOA) supports the availability ~~of~~ TO state of the art emergency medical care for ill and injured children and adolescents; that pediatric services are well integrated into an emergency medical service system backed by optimal resources; and the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, are provided to children and adolescents as well as adults, no matter where they live, attend school or travel. The federal Emergency Medical Services for Children (EMSC) program achieves these goals and as such, AOA supports full funding and reauthorization of this program WHEN NEEDED. 2005, reaffirmed 2010; reaffirmed as revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____

DATE _____

SUBJECT: H324-A/15 PHYSICIAN INCENTIVES TO UNDERSERVED AREAS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H324-A/15 PHYSICIAN INCENTIVES TO UNDERSERVED AREAS**
5 The American Osteopathic Association will ~~focus attention on potential~~ SUPPORT
6 FEDERAL AND STATE legislation to increase physician loan repayment programs and tax
7 deductions/~~ or tax ~~credits FOR INDIVIDUALS WHO ~~when initiating a~~ practice in
8 underserved RURAL AND URBAN areas~~ to assist and assure an adequate supply of physicians~~
9 ~~in the future~~. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H326-A/15 VACCINES SHORTAGES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H326-A/15 ACCESS TO VACCINES ~~SHORTAGES~~**
5 The American Osteopathic Association (AOA) will COMMUNICATE WITH THE
6 CENTERS FOR DISEASE CONTROL AND PREVENTION ~~AND~~ **AS WELL AS** FOOD
7 AND DRUG ADMINISTRATION ON ISSUES RELATING TO SCHEDULE
8 ADHERENCE AND VACCINE SHORTAGES AND WILL ENGAGE FEDERAL
9 LAWMAKERS ON POLICY SOLUTIONS AS NEEDED**.** ~~outreach federal legislators and~~
10 ~~the Centers for Disease Control & Prevention on the critical issue of vaccine shortage.~~ The
11 AOA will also communicate ANY ACTIONS BEING TAKEN TO URGE ~~that steps be taken~~
12 ~~to give manufacturers of vaccine immunity from lawsuits because of complications which are~~
13 ~~not due to negligence; that~~ additional U.S. companies ~~will be urged~~ to manufacture vaccines for
14 ~~the~~ U.S. citizens~~; and that the public be provided information on potential side effects and~~
15 ~~complications of vaccines so they are fully informed and responsible for their decision to be~~
16 ~~immunized~~. 2005; revised 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H329-A/15 MEDICARE BALANCE BILLING

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H329-A/15 MEDICARE BALANCE BILLING**
5 The American Osteopathic Association (AOA) SUPPORTS ENACTMENT OF FEDERAL
6 LEGISLATION THAT PROMOTES EQUITABLE BALANCE BILLING PRACTICES
7 WITHIN MEDICARE THAT FACILITATE CONTINUED PHYSICIAN
8 PARTICIPATION IN MEDICARE. ~~**encourages federal legislation to support Medicare**~~
9 ~~**balance billing and take the necessary steps to initiate federal legislation to achieve**~~
10 ~~**balance billing for Medicare patients to support continued participation by physicians**~~.
11 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H332-A/15 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H332-A/15 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES**
5 The American Osteopathic Association will continue to encourage the US Drug Enforcement
6 Administration to modify rules to reduce any potential administrative barriers to electronic
7 prescribing of controlled substances. Electronic prescribing systems should be interoperable
8 with data collection and tracking systems for the prescribing of controlled substances. 2010;
9 reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
The content of this resolution is already covered by H318-A/19 which was approved last year. This policy is duplicative and therefore should be sunset.

Background Information: Provided by AOA Staff
Current AOA Policy: H318-A/19 ELECTRONIC PRESCRIBING

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H334-A/15 PROFESSIONAL ORGANIZATION -- PHYSICIANS CHOOSING TO WHICH THEY BELONG

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of Membership recommend that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H334-A/15 PROFESSIONAL ORGANIZATION -- PHYSICIANS CHOOSING TO**
5 **WHICH THEY BELONG**
6 The American Osteopathic Association supports all physicians having the right to choose
7 which medical associations they join, even when the employer is paying the membership fees;
8 and will provide the physician with a letter template stating their desire to have dues paid to an
9 osteopathic medical association. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
The AOA acknowledges that the number of employed physicians is increasing each year.

The AOA strongly supports and advocates this self-determination of choice of medical association membership.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H335-A/15 PRESCRIPTION DRUG DIVERSION AND ABUSE – EDUCATION, RESEARCH, AND ADVOCACY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H335-A/15 PRESCRIPTION DRUG DIVERSION AND ABUSE – EDUCATION, RESEARCH, AND ADVOCACY

The American Osteopathic Association (AOA) will advance knowledge and understanding of appropriate use of prescription drugs through the education of the public and osteopathic medical education at all levels.

The AOA will work with other associations representing health care professionals to educate on the indicators of potential prescription drug abuse, misuse and diversion. The AOA will encourage the Institute of Medicine and other private and public organizations/agencies to conduct further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse, misuse and diversion.

The AOA will advocate for evidence-informed use of state prescription monitoring programs, tamper resistant drug formulas and support efforts to assist state osteopathic medical associations in developing physician drug abuse, misuse and diversion awareness and prevention education programs.

The AOA supports policies that do not hinder patient access to and coverage of appropriate pharmacologic and non-pharmacologic treatments. It is a right of all patients to have access to medically appropriate intervention and/or treatment for conditions, including acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective treatment, including pain control, for all their patients.

The AOA will not support any program which limits access to prescription drugs for patients with legitimate need and will not support any program which reduces the provider's ability to inform the patient's care. In addition, it is in the best interest of all patients not to confine, or seek to regulate medications, including opioid/opiate, by limiting their use to a small number of selected specialties of medicine. This would also extend to modalities now developed, or yet to be developed, such as long-acting opioid/opiate preparations. These exclusionary strategies will limit access for patients with medical indications for therapy, complicate delivery of care, and add to pain and suffering of patients.

The AOA will continue to cooperate with the pharmaceutical industry, law enforcement, and government agencies to stop prescription drug abuse, misuse and diversion as a threat to the health and well-being of the American public.

1 The AOA opposes the imposition of administrative or financial deterrents that decrease access
2 to and coverage of prescription drugs with abuse-deterrent properties. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE**
5 **COVERAGE**
6 The American Osteopathic Association (AOA) recommends that state Medicaid administrators
7 remove any arbitrary and restrictive limits for buprenorphine coverage and that state Medicaid
8 administrators and third party payers recognize that chronic disease management includes a
9 combination of psychotherapeutic and pharmacological interventions that will yield the best
10 outcomes for patients with opioid use disorder. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H337-A/15 VIOLENCE AGAINST HEALTHCARE STAFF

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H337-A/15 VIOLENCE AGAINST HEALTHCARE STAFF**
5 The American Osteopathic Association supports LEGISLATION TO ~~legislative change~~ hold
6 patients and their associates (that includes friends, family, and anyone WHO ACCOMPANIES
7 ~~that affiliates with~~ them) accountable for PHYSICAL ASSAULT AND VERBAL THREATS
8 TO HEALTH CARE STAFF by upgrading penalties under **FEDERAL AND** relevant state
9 ~~laws~~ **LAW AND LEGISLATION** from misdemeanors to felonies where applicable. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H338-A/15 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF

SUBMITTED BY: Bureau on Osteopathic Clinical Education & Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Osteopathic Clinical Education & Research recommend that the following policy be REAFFIRMED:

(Old language is crossed out and new language is in CAPS)

H338-A/15 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF

The American Osteopathic Association approves the attached Guidelines for Patients with Low Back Pain. 2009; referred 2014; reaffirmed as amended 2015.

American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain

Executive Summary:
The American Osteopathic Association recommends that osteopathic physicians use Osteopathic manipulative treatment (OMT) in the care of patients with low back pain. Evidence from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a) supports this recommendation.

1. Overview material: Provide a structured abstract that includes the guideline's release date, status (original, revised, updated), and print and electronic sources.

~~**Release Date (expected) August 1, 2015.**~~ **THE CURRENT** ~~**This G**~~guideline**S ARE** ~~**is**~~ available through the AOA web site and National Guidelines Clearinghouse, AHRQ. The guideline is partially based upon the following study:

Franke H, Franke J-D, Fryer G. Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders 2014, 15:286 doi:10.1186/1471-2474-15-286. (Published: 30 August 2014)

The format used for this guideline is in accordance with the 2013 (Revised) Criteria for Inclusion of Clinical Practice Guidelines in NGC and uses the 2011 definition of clinical practice guideline developed by the Institute of Medicine (IOM): "Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options".

ABSTRACT

Background
Osteopathic manipulative treatment (OMT) is a distinctive modality commonly used by osteopathic physicians to complement conventional treatment of musculoskeletal disorders, including those that cause low back pain. OMT is defined in the Glossary of Osteopathic Terminology as: "The therapeutic

application of manually guided forces by an osteopathic physician (US Usage) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques" (see Appendix 1 for list). Somatic dysfunction is defined as: "Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment."

This guideline updates the AOA guideline for osteopathic physicians to utilize OMT for patients with nonspecific acute or chronic LBP published in 2010 on the National Guideline Clearinghouse.[1]

Methods

This guideline update process commenced with literature searches that included electronic databases, personal contact with key researchers of OMT and low back pain, and internet search engines. Early in the process, the AOA discovered the systematic literature review conducted by Franke, Franke and Fryer (2014)[2] which serves as the basis for this updated guideline.

Franke et al searched electronic databases, reference lists and personal communications. Their inclusion criteria consisted of randomized clinical trials of adults (>18 years of age) with nonspecific back pain treated by osteopathic physicians or osteopaths who used their clinical judgment as opposed to a standard predetermined protocol. Studies with pregnant and postpartum participants were also included. Studies excluded from the review were those where co-interventions were not performed on both comparison groups; the OMT intervention could not be assigned an effect size; participants had specific back pain from pathology (i.e., fracture, tumor, metastasis, inflammation, infection); or the intervention consisted of a single manual technique (see Appendix 2 for the list of references in Franke et al).

The primary outcomes for the Franke et al review were pain and functional status. The authors measured pain using the visual analogue scale (VAS), number rating scale (NRS), or the McGill Pain Questionnaire. Functional status was measured using the Roland-Morris Disability Questionnaire, Oswestry- Disability Index, or other valid instrument. The point of measurement for both outcomes was the first 3 month interval.

Studies were independently reviewed using a standardized form. The mean difference (MD) or standard mean difference (SMD) with 95% confidence intervals (CIs) and overall effect size were calculated at 3 months post treatment. GRADE approach, as recommended by the updated Cochrane Back Review Group method guidelines, was used to assess quality of evidence.

Results

The authors of the systematic review identified 307 studies. Thirty-one were evaluated and 16 excluded. Of the 15 studies included in the review, 6 were retrieved from the grey literature in Germany, 5 from the United States, 2 from the United Kingdom, and 2 from Italy. Ten studies investigated effectiveness of OMT for nonspecific LBP, 3 studies examined the effect of OMT for LBP in pregnant women, and 2 studied the effect of OMT for LBP in postpartum women. All studies reported on the effect of OMT on pain, and all but one reported on back pain specific functional status. There were a total of 1502 participants included in the qualitative and quantitative analysis.

OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP. Franke et al found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95%CI: -0.58 to -0.14). More specifically, in chronic nonspecific LBP, evidence suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95%CI:-25.18 to -4.68) and functional status (SMD:-0.32, CI:-0.58 to

-0.07). When examining nonspecific LBP in pregnancy, low-quality evidence suggested a significant difference in favor of OMT for pain (MD, -23.01; 95% CI, -44.13 to -1.88) and functional status (SMD, -0.80; 95% CI, - 1.36 to -0.23). Conversely for nonspecific LBP postpartum, Franke et al found that moderate-quality evidence suggested a significant difference in favor of OMT for pain (MD, -41.85; 95% CI, -49.43 to -34.27) and functional status (SMD, -1.78; 95% CI, -2.21 to -1.35).[2]

Conclusions

Clinically relevant effects of OMT were found for reducing pain and improving functional status in patients with acute and chronic nonspecific LBP and for LBP in pregnant and postpartum women at 3 months post treatment.

OMT significantly reduces low back pain. The level of pain reduction is clinically important, greater than expected from placebo effects alone, and may persist through the first year of treatment. Additional research is warranted to elucidate mechanistically how OMT exerts its effects, to determine if OMT benefits extend beyond the first year of treatment, and to assess the cost-effectiveness of OMT as a complementary treatment for low back pain.

2. Focus: Describe the primary disease/condition and intervention/service/technology that the guideline addresses. Indicate any alternative preventive, diagnostic or therapeutic interventions that were considered during development.

These guidelines are intended to assist osteopathic physicians in appropriate utilization of OMT for patients with low back pain. Other alternative preventive, diagnostic and therapeutic interventions considered during development of these guidelines were those noted in the following published guidelines for physicians caring for patients with low back pain:

> 1) Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK: Clinical Efficacy Assessment Subcommittee of the American College of Physicians, American College of Physicians, American Pain Society Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med 2007 Oct 2;147(7):478-91)

BACKGROUND

Historically, low back pain has been the most common reason for visits to osteopathic physicians.[3] More recent data from the Osteopathic Survey of Health Care in America has confirmed that a majority of patients visiting osteopathic physicians continue to seek treatment for musculoskeletal conditions.[4, 5] A distinctive element of low back care provided by osteopathic physicians is osteopathic manipulative treatment (OMT). A comprehensive evaluation of spinal manipulation for low back pain undertaken by the Agency for Health Care Policy and Research in the United States concluded that spinal manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms.[6]Nevertheless, because most studies of spinal manipulation involve chiropractic or physical therapy,[7]it is unclear if such studies adequately reflect the efficacy of OMT for low back pain. Although the professional bodies that represent osteopaths, chiropractors, and physiotherapists in the United Kingdom developed a spinal manipulation package consisting of three common manual elements for the UK Back pain Exercise and Manipulation (UK BEAM) trial,[8] there are no data on the comparability of profession specific outcomes.[9,10] It is well known that OMT comprises a diversity of techniques.[11] These OMT techniques are not adequately represented by the UK BEAM trial package. Professional differences in spinal manipulation are more pronounced in research studies, in which chiropractors have focused almost exclusively on high-velocity-low amplitude techniques.[12] For example, a major trial of chiropractic manipulation as adjunctive treatment for childhood asthma used a high-velocity-low amplitude thrust as the active treatment.[13] The simulated

treatment provided in the sham manipulation arm of this chiropractic trial, which ostensibly was used to provide no therapeutic effect, bore a marked similarity to OMT.[12, 14] Because differences in professional background and training lend themselves to diverse manipulation approaches, clinicians have been warned about generalizing the findings of systematic reviews to practice.[15] In additional to professional differences in the manual techniques themselves, osteopathic physicians in the United States, unlike allopathic physicians or chiropractors, can treat this condition simultaneously using both conventional primary care approaches and complementary spinal manipulation. This represents a unique philosophical approach in the treatment of low back pain. Consequently, there is a need for empirical data that specifically address the efficacy of OMT for conditions such as low back pain.[16]

These guidelines are based on a systematic review of the literature on OMT for patients with low back pain and a meta-analysis of all randomized controlled trials of OMT for patients with low back pain in ambulatory settings.[2]

3. Goal: Describe the goal that following the guideline is expected to achieve, including the rationale for development of a guideline on this topic.

The goal of these guidelines is to enable osteopathic physicians as well as other physicians, other health professionals, and third party payers, to understand the evidence underlying recommendations for appropriate utilization of OMT, which is not detailed in the current sets of guidelines developed by other physicians. The American Osteopathic Association does not believe it is appropriate for other professionals to create guidelines for utilization of OMT since it is not a procedure or approach used by those physicians. It is, however, the purview and duty of the American Osteopathic Association to inform its members and the public about the appropriate utilization of OMT.

4. Users/setting: Describe the intended users of the guideline (e.g., provider types, patients) and the settings in which the guideline is intended to be used.

These guidelines are to be used by osteopathic physicians in application of OMT to patients with nonspecific low back pain, which can be defined as tension, soreness, or stiffness in the lower back region with an unidentified cause[2], in the ambulatory setting.

5. Target population: Describe the patient population eligible for guideline recommendations and list any exclusion criteria.

Patients with nonspecific low back pain of musculoskeletal origin are eligible for guideline recommendations. Patients with visceral disease conditions that refer pain to the low back are excluded from these guidelines. Other conditions of exclusion are when the following are the identified source of the low back pain: vertebral fracture; vertebral joint dislocation; muscle tears or lacerations; spinal or vertebral joint ligament rupture; inflammation of intervertebral discs, spinal zygapophyseal facets joints, muscles or fascia; skin lacerations; sacroiliitis; ankylosing spondylitis; or masses in or from the low back structures that are the source of the pain. Exclusion from this guideline does not imply that OMT is contraindicated in these conditions.

6. Developer: Identify the organization(s) responsible for guideline development and the names/credentials/potential conflicts of interest of individuals involved in the guideline's development.

American Osteopathic Association, Bureau of Osteopathic Clinical Education and Research, Task Force on the Low Back Pain Clinical Practice Guidelines: Richard J. Snow, DO, MPH, (chair), Michael Seffinger, DO, Kendi Hensel, DO, PhD, and Rodney Wiseman, DO.

7. Funding source/sponsor: Identify the funding source/sponsor and describe its role in developing and/or reporting the guideline. Disclose potential conflict of interest.

This project was funded by the American Osteopathic Association. The AOA Bureau of Osteopathic Clinical Education and Research convened a Task Force on the Low Back Pain Clinical Practice Guidelines to revise the guidelines. Upon approval of these recommendations by the AOA Board of Trustees and the AOA House of Delegates, the guidelines will be submitted to the National Guidelines Clearinghouse for public record and access. As the guidelines were developed based on the peer reviewed scientific literature, no conflict of interest is claimed by the developers. A well rounded, objective perspective is presented. Any views from an osteopathic perspective that is not supported by the scientific literature is stated and clearly identified so the reader is able to discern any potential for bias.

8. Evidence collection: Describe the methods used to search the scientific literature, including the range of dates and databases searched, and criteria applied to filter the retrieved evidence.

This guideline update process commenced with literature searches that included electronic databases, personal contact with key researchers of OMT and low back pain, and internet search engines. Early in the process, the AOA discovered the systematic literature review conducted by Franke, Franke and Fryer (2014) which serves as the basis for this updated guideline.

Franke et al[2] searched electronic reference databases, Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, Embase, CINAHL, PEDro, OSTMED.DR, and Osteopathic Web Research using thefollowing search terms: low back pain, back pain, lumbopelvic pain, dorsalgia, osteopathic manipulative treatment, OMT, and osteopathic medicine. In addition to the listed databases, the authors conducted searches in anongoing trial database (metaRegister of Controlled Trials. To enhance their search, the authors tracked citations of identified trials, and manually searched reference lists for other relevant papers.

The authors reviewed all the studies using a standardized form, and all mean differences (MD) and standard mean differences (SMD) were calculated with 95% confidence intervals (CIs). Overall effect size was calculated at the 3month post treatment follow-up. GRADE approach, as recommended by the updated Cochrane Back Review Group method guidelines, was used to assess quality of evidence.

9. Recommendation grading criteria: Describe the criteria used to rate the quality of evidence that supports the recommendations and the system for describing the strength of the recommendations. Recommendation strength communicates the importance of adherence to a recommendation and is based on both the quality of the evidence and the magnitude of anticipated benefits or harms.

Franke et al[2] evaluated the methodological quality of the studies using the Risk of Bias tool of the Cochrane Back Review Group. Studies were scored as 'low risk', 'high risk', or 'unclear', and included assessments of randomization, blinding, baseline comparability between groups, patient compliance, and dropping out. Per the Cochrane Back Review Group, studies received a 'low risk' score when a minimum of 6 criteria were met and it was determined that the study had no serious flaws (e.g., a drop-out rate over 50%). Disagreements about the quality of the studies were resolved through discussion and consensus. Franke et al used Review Manager to analyze the data for the meta-analysis. The authors converted the NRS and VAS scores from the included studies to a 100-point scale for the pain measurement, and calculated the mean difference (MD) with 95% CIs for the random effects model.

Franke et al conducted other noteworthy analysis. They used the standard mean difference (SMD) was also used in a random effects model to determine functional status. The authors grouped the 1 study examining acute LBP and the 3 studies examining patients with both acute and chronic LBP together for the purpose of their meta-analyses. Overall, they created four groups: (1) acute and chronic LBP;

(2) chronic LBP (duration of pain more than 3 months); (3) LBP in pregnant women; and (4) LBP in postpartum women.

Franke et al also assessed the clinical relevance of each study using the Cochrane Back Review Group recommendations. A small effect was defined as MD less than 10% of the scale and SMD less than 0.5. A medium effect was defined as MD 10% to 20% of the scale and SMD from 0.5 to 0.8. A large effect was defined as MD greater than 20% of the scale and SMD greater than 0.8.

10. Method for synthesizing evidence: Describe how evidence was used to create recommendations, e.g., evidence tables, meta-analysis, decision analysis.

Due to the applicability of the Franke et al review to this updated guideline and consequently, the reliance thereon, the AOA will describe how the authors synthesized their evidence.

OMT versus other interventions for acute and chronic nonspecific low back pain

Franke et al[2] analyzed the effect of OMT for pain in acute and chronic LBP using ten studies with 12 comparison groups and 1141 participants. Six studies reported a significant effect of OMT on pain, 3 studies showed a non-significant effect, and 3 studies reported a non-significant effect in favor of the control treatment. Collectively, the studies showed moderate-quality evidence that OMT had a significant effect on pain relief (MD:-12.91, 95% CI: −20.00 to −5.82).

For functional status, the authors based their results on 9 studies with 10 comparisons groups and 1046 participants. The studies revealed moderate-quality evidence that a significant difference in favor of OMT existed (SMD:-0.36, 95%CI: −0.58 to −0.14). Four studies reported a significant effect of OMT, 3 studies reported a non- significant effect, and 1 study reported a non-significant effect in favor of the control group.

OMT versus other interventions for chronic nonspecific low back pain

For nonspecific LBP, Franke et al[2] analyzed 6 studies with 7 comparisons and 769 participants. This analysis revealed moderate-quality evidence that a significant difference in favor of OMT existed (MD:-14.93, 95%CI:-25.18 to −4.68)

For functional status outcomes, the authors reviewed 3 studies which reported a significant improvement for OMT. One study reported a non-significant effect for OMT, and 1 study reported an effect for the control group Collectively, the analysis showed moderate-quality evidence for a significant difference in favor of OMT (SMD:-0.32, CI:-0.58 to −0.07).

OMT versus usual obstetric care, sham ultrasound, and untreated for nonspecific low back pain in pregnant women

For LBP in pregnant women, the authors reviewed three studies with 4 comparisons and 242 participants. Two studies showed a significant improvement following OMT, and 1 study showed a non-significant improvement. The final analysis of these studies resulted in low- quality evidence for a significant difference in favor of OMT for LBP in pregnant women (MD, −23.01; 95% CI, −44.13 to −1.88) and functional status (SMD, −0.80; 95% CI, −1.36 to −0.23).[2]

Hensel, et al[17] found that OMT was effective for mitigating pain and functional deterioration compared with usual care only; however, OMT did not differ significantly from placebo ultrasound treatment. The authors concluded that OMT is a safe, effective adjunctive modality to improve pain and functioning during the third trimester.

OMT versus untreated for nonspecific low back pain in postpartum women

Franke et al reviewed two studies focusing on OMT for LBP in postpartum women. Both studies reported significant improvement following OMT. The moderate-quality evidence showed a significant difference in favor of OMT for pain (MD, −41.85; 95% CI, −49.43 to −34.27) and functional status (SMD, −1.78; 95% CI, −2.21 to −1.35).

DISCUSSION

Efficacy of OMT

The overall results clearly demonstrate a statistically significant reduction in low back pain with OMT. Subgroup meta-analyses to control for moderator variables demonstrated that OMT significantly reduced low back pain vs active treatment or placebo control and vs no treatment control. If it is assumed, as shown in a review[18], that the effect size is –0.27 for placebo control vs no treatment in trials involving continuous measures for pain, then the results of our study are highly congruent (i.e., effect size for OMT vs no treatment [–0.53] = effect size for OMT vs active treatment or placebo control [–0.26] + effect size for placebo control vs no treatment [–0.27]). It has been suggested that the therapeutic benefits of spinal manipulation are largely due to placebo effects.[19] A preponderance of results from our sensitivity analyses supports the efficacy of OMT vs active treatment or placebo control and therefore indicates that low back pain reduction with OMT is attributable to the manipulation techniques, not merely placebo effects. Also, as indicated above, OMT vs no treatment control demonstrated pain reductions twice as great as previously observed in clinical trials of placebo vs no treatment control.[18] The clinical significance of our findings is readily evident when compared with nonsteroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors. A recent meta-analysis of the efficacy of these drugs included 23 randomized placebo controlled trials for osteoarthritic knee pain, representing over 10,000 subjects, and measured pain outcomes up to three months following randomization.[20] This study found an overall effect size of –0.32 (95% CI, –0.24 - –0.39) and effect size of –0.23 (95% CI, –0.16 - –0.31) when drug non-responders were not excluded from the analyses. Thus, our effect size of –0.26 (95% CI, –0.48 - –0.05) for OMT in trials vs active treatment or placebo control suggests that OMT provides an analgesic effect comparable to nonsteroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors. Unlike the meta-analysis of nonsteroidal anti-inflammatory drugs,[20] however, Licciardone et al found that OMT also significantly reduced pain during the three to 12 month period following randomization.[21] Thus, OMT for low back pain may eliminate or reduce the need for drugs that can have serious adverse effects.[22] Because osteopathic physicians provide OMT to complement conventional treatment for low back pain, they tend to avoid substantial additional costs that would otherwise be incurred by referring patients to chiropractors or other practitioners.[23]With regard to back pain, osteopathic physicians make fewer referrals to other physicians and admit a lower percentage of patients to hospitals than allopathic physicians,[3] while also treating back pain episodes with substantially fewer visits than chiropractors.[24] Although osteopathic family physicians are less likely to order radiographs or prescribe nonsteroidal anti-inflammatory drugs, aspirin, muscle relaxants, sedatives, and narcotic analgesics for low back pain than their allopathic counterparts, osteopathic physicians have a substantially higher proportion of patients returning for follow-up back care than allopathic physicians.[25] In the United Kingdom, where general practitioners may refer patients with spinal pain to osteopaths for manipulation, it has been shown that OMT improved physical and psychological outcomes at little extra cost.[26]

Licciardone et al [27], in the OSTEOPAThic Health outcomes In Chronic low back pain (OSTEOPATHIC) Trial studied OMT and ultrasound therapy for short term relief of nonspecific chronic low back pain. The authors found that the patients receiving OMT showed moderate to substantial improvements in low back pain which met or exceeded the Cochrane Back Review Group criterion for a medium effect size in relieving chronic low back pain.

11. Prerelease review: Describe how the guideline developer reviewed and/or tested the guidelines prior to release.

Guidelines were reviewed by the Bureau of Osteopathic Clinical Education and Research, the AOA Board of Trustees, and the AOA House of Delegates.

12. Update plan: State whether or not there is a plan to update the guideline and, if applicable, an expiration date for this version of the guideline. The guidelines will be updated every 5 years.

13. Definitions: Define unfamiliar terms and those critical to correct application of the guideline that might be subject to misinterpretation.

OMT referred specifically to manual treatment provided by osteopathic physicians, or other physicians who had demonstrated training and proficiency in OMT, such as those practitioners in Europe who may have undertaken osteopathic conversion programs.

14. Recommendations and rationale: State the recommended action precisely and the specific circumstances under which to perform it. Justify each recommendation by describing the linkage between the recommendation and its supporting evidence. Indicate the quality of evidence and the recommendation strength, based on the criteria described in 9.

Based on this meta-analysis (evidence level 1a – see Table 1) of RCTs on OMT for patients with low back pain, it is recommended that OMT be utilized by osteopathic physicians for musculoskeletal causes of low back pain, i.e., to treat the diagnoses of somatic dysfunctions related to the low back pain.

Table 1. Levels of Evidence

Strength of evidence	Type of Study	Comment
1a	Systematic review with homogeneity of randomized controlled trials	Individual trials should be free of substantial variations in the directions and magnitudes of results
1b	Individual randomized controlled trial with narrow confidence interval	Confidence interval should indicate a clinically important OMT effect
1c	Differential frequency of adverse outcomes	An adverse outcome was frequently observed in patients who did not receive OMT, but was infrequently observed in patients who did receive OMT (equivalent to a small number needed to treat)
2a	Systematic review with homogeneity of cohort studies	Individual studies should be free of substantial variations in the directions and magnitudes of OMT effects

2b	Individual cohort study or low-quality randomized controlled trial	Low quality may be indicated by such factors as important differences in baseline characteristics between groups, lack of concealment of treatment allocation, and excessive losses to follow-up
3a	Systematic review with homogeneity of case-control studies	Individual studies should be free of substantial variations in the directions and magnitudes of OMT effects
3b	Individual case-control study	These should be free of substantial evidence of selection bias, information bias, or confounding variables
4	Case series and low quality cohort and case-control studies	Low quality of cohort and case control studies may be indicated by such factors as important sources of selection bias, information bias, or confounding variables
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research, or "first principles"	These generally will have limited empirical data relevant to OMT effects in human populations

*Adapted from Straus SE, Richardson WS, Glasziou P, and Haynes RB, Evidence-Based Medicine. How to Practice and Teach EBM (3rd ed), 2005

15. Potential benefits and harms: Describe anticipated benefits and potential risks associated with implementation of guideline recommendations.

Potential benefits include but are not limited to improved care for patients seeing osteopathic physicians or practitioners for somatic dysfunctions causing low back pain. Harms have not been identified in randomized clinical trials on OMT for patients with low back pain. OMT for somatic dysfunction has not demonstrated harm in any clinical trials to date.

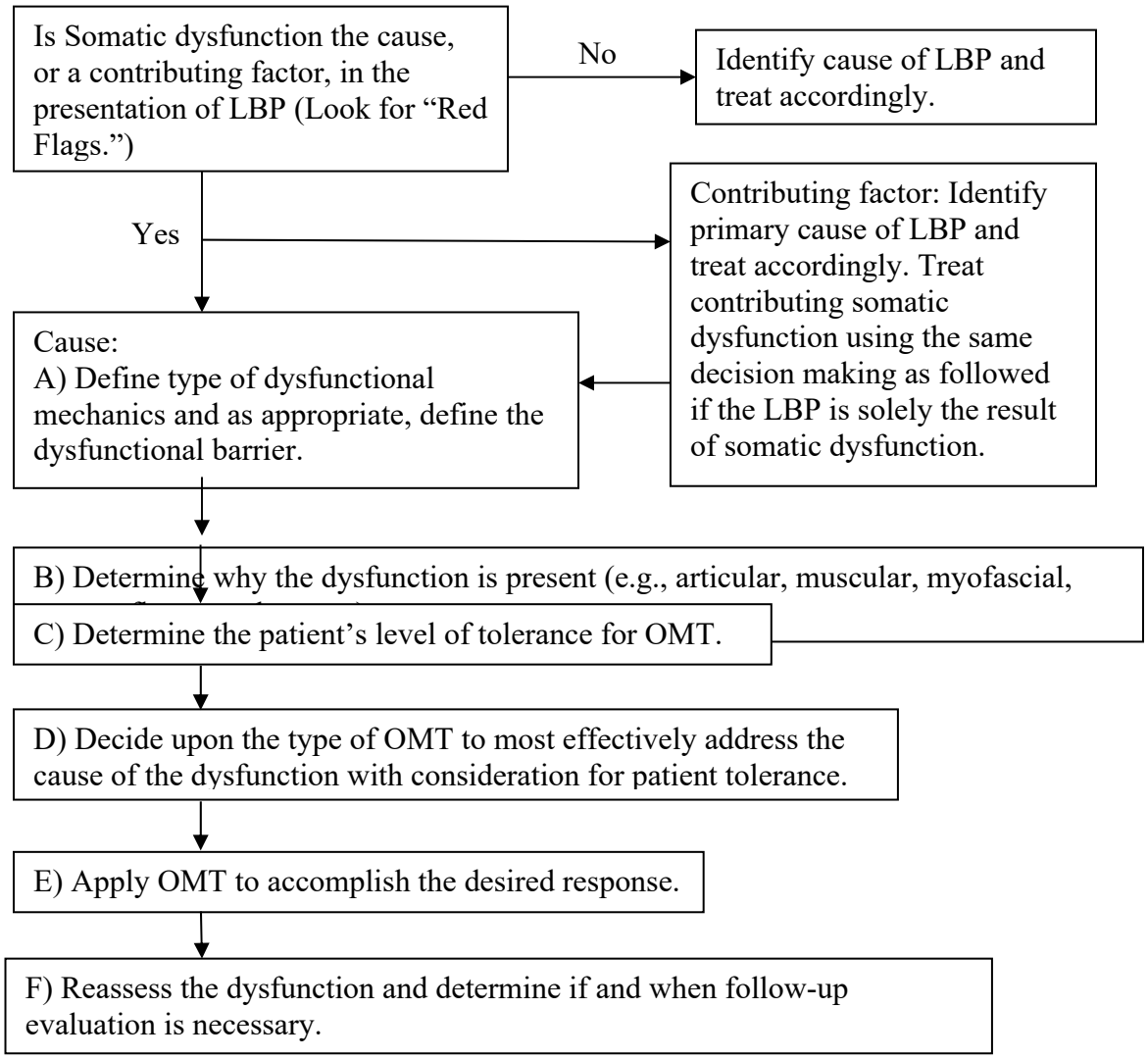
16. Patient preferences: Describe the role of patient preferences when a recommendation involves a substantial element of personal choice or values.

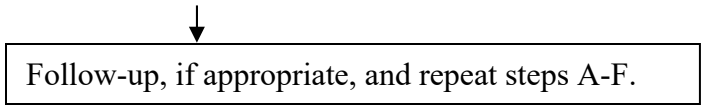
Patients have a choice of provider and services when they suffer from low back pain. OMT offers another option for care for low back pain from somatic dysfunction and can be provided by osteopathic physicians. It is utilized as an adjunct or complementary to conventional or alternative methods of treatment.

17. Algorithm: Provide (when appropriate) a graphical description of the stages and decisions in clinical care described by the guideline.

Once a patient with low back pain is diagnosed with somatic dysfunction as the cause, or contributing factor, of the low back pain, OMT should be utilized by the osteopathic physician. The diagnosis of somatic dysfunction entails a focal or complete history and physical exam, including an osteopathic structural exam that provides evidence of asymmetrical anatomical landmarks, restriction or altered range of joint motion, and palpatory abnormalities of soft tissues. OMT to treat somatic dysfunction is utilized after other potential causes of low back pain are ruled out or considered improbable by the treating physician; i.e., vertebral fracture; vertebral joint dislocation; muscle tears or lacerations; spinal or vertebral joint ligament rupture; inflammation of intervertebral discs, spinal zygapophyseal facets joints, muscles or fascia; skin lacerations; sacroiliitis; ankylosing spondylitis; masses in or from the low back structures; or organic (visceral) disease referring pain to the back or causing low back muscle spasms.

Algorithm for OMT LBP decision making.
Adapted from: Chapter 4. "The manipulative prescription," In: Somatic Dysfunction in Osteopathic Family Medicine. Nelson, Glonek, eds., Baltimore, MD: Lippincott, Williams & Wilkins; 2007;27-32.





18. Implementation considerations: Describe anticipated barriers to application of the recommendations. Provide reference to any auxiliary documents for providers or patients that are intended to facilitate implementation. Suggest review criteria for measuring changes in care when the guideline is implemented.

One of the barriers to application of the recommendations cited by osteopathic physicians has been poor reimbursement for OMT.[28] However, Medicare has reimbursed osteopathic physicians for this procedure (ICD-9 code: 98926-9), for over 30 years. Many osteopathic physicians apparently do not utilize OMT in clinical practice due to a number of barriers, including time constraints, lack of confidence, loss of skill over time from disuse, and inadequate office space.[28] Some specialists, i.e., pathologists and radiologists, do not use OMT as it is not applicable to their duties within their specialty. The AOA believes patients with low back pain should be treated with OMT given the high level of evidence that supports its efficacy. Changes in care when this guideline is implemented will be determined by physician and patient surveys, billing and coding practice patterns amongst osteopathic physicians, data gathered from osteopathic physicians via the AOA's Clinical Assessment Program, and other registry data gathering tools currently being developed by researchers.

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Appendix 1

DEFINITION OF TERMS USED

Glossary of Osteopathic Terminology, Revised November 2011. Reprinted with permission from the American Association of Colleges of Osteopathic Medicine. All rights reserved.

To download the complete Glossary, please go to http://www.aacom.org/news-and-events/publications/glossary-of-osteopathic-terminology

osteopathic manipulative treatment (OMT): The therapeutic application of manually guided forces by an osteopathic physician (U.S. usage) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques including:

> **active method,** technique in which the person voluntarily performs an osteopathic practitioner-directed motion.
>
> **articulatory treatment,** (Archaic). See *osteopathic manipulative treatment, articulatory treatment system.*
>
> **articulatory (ART),** a low velocity/ moderate to high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased range of movement. The activating force is either a repetitive springing motion or repetitive concentric movement of the joint through the restrictive barrier.

balanced ligamentous tension (BLT), 1. According to Sutherland's model, all the joints in the body are balanced ligamentous articular mechanisms. The ligaments provide proprioceptive information that guides the muscle response for positioning the joint, and the ligaments themselves guide the motion of the articular components. (*Foundations*) 2. First described in "Osteopathic Technique of William G. Sutherland," that was published in the *1949 Year Book of Academy of Applied Osteopathy.* See also *ligamentous articular strain.*

Chapman reflex, See *Chapman reflex.*

combined method, 1. A treatment strategy where the initial movements are indirect; as the technique is completed the movements change to direct forces. 2. A manipulative sequence involving two or more different osteopathic manipulative treatment systems (e.g., Spencer technique combined with muscle energy technique). 3. A concept described by Paul Kimberly, DO.

combined treatment, (Archaic). See *osteopathic manipulative treatment, combined method.*

compression of the fourth ventricle (CV-4), a cranial technique in which the lateral angles of the occipital squama are manually approximated slightly exaggerating the posterior convexity of the occiput and taking the cranium into sustained extension.

counterstrain (CS), 1. A system of diagnosis and treatment that considers the dysfunction to be a continuing, inappropriate strain reflex, which is inhibited by applying a position of mild strain in the direction exactly opposite to that of the reflex; this is accomplished by specific directed positioning about the point of tenderness to achieve the desired therapeutic response. 2. Australian and French use: Jones technique, (correction spontaneous by position), spontaneous release by position. 3. Developed by Lawrence Jones, DO in 1955 (originally "Spontaneous Release by Positioning," later termed "strain-counterstrain").

cranial treatment (CR), See *primary respiratory mechanism.* See *osteopathy in the cranial field.*

CV-4, abbreviation for compression of the fourth ventricle. See *osteopathic manipulative treatment, compression of the fourth ventricle.*

Dalrymple treatment, See *osteopathic manipulative treatment, pedal pump.*

direct method (D/DIR), an osteopathic treatment strategy by which the restrictive barrier is engaged and a final activating force is applied to correct somatic dysfunction.

exaggeration method, an osteopathic treatment strategy by which the dysfunctional component is carried away from the restrictive barrier and beyond the range of voluntary motion to a point of palpably increased tension.

exaggeration technique, an indirect procedure that involves carrying the dysfunctional part away from the restrictive barrier, then applying a high velocity/low amplitude force in the same direction.

facilitated oscillatory release technique (FOR), 1. A technique intended to normalize neuromuscular function by applying a manual oscillatory force, which may be combined with any other ligamentous or myofascial technique. 2. A refinement of a long-standing use of oscillatory force in osteopathic diagnosis and treatment as published in early osteopathic literature. 3. A technique developed by Zachary Comeaux, DO.

facilitated positional release (FPR), a system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue and joint tension in all planes, and an activating force (compression or torsion) is added. 2. A technique developed by Stanley Schiowitz, DO.

fascial release treatment, See *osteopathic manipulative treatment, myofascial release.*

fascial unwinding, a manual technique involving constant feedback to the osteopathic practitioner who is passively moving a portion of the patient's body in response to the sensation of movement. Its forces are localized using the sensations of ease and bind over wider regions.

functional method, an indirect treatment approach that involves finding the dynamic balance point and one of the following: applying an indirect guiding force, holding the position or adding compression to exaggerate position and allow for spontaneous readjustment. The osteopathic practitioner guides the manipulative procedure while the dysfunctional area is being palpated in order to obtain a continuous feedback of the physiologic response to induced motion. The osteopathic practitioner guides the dysfunctional part so as to create a decreasing sense of tissue resistance (increased compliance).

Galbreath treatment, See *osteopathic manipulative treatment, mandibular drainage.*

hepatic pump, rhythmic compression applied over the liver for purposes of increasing blood flow through the liver and enhancing bile and lymphatic drainage from the liver.

high velocity/low amplitude technique (HVLA), an osteopathic technique employing a rapid, therapeutic force of brief duration that travels a short distance within the anatomic range of motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction. Also known as thrust technique.

Hoover technique, 1. A form of functional method. 2. Developed by H.V. Hoover, DO. See also *osteopathic manipulative treatment, functional technique.*

indirect method (I/IND), a manipulative technique where the restrictive barrier is disengaged and the dysfunctional body part is moved away from the restrictive barrier until tissue tension is equal in one or all planes and directions.

inhibitory pressure technique, the application of steady pressure to soft tissues to reduce reflex activity and produce relaxation.

integrated neuromusculoskeletal release (INR), a treatment system in which combined procedures are designed to stretch and reflexly release patterned soft tissue and joint-related restrictions. Both direct and indirect methods are used interactively.

Jones technique, See *osteopathic manipulative treatment, counterstrain.*

ligamentous articular strain technique (LAS), 1. A manipulative technique in which the goal of treatment is to balance the tension in opposing ligaments where there is abnormal tension present. 2. A set of myofascial release techniques described by Howard Lippincott, DO, and Rebecca Lippincott, DO. 3. Title of reference work by Conrad Speece, DO, and William Thomas Crow, DO.

liver pump, See *hepatic pump.*

lymphatic pump, 1. A term used to describe the impact of intrathoracic pressure changes on lymphatic flow. This was the name originally given to the thoracic pump technique before the more extensive physiologic effects of the technique were recognized. 2. A term coined by C. Earl Miller, DO.

mandibular drainage technique, soft tissue manipulative technique using passively induced jaw motion to effect increased drainage of middle ear structures via the eustachian tube and lymphatics.

mesenteric release technique (mesenteric lift), technique in which tension is taken off the attachment of the root of the mesentery to the posterior body wall. Simultaneously, the abdominal contents are compressed to enhance venous and lymphatic drainage from the bowel.

muscle energy, a form of osteopathic manipulative diagnosis and treatment in which the patient's muscles are actively used on request, from a precisely controlled position, in a specific direction, and against a distinctly executed physician counterforce. First described in 1948 by Fred Mitchell, Sr, DO.

myofascial release (MFR), a system of diagnosis and treatment first described by Andrew Taylor Still and his early students, which engages continual palpatory feedback to achieve release of myofascial tissues.

> **direct MFR,** a myofascial tissue restrictive barrier is engaged for the myofascial tissues and the tissue is loaded with a constant force until tissue release occurs.
>
> **indirect MFR**, the dysfunctional tissues are guided along the path of least resistance until free movement is achieved.

myofascial technique, any technique directed at the muscles and fascia. See also *osteopathic manipulative treatment, myofascial release.* See also *osteopathic manipulative treatment, soft tissue technique.*

myotension, a system of diagnosis and treatment that uses muscular contractions and relaxations under resistance of the osteopathic practitioner to relax, strengthen or stretch muscles, or mobilize joints.

Osteopathy in the Cranial Field (OCF), 1. A system of diagnosis and treatment by an osteopathic practitioner using the primary respiratory mechanism and balanced membranous tension. See also *primary respiratory mechanism.* 2. Refers to the system of diagnosis and treatment first described by William G. Sutherland, DO. 3. Title of reference work by Harold Magoun, Sr, DO.

passive method, based on techniques in which the patient refrains from voluntary muscle contraction.

pedal pump, a venous and lymphatic drainage technique applied through the lower extremities; also called the pedal fascial pump or Dalrymple treatment.

percussion vibrator technique, 1. A manipulative technique involving the specific application of mechanical vibratory force to treat somatic dysfunction. 2. An osteopathic manipulative technique developed by Robert Fulford, DO.

positional technique, a direct segmental technique in which a combination of leverage, patient ventilatory movements and a fulcrum are used to achieve mobilization of the dysfunctional segment. May be combined with springing or thrust technique.

progressive inhibition of neuromuscular structures (PINS), 1. A system of diagnosis and treatment in which the osteopathic practitioner locates two related points and sequentially applies inhibitory pressure along a series of related points. 2. Developed by Dennis Dowling, DO.

range of motion technique, active or passive movement of a body part to its physiologic or anatomic limit in any or all planes of motion.

soft tissue (ST), A system of diagnosis and treatment directed toward tissues other than skeletal or arthrodial elements.

soft tissue technique, a direct technique that usually involves lateral stretching, linear stretching, deep pressure, traction and/or separation of muscle origin and insertion while monitoring tissue response and motion changes by palpation. Also called myofascial treatment.

Spencer technique, a series of direct manipulative procedures to prevent or decrease soft tissue restrictions about the shoulder. See also *osteopathic manipulative treatment (OMT), articulatory treatment (ART).*

splenic pump technique, rhythmic compression applied over the spleen for the purpose of enhancing the patient's immune response. See also *osteopathic manipulative treatment (OMT), lymphatic pump.*

spontaneous release by positioning, See *osteopathic manipulative treatment, counterstrain.*

springing technique, a low velocity/ moderate amplitude technique where the restrictive barrier is engaged repeatedly to produce an increased freedom of motion. See also *osteopathic manipulative treatment, articulatory treatment system.*

Still Technique, 1. Characterized as a specific, non-repetitive articulatory method that is indirect, then direct. 2. Attributed to A.T. Still. 3. A term coined by Richard Van Buskirk, DO, PhD.

Strain-Counterstrain,® 1. An osteopathic system of diagnosis and indirect treatment in which the patient's somatic dysfunction, diagnosed by (an) associated myofascial tenderpoint(s), is treated by using a passive position, resulting in spontaneous tissue release and at least 70 percent decrease in tenderness. 2. Developed by Lawrence H. Jones, DO, in 1955. See *osteopathic treatments, counterstrain.*

thoracic pump, 1. A technique that consists of intermittent compression of the thoracic cage. 2. Developed by C. Earl Miller, DO.

thrust technique (HVLA), See *osteopathic manipulative treatment, high velocity/low amplitude technique (HVLA).*

toggle technique, short lever technique using compression and shearing forces.

traction technique, a procedure of high or low amplitude in which the parts are stretched or separated along a longitudinal axis with continuous or intermittent force.

v-spread, technique using forces transmitted across the diameter of the skull to accomplish sutural gapping.

ventral techniques, See *osteopathic manipulative treatment, visceral manipulation.*

visceral manipulation (VIS), a system of diagnosis and treatment directed to the viscera to improve physiologic function. Typically, the viscera are moved toward their fascial attachments to a point of fascial balance. Also called ventral techniques.

somatic dysfunction: Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

Appendix 2

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Explanatory Statement: Submitted by Author

None provided.

Explanatory Statement: Reference Committee

RECOMMEND THAT REFERENCES BE UPDATED PRIOR TO THE NEXT PUBLICATION OF THE RESOLUTION

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: ADDRESSING THE EFFECTS OF CLIMATE ON NATIONAL HEALTH

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, rising average temperatures will lead to increased frequency and longevity of heat waves[2]; and

WHEREAS, these environmental changes will translate to poorer health outcomes in the United States—projections show, within the next 80 years, additional deaths due to climate change may reach up to tens of thousands per year[1]; and

WHEREAS, these deaths will not be offset by a smaller reduction in cold-related deaths in winter months[1]; and

WHEREAS, exposure to extreme heat can lead to heat stroke and dehydration, as well as cardiovascular, respiratory, and cerebrovascular disease[4]; and

WHEREAS, certain patient populations will be more vulnerable to extreme heat due to impaired heat regulatory functions, including young children, pregnant women, the elderly, and persons with inherent medical conditions and/or disabilities [1]; and

WHEREAS, climate change is projected to increase the vulnerability of urban populations to heat-related health impacts in the future[1]; and

WHEREAS, metropolitan areas such as St. Louis, Philadelphia, Chicago, and Cincinnati have already seen notable increases in death rates during heat waves[2]; and

WHEREAS, warmer temperatures are associated with periods of stagnant air, leading to increases in air pollution and associated health effects[2]: asthma attacks and other respiratory and cardiovascular health effects[1]: and

WHEREAS, wildfires, which are expected to continue to increase in number and severity as the climate changes, create smoke and other air pollutants[1]: and

WHEREAS, despite significant improvements in U.S. air quality since the 1970s, as of 2014 about 57 million Americans lived in counties that did not meet national air quality standards[5]; and

WHEREAS, scientists predict warmer temperatures from climate change will increase the frequency of days with unhealthy levels of ground-level ozone, a harmful air pollutant, and a component in smog[1]; and

WHEREAS, people exposed to higher levels of ground-level ozone are at greater risk of dying prematurely or being admitted to the hospital for respiratory problems[1]; and

WHEREAS, ground-level ozone can damage lung tissue, reduce lung function, and inflame airways: increasing national incidences of asthma or other lung diseases[1]; and

WHEREAS, children, older adults, outdoor workers, and those with asthma and other chronic lung diseases are particularly at risk[5]; and

WHEREAS, warm, stagnant air tends to increase the formation of ozone, therefore, climate change is likely to increase levels of ground-level ozone in already-polluted areas of the United States, thereby further decreasing air quality[1]; and

WHEREAS, the higher concentrations of ozone due to climate change may result in tens to thousands of additional ozone-related illnesses and premature deaths per year by 2030 in the United States, assuming no change in projected air quality policies[1]; and

WHEREAS, climate-related changes in stagnant air episodes, wind patterns, emissions from vegetation and the chemistry of atmospheric pollutants will also affect particulate matter levels[1]; and

WHEREAS, inhaling fine particles can lead to a broad range of adverse health effects, including lung cancer, chronic obstructive pulmonary disease (COPD), and cardiovascular disease[1]; and

WHEREAS, allergic illnesses, including hay fever, affects roughly one-third of the U.S. population, and more than 34 million Americans have been diagnosed with asthma[1]; and

WHEREAS, pollen season in the United States is occurring earlier and increasing in season duration, especially for vegetation with highly allergenic pollen, such as ragweed[1]; and

WHEREAS, rising carbon dioxide concentrations and temperatures may also lead to earlier flowering, more flowers, and increased pollen levels in ragweed[4]; and

WHEREAS, increases in the frequency or severity of some extreme weather events, such as extreme precipitation, flooding, droughts, and storms, threaten the health of people during and after the event[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by damaging roads and bridges, disrupting access to hospitals and pharmacies[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by interrupting communication, utility, and access to health care services[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by reducing the availability of food and drinking water[1]; and

WHEREAS, runoff and flooding resulting from increased precipitation, hurricane rainfall, and storm surge will increasingly contaminate water bodies used for recreation (such as lakes and beaches), shellfish harvesting waters, and sources of drinking water[1]; and

WHEREAS, health impacts may include gastrointestinal illness, negative effects on the body's nervous and respiratory systems, or liver and kidney damage[1]; and

WHEREAS, extreme weather events and storm surges can damage or exceed the capacity of water infrastructure (such as drinking water or wastewater treatment plants), increasing the risk that people will be exposed to contaminants[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by contributing to carbon monoxide poisoning from improper use of portable electric generators during and after storms[1]; and

WHEREAS, changes in temperature and precipitation, such as droughts and floods, could reduce agricultural output and increasing incidences of malnutrition in the United States[7]; and

WHEREAS, higher air temperature can increase morbidity and mortality of Salmonella and other bacteria-related food poisoning because bacteria grow more rapidly in warm environments[1]; and

WHEREAS, climate change will have a variety of impacts that may increase the risk of exposure to chemical contaminants in food[1]; and

WHEREAS, higher concentrations of carbon dioxide in the air lowers the levels of protein and essential minerals in crops such as wheat, rice, and potatoes, making these foods less nutritious[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by creating or worsening mental health impacts such as depression and post-traumatic stress disorder (PTSD)[1]; and

WHEREAS, individuals with mental illness are especially vulnerable to extreme heat; studies have found that having a pre-existing mental illness tripled the risk of death during heat waves[1]; and

WHEREAS, the perceived threat of climate change (from news sources and/or social media) can influence stress responses and mental health[1]; and

WHEREAS, some groups of people are at higher risk for mental health impacts, such as children and older adults, pregnant and postpartum women, people with pre-existing mental illness, people with low incomes, and emergency workers[1]; and

WHEREAS, the geographic range of ticks that carry Lyme disease is limited by temperature[1]; and

WHEREAS, as air temperatures rise, ticks are likely to become active earlier in the season, and their range is likely to continue to expand northward[1]; and

WHEREAS, the risks for climate-sensitive diseases can be much higher in poorer communities with fewer resources to prevent and treat illness[6]; and

WHEREAS, communities of color (including Indigenous communities as well as specific racial and ethnic groups), low income, immigrants, and limited English proficiency face disproportionate vulnerabilities due to a wide variety of factors, such as higher risk of exposure, socioeconomic and educational factors that affect their adaptive capacity, and a higher prevalence of medical conditions that affect their sensitivity[1]; and

WHEREAS, children are vulnerable to many health risks due to biological sensitivities and more opportunities for exposure (due to activities such as playing outdoors)[1]; and

WHEREAS, occupational groups, such as outdoor workers, paramedics, firefighters, and transportation workers, as well as workers in hot indoor work environments, will be especially vulnerable to extreme heat and exposure to vector borne diseases[1]; and

WHEREAS, people with chronic medical conditions are typically vulnerable to extreme heat, especially if they are taking medications that make it difficult to regulate body temperature[1]; and

WHEREAS, there must be a just transition for all communities and workers to ensure economic security for people and communities that have historically relied on fossil fuel industry; and

WHEREAS, there must be justice and equity for frontline communities by prioritizing investment, training, climate and community resiliency, economic and environmental benefits in these communities; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes climate change as a public health crisis; and, be it further

RESOLVED, that the AOA publicly endorse legislation that includes provisions such as a plan to create an ecologically friendly economy and infrastructure; and, be it further

RESOLVED, that the AOA joins the U.S. Call to Action.

Explanatory Statement: Submitted by Author:

The US Call to Action is an organization that calls "on government, business, and civil society leaders, elected officials, and candidates for office to recognize climate change as a health emergency and to work across government agencies and with communities and businesses to prioritize action on this Climate, Health and Equity Policy Action Agenda."

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Explanatory Statement: Reference Committee
Intent of resolution needs to be clarified; second RESOLVED references legislation that is not defined; third RESOLVED calls for partnering with an unknown organization. There are at least three issues identified in the many WHEREAS statements that are best divided into three separate resolutions.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ADVERSE CHILDHOOD EXPERIENCES SCREENING

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Adverse Childhood Experiences (ACEs) are cumulative potentially traumatic events that occur in childhood (0-17 years), including experiencing or witnessing violence in the home or community, having a family member attempt or die by suicide, or growing up in a household with substance misuse, mental health problems, or instability due to parental separation or household members being in jail or prison[1]; and

WHEREAS, the ACEs can be accurately scored on a validated screening instrument in the primary care setting[2]; and

WHEREAS, the ACEs score has been recognized as a strong predictor of both medical and physical health outcomes, including but not limited to: risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases, education and job opportunity losses, and leading causes of death[1, 3-6]; and

WHEREAS, as of January 1, 2020, per the Surgeon General of California, Dr. Nadine Burke Harris, the ACEs Aware Initiative in California has begun funding providers for ACEs Screening to improve public health and address the state's estimated $112.5 billion per year cost in health care expenditures and disease burden as a result of ACEs-related premature death and years of productive life lost to disability[2]; and

WHEREAS, preventing ACEs could potentially reduce many health conditions with economic and social costs to families, communities, and society of hundreds of billions of dollars each year[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **ENCOURAGES** ~~**support and advocate for**~~ the inclusion of Adverse Childhood Experiences (ACEs) screenings in primary care settings.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: INCLUSION OF PATIENT EDUCATION ON ORGAN DONATION AS A COMPONENT OF A PRIMARY CARE VISIT

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, there are more than 110,000 patients are on the waiting list in need of a life-saving
2 organ transplantation in the United States[1,2]; and

3 WHEREAS, an average of 20 patients die each day while waiting for a transplant due to a
4 shortage of donated organs[3]; and

5 WHEREAS, in 2008, children, especially those under 5 years of age, had the highest death rate
6 on the transplant waiting list compared to any other age range[4]; and

7 WHEREAS, the number of pediatric deceased donors continued to decline and majority of
8 pediatric donors less than 18 years of age are allocated to adults[4]; and

9 WHEREAS, liver and kidney disease kill over 120,000 individuals each year, which is more
10 people than Alzheimer's, breast cancer, or prostate cancer[3]; and

11 WHEREAS, in 2019, 83.7% of patients on the waiting list were waiting for a kidney and 11.6%
12 of patients were waiting on a liver donation[5]; and

13 WHEREAS, 95% of adults support organ donation but only 58% are actually registered as
14 organ donors[5]; and

15 WHEREAS, every ten minutes, someone is added to the national transplant waiting list,
16 contributing to the persistent gap between the supply and demand of organs[5]; and

17 WHEREAS, "currently, there are limited programs educating the population about organ
18 donation in the United States resulting in a situation in which the public lacks basic
19 knowledge and understanding of organ donation, i.e. the dire need, living vs. deceased,
20 which organs can be donated during one's lifetime, the time, effort and risk involved"[3];
21 and

22 WHEREAS, education provided by United States federal government organizations, including
23 the national DMV website, does not sufficiently educate the public on organ donation
24 facts, myths, and resources[6]; and

25 WHEREAS, American Osteopathic Association (AOA) Policy H411-A/16 states that the AOA
26 "will develop and continue to promote physician and public education programs to
27 advance the cause of organ and tissue donation and transplantation," and "urges the
28 Osteopathic Family" to not only volunteer personally as organ and tissue donors, but
29 also to "actively encourage their patients to do the same"; and

WHEREAS, a Quality Improvement (QI) study, in which patients were provided an organ donation pamphlet and registration form, performed by the University of Toronto at a primary care clinic showed an overall 18.3% increase in successful organ donor registrations[7]; and

WHEREAS, a study of 300 patients showed that 40% of the participants who were previously not organ donors committed to becoming organ donors after receiving a verbal or written intervention that shared information regarding organ donations during a visit at a family practice medical center. The data from this study suggests that "the family physician-patient encounter is an excellent opportunity for educating patients and increasing the commitment to organ donation[8]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts an official position supporting organ donation counseling during a visit with a new primary care physician at the provider's discretion as a means of educating and encouraging patients to become organ donors in order to ameliorate the national organ shortage.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

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Explanatory Statement: Reference Committee

The Committee believes the current policy on file (411-A/16) addresses this issue. In addition, many states already show such information on drivers' licenses.

Background Information: Provided by AOA Staff

Current AOA Policy: H411-A/16 ORGAN AND TISSUE DONATION AND TRANSPLANTATION INITIATIVES – COMMITMENT TO

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: INEQUALITIES IN MEDICAID FUNDING AFFECTING U.S. TERRITORIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana
2 Islands (CNMI), Guam, and the U.S. Virgin Islands (USVI) are U.S. territories, which
3 poses the obligation to pay federal taxes[5]; and

4 WHEREAS, a large proportion of U.S. citizens living on U.S. territories rely on Medicaid or
5 Children's Health Insurance Program (CHIP) to pay for their healthcare, although the
6 total number varies per territory[7]; and

7 WHEREAS, 79% of U.S. citizens living in American Samoa were enrolled in Medicaid,
8 compared to 37% in Puerto Rico, in 2017[7]; and

9 WHEREAS, differences in funding between territorial and mainland Medicaid programs can be
10 narrowed down to two key policies: statutory caps on federal funding and the federal
11 Medicaid match rate formula[1,7]; and

12 WHEREAS, federal funding for mainland Medicaid programs are not capped, therefore every
13 dollar spent is reimbursed by the federal government as long as they are valid under the
14 program's rules[1,7]; and

15 WHEREAS, federal funding for territorial Medicaid programs are statutorily capped based on
16 Section 1108 of the Social Security Act[7]; and

17 WHEREAS, U.S. territories receive an allotted amount of funds for Medicaid every year
18 regardless of fluctuations in enrollment or service usage[7]; and

19 WHEREAS, the federal government does not match territorial Medicaid spending beyond the
20 annual cap, therefore shifting the economic burden to each territory's finances[1,7]; and

21 WHEREAS, the federal Medicaid match rate (Federal Medical Assistance Percentage, or
22 FMAP) is used for determining the amount of federal matching funds for most
23 Medicaid expenditures[3]; and

24 WHEREAS, on the mainland, FMAPs vary depending on the state's per capita income, and
25 states with lower per capita incomes have an increased FMAP due to greater economic
26 need[1]; and

27 WHEREAS, in U.S. territories, the FMAP is a fixed rate and is based on a different formula
28 that does not consider per capita income, in which the statutory FMAP for all U.S.
29 territories is set at 55%, with exception of recent, temporary changes[1,7]; and

WHEREAS, in U.S. territories, the statutory cap on Medicaid funding along with the fixed FMAP has led to budget deficits and the need for frequent infusions of funds to support the programs temporarily[1,7]; and

WHEREAS, territories received a considerable infusion of federal funds for Medicaid under the Patient Protection and Affordable Care Act in 2010[7]; and

WHEREAS, the Balanced Budget Act of 2018 gave Puerto Rico and the USVI further funding for Medicaid at 100% FMAP until September 30, 2019[7]; and

WHEREAS, the Additional Supplemental Appropriations for Disaster Relief Act of 2019 was enacted to provide added funds to CNMI at 100% FMAP through the end of fiscal year 2019, and permitted Guam and American Samoa to use their remaining ACA funds at 100% FMAP during the same period[7]; and

WHEREAS, although it is estimated that all territories will be able to adequately fund their Medicaid and CHIP programs through the end of fiscal year 2019, the added funds that are keeping them viable will expire at the end of this year[7]; and

WHEREAS, estimates show that there will be significant budget deficits in fiscal year 2020 in all five territories once the additional funds have expired[7]; and

WHEREAS, prior to these infusions, territories such as Puerto Rico had substantial shortcomings in federal funding for its Medicaid program[1,7]; and

WHEREAS, the combinatory effect of a low FMAP and the statutory cap creates an estimated effective match rate of approximately 18% in Puerto Rico, a rate usually found in states with a high PCI[2]; and

WHEREAS, for Puerto Rico, it is estimated that if the statutory cap is removed and the territorial FMAP is calculated using the mainland's formula, which reflects per capita income, the effective match rate would increase from 18% to 83%, the maximum allowed under these laws[4,6]; and

WHEREAS, unjustified differences in Medicaid federal funding between Puerto Rico and the mainland has led the island to set limits on medical services typically provided under the mainland program[2]; and

WHEREAS, prior to the recent temporary federal infusions, inadequate funding for the island's Medicaid program led Puerto Rico to take measures that reduce spending by: decreasing the eligibility for Medicaid as compared to mainland criteria, withholding investment in health information technology despite CMS incentives, reducing or suspending provider payments, and excluding benefits from Medicaid coverage, such as long term care[2]; and

WHEREAS, it is estimated that the impending Medicaid budget shortfalls of fiscal year 2020 will drive all five territories to enact changes that reduce costs, such as the aforementioned measures taken by Puerto Rico in the past[7]; and

WHEREAS, the Congressional Task Force on Economic Growth in Puerto Rico warned in 2016 that failure to increase funding for Puerto Rico's Medicaid program would

presumably compel its government to reduce enrollment of low-income individuals, therefore harming their quality of life and spurring outmigration, which can further exacerbate an already critical fiscal crisis[8]; and

WHEREAS, despite differences between territories and the mainland in the amount of federal taxes paid by individuals and businesses, all members of the Congressional Task Force on Economic Growth in Puerto Rico concluded that territories deserved more equitable treatment in Medicaid funding[8]; and

WHEREAS, the Congressional Task Force on Economic Growth in Puerto Rico recommended in 2016 that Congress act swiftly to improve financing for territorial Medicaid programs so that it reflects the size and need of their low-income citizens[8]; and

WHEREAS, the American Osteopathic Association represents a profession that advocates for access to healthcare; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports an increase in or removal of the federal funding cap on territorial Medicaid programs, thereby ~~alleviating~~ **REDUCING** costs and preventing the cost-reducing measures that negatively impact the quality of and access to healthcare of low-income U.S. citizens **AND U.S. NATIONALS** living on the U.S. territories; and, be it further

RESOLVED, that the AOA supports changing the territorial Federal Medical Assistance Percentage formula so that it considers per capita income, thereby tailoring the federal matching rate to each population's financial needs.

Explanatory Statement: Submitted by Author

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Explanatory Statement: Reference Committee
The addition of "Nationals" to page 3, line 17 will cover citizens of American Samoa.

Background Information: Provided by AOA Staff
Current AOA Policy: H339-A/17 EQUITY IN MEDICARE & MEDICAID PAYMENTS

Prior HOD action on similar or same topic: Policy approved in 2017.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: IMPROVING INSULIN AFFORDABILITY

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, Diabetes Type 1 is one of the most common chronic diseases starting in early
2 childhood in the United States that is fatal without lifelong insulin treatment[1]; and

3 WHEREAS, over 1.4 million American children and adults are living with Type I diabetes
4 mellitus and 7.4 million Americans with diabetes use one or more formulations of
5 insulin[2]; and

6 WHEREAS, the number of youth with Type 1 diabetes is projected to increase by 23% in
7 2050[3]; and

8 WHEREAS, the researchers who discovered insulin, Richard Banting, J. B. Collip, and Charles
9 Best, sold their patent rights for only $1 each because their goal was to ensure the
10 quality, purity, and potency of insulin sold on the market rather than to profit[4]; and

11 WHEREAS, the first license to manufacture insulin was granted for humanitarian purposes
12 rather than for profit[5]; and

13 WHEREAS, counter to the spirit of the initial sale and licensure of insulin, the global insulin
14 market was a $24 million industry in 2014 and will top $48 billion by 2020[6]; and

15 WHEREAS, the cost of insulin has tripled over a mere decade from 2002-2013, despite only
16 incremental added benefits of new insulin products on the market[7,8,9]; and

17 WHEREAS, 39% of insulin users reported an increase in the amount they personally pay for
18 insulin in the past year, including 52% of insulin-dependent children[10]; and

19 WHEREAS, an uninsured person pays up to $480 per vial of insulin, with varying out-of-
20 pocket expenses for insured persons[11]; and

21 WHEREAS, the out-of-pocket expense for insulin has doubled per prescription[11]; and

22 WHEREAS, it costs uninsured patients ten times more for insulin treatment at $7,000 annually
23 versus $700 annually with insurance[12]; and

24 WHEREAS, the diabetes related costs from the Medicare eligible population is expected to
25 skyrocket to $171 billion in 2034, an increase of 380% from 2009[13]; and

26 WHEREAS, one in four insulin dependent diabetics with associated poor glycemic control
27 reported insulin underuse or rationing due to cost[12,14,15,16]; and

WHEREAS, those who regularly take less insulin than prescribed or miss doses report being forced to choose between affording insulin versus essentials like housing, utilities, transportation, and even other health related purchases, such as doctors visits[10]; and

WHEREAS, one-third of patients with lower incomes who report cost-related insulin underuse also report difficulty affording diabetes equipment, thus increasing the risk for hospitalization[16]; and

WHEREAS, many uninsured and underinsured patients are not only rationing insulin but also resorting to black market purchases of discounted insulin on unregulated classified advertisement websites such as Craigslist[17,18]; and

WHEREAS, diabetics who are forced to ration their insulin have developed preventable complications like diabetic ketoacidosis with some resulting in diabetic coma or death[12,14,15,19]; and

WHEREAS, diabetic ketoacidosis is a complication that could be avoided with adequate insulin treatment, but costs $26,566 per hospitalization, resulting in a healthcare burden of $5.1 billion[2]; and

WHEREAS, an increasing number of patients are dying due to inability to afford insulin with diabetes being the 7th leading cause of death in 2017[2,21]; and

WHEREAS, deaths related to insulin rationing occurs even amongst middle class individuals with health insurance coverage[22,23]; and

WHEREAS, the expansion of Medicaid eligibility in some states addressing gaps in affordable access to diabetes medication and treatment has resulted in a significant increase in insulin prescriptions being filled[22,24]; and

WHEREAS, when primary patents expired in 2015 for Sanofi's Lantus, the world's most widely prescribed insulin and the world's leading drug for Type 1 Diabetics, more than 70 secondary patent applications were filed in an effort to maintain its market monopoly[25,26,27]; and

WHEREAS, market share holding pharmaceutical companies consistently file lawsuits against other companies over plans to produce and sell a generic form of insulin, claiming that patents will be violated and that rights will be infringed upon[25,27]; and

WHEREAS, Eli Lilly agreed to make an 'authorized generic' known as insulin Lispro available for purchase at a 50% price reduction, but a spot check found it was only stocked in 17% of pharmacies across the country in favor of Eli Lilly's 'name brand' drug known as Humalog, which offer a larger, more profitable rebate to insurance companies[28]; and

WHEREAS, cheaper forms of insulin being made available are older formulations or analog insulins that are now rarely prescribed because it takes too long to take effect and then stays in the bloodstream for over 8 hours postprandial, increasing the risk for hypoglycemic events[29]; and

WHEREAS, unbranded biosimilar versions of insulin are projected to be priced at 10-51% less than name brand biologic insulins, with a cost saving potential of between $25 billion to $150 billion over ten years[30,31]; and

WHEREAS, unbranded biosimilar drugs have been available in Europe for years, pharmaceutical companies are distorting safety concerns to delay or prohibit the introduction of biosimilars into the American market[30]; and

WHEREAS, pharmaceutical companies have resorted cutting deals with makers of biosimilars to prevent or delay the entry of lower cost biosimilars into the American market[30,32]; and

WHEREAS, forty-five states and Puerto Rico have enacted laws protecting patients' rights to try a biosimilar drug and protecting the substitution of biosimilar products by pharmacists[33]; and

WHEREAS, two Congressional bills aimed at protecting against industry collusion to keep biosimilars out of the American market and at advancing public awareness and education on biosimilars have had no actions taken since they were introduced in 2019[34,35]; and

WHEREAS, the Food and Drug Administration has set standards for biosimilar drugs that protect against concerns of safety, efficacy, and quality[36]; and

WHEREAS, the Senate Finance Committee Chairman initiated an investigation into the price spikes and high cost of insulin for people with diabetes in January 2019, but the only action taken to date is seeking insulin cost data from the Centers for Medicare and Medicaid Services Administrator[37,38,39];" and

WHEREAS, the Chairman of the House Committee on Oversight and Reform confirmed in January 2019 that "there is a strong bipartisan consensus that we must do something to rein in out-of-control price increases…" by the pharmaceutical industry[40];" and

WHEREAS, two Congressional bills aimed at making insulin affordable have had no actions taken since they were introduced in January and February 2019[41,42]; and

WHEREAS, Colorado and Illinois are the first two states to enact laws that cap insulin co-pays[43,44,45,46]; and

WHEREAS, Virginia recently passed a bill capping insulin copays that is pending their governor's signature into law, which would make it the third state in the country to pass a law capping the cost of insulin and it would be the lowest cap set by any state at $50 per month[47,48]; and

WHEREAS, the bills in Colorado, Illinois, and Virginia only apply to patients who have health insurance coverage and only those who are covered through state-regulated commercial insurance plans[43,44,45,46,47,48]; and

WHEREAS, 28 U.S. Code § 1498 grants the U.S. federal government the right to use or manufacture a patented drug at reasonable compensation to the patent owner[49,50]; and

WHEREAS, 28 U.S. Code § 1498 affords patent owners the right to petition the Court of Federal Claims for compensation, which would allow pharmaceutical companies the ability to seek a reasonable amount while prohibiting them from unilaterally setting predatory market prices on insulin[50,51]; and

WHEREAS, 28 U.S. Code § 1498 was frequently used for crucial drugs in the 1960s and 1970s, including a Department of Defense purchase of an antibiotic directly from a generic manufacturer at 28% of the price charged by the patent holder, Pfizer[49]; and

WHEREAS, the government's use of 28 U.S. Code § 1498 has waned not due to decreased need but due to the increasing strength of the pharmaceutical lobby[49]; and

WHEREAS, Medicare is prohibited from negotiating drug prices due to language inserted into legislation that was written by the pharmaceutical lobby[49,52]; and

WHEREAS, 28 U.S. Code § 1498 provides a reasonable counterweight to Medicare's inability to negotiate drug prices, allowing the government to negotiate prices directly with the manufacturer and function as a free market buyer[49,52,53]; and

WHEREAS, 28 U.S. Code § 1498 continues to be applied today in areas outside of prescription drugs, such as patented methods of hazardous waste clean up, electronic passport technology, and genetically mutated mice in scientific research[49,50]; and

WHEREAS, 28 U.S. Code § 1498 continues to be applied for prescription drugs in cases of extreme need or urgency, such as the anthrax scare in 2001[49]; and

WHEREAS, just the threat of 28 U.S. Code § 1498 from the federal government to purchase a generic version of the antibiotic ciprofloxacin during the anthrax scare in 2001 prompted the patent holder, Bayer, to cut the selling price in half[49,54]; and

WHEREAS, there is growing support of exercising 28 U.S. Code § 1498 to procure Hepatitis C treatment drugs, which have been priced by the patent holder, Gilead, at $80,000 per person for the full course of treatment, earning them $36 billion in just two years, well above the initial cost of research and development[49,50,55,56]; and

WHEREAS, the costs of initial research and development can ultimately amount to as little as 4% of profits[51,53]; and

WHEREAS, the American Osteopathic Association (AOA) enacted H339-A/19 to support increased regulation of pharmacy benefit managers as a way to make life-saving medications, including but not limited to insulin, free for all uninsured patients and fully covered for all insured patients, but has no broader policy directly aimed at insulin cost control; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support legislation capping insulin copays with every state legislature via their respective state medical societies; and, be it further

1 RESOLVED, that the AOA support legislation that protects the introduction of biosimilar
2 insulin products into the American market and patient access to biosimilar; and, be it
3 further

4 RESOLVED, that the AOA support federal enforcement of 28 U.S. Code § 1498 for recent
5 and medically effective short-acting and long-acting forms of insulin to address
6 affordability and accessibility for all diabetic patients, including the uninsured.

Explanatory Statement: Submitted by Author:
While there is bipartisan support for solutions to this issue, attempts at new and comprehensive federal legislation have stalled. There have been recent movements in the right direction from a handful of state legislatures capping the cost of insulin. This is a realistic interim solution for insured individuals and this proposal aims to support the implementation of similar bills in remaining states. The limitation is that these legislations do not benefit uninsured individuals. Therefore, to address insulin affordability more broadly, this proposal seeks legislation that protects the introduction of biosimilars that would foster the market competition in insulin costs. Finally, gaps in insulin affordability is a long-standing, drastic problem that requires a drastic solution. This proposal, rather than seeking a wholly new legislation, seeks enforcement of an existing law that the federal government can invoke at its discretion.

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Explanatory Statement: Reference Committee
With the numerous WHEREAS statements, the intent of resolution needs to be clarified. There are multiple issues covered that should be separated into separate resolutions.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: MEDICATION FOR OPIOID USE DISORDER INSURANCE COVERAGE

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, the American Osteopathic Association has previously resolved to "remove any
2 arbitrary and restrictive limits for buprenorphine insurance coverage" (H336-A/15) for
3 the treatment of Opioid Use Disorder (OUD); and

4 WHEREAS, only 29.9% of patients with OUD received evidence-based Medication for Opioid
5 Use Disorder (MOUD) treatment in 2017; and

6 WHEREAS, prior authorization is a burdensome process that impedes upon the physician-
7 patient relationship, often in an arbitrary and non-evidence-based manner; and

8 WHEREAS, failure to expeditiously begin MOUD treatment, or an interruption in therapy, can
9 cause devastating consequences for patients, families, and communities, including
10 preventable deaths; now, therefore be it

11 RESOLVED, that the American Osteopathic Association (AOA) will explicitly advise the
12 Center for Medicare and Medicaid Services (CMS) and commercial insurers to remove
13 prior authorization restrictions for Medication for Opioid Use Disorder (MOUD); and,
14 be it further

15 RESOLVED, that the AOA strongly encourage the American Osteopathic Academy of
16 Addiction Medicine (AOAAM) to maintain the above position.

Explanatory Statement: Submitted by Author:
In 2017 overdose deaths due to opioids once again constituted the highest single cause of accidental deaths in the United States. Various buprenorphine preparations, including long-acting injectable buprenorphine, have been shown to be very effective as reducing deaths and decreasing illicit opioid use, but burden prior authorization requirements often render physicians and other providers unable to optimize treatment. Given the various tolerance and efficacy patients experience with regard to various buprenorphine preparations, every effort should be made to limit or eliminate prior authorization, as even a slight delay in treatment or interruption of therapy can be deadly.

Explanatory Statement: Reference Committee
The Committee believes the current policy on file (336-A/15) addresses this issue.

H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE
The American Osteopathic Association (AOA) recommends that state Medicaid administrators remove any arbitrary and restrictive limits for buprenorphine coverage and that state Medicaid administrators and third party payers recognize that chronic disease management includes a combination of psychotherapeutic and pharmacological interventions that will yield the best outcomes for patients with opioid use disorder. 2015

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: RECRUITMENT AND RETENTION OF NATIVE AMERICANS IN MEDICINE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, there are approximately 5.2 million American Indian/Alaska Native (AI-AN)
2 people in the United States, including those of more than one race; 1.7% of the
3 population[1]; and

4 WHEREAS, there are currently 95 (0.3%) students of AI-AN ethnicity enrolled in osteopathic
5 medical schools and 3,400 (0.4%) AI-AN physicians practicing in the United States[2];
6 and

7 WHEREAS, the AI-AN population has an average life expectancy that is 5.5 years less than
8 that of the United States population, and has higher mortality rates in many categories,
9 including: heart disease, malignant neoplasm, chronic liver disease and cirrhosis,
10 diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide,
11 and chronic lower respiratory diseases[3]; and

12 WHEREAS, research indicates that physician-patient racial and ethnic concordance leads to
13 patients perceiving a higher quality of care, increased use of care, and higher satisfactory
14 rating of care[4]; and

15 WHEREAS, AI-AN physicians are more likely to practice in Native communities[5]; and

16 WHEREAS, there have been instances of medical schools succeeding in enrolling higher
17 average numbers of AI-AN students by integrating social and cultural aspects into their
18 institutions and engaging the tribal nations and communities by setting up educational
19 pathway programs in these areas[6]; and

20 WHEREAS, the Association of Native American Medical Students (ANAMS) is a student
21 organization representing Native American graduate health professional students that
22 supports and provides a resource network with the goal of increasing the number of
23 Native American students in medicine and the successful completion of their graduate
24 health professions curricula[7]; and

25 WHEREAS, the Student Osteopathic Medical Association (SOMA) has made it a priority to
26 recruit underrepresented minorities in medicine through the National Outreach for
27 Diversity (NOD) programming and through advocating for the improvement of
28 accreditation standards on diversity at Osteopathic medical schools outlined in Policy S-
29 19-23[8]; and

30 WHEREAS, existing American Osteopathic Association policy H433-A/15 (Minority Health
31 Disparities) states for action to be taken for the development of strategies to actively
32 recruit underrepresented minority physicians into the profession in both primary care

and subspecialties, but does not mention retaining minority physicians[9]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with various stakeholders (including the Student Osteopathic Medical Association and the Association of Native American Medical Students) to establish best practices to increase the number of Native Americans recruited and retained in medicine and the allied professions.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

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Explanatory Statement: Reference Committee

The Committee believes the American Osteopathic Association should be supportive and inclusive of all minorities who pursue a career in the osteopathic medicine, and not just one. Support and inclusion of all minorities is currently covered under existing AOA policy, as was noted in the resolution.

Background Information: Provided by AOA Staff

Current AOA Policy:

H429-A/14 MINORITIES, UNDERREPRESENTED (URM) -- INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

H409-A/16 MINORITY HEALTH AND OSTEOPATHIC MEDICAL EDUCATION

Prior HOD action on similar or same topic: H429-A/14 policy approved in 2014 (Referred to BOE and BSAPH in 2019). H409-A/16 policy reaffirmed in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: SUSTAINABILITY AT AOA EVENTS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Professional Affairs

1 WHEREAS, there is agreement within the scientific community that the Earth is undergoing
2 adverse global climate change and that anthropogenic contributions are significant; and

3 WHEREAS, large in person events can generate significant waste and be harmful to the
4 environment; and

5 WHEREAS, the American Osteopathic Association (AOA) has traditionally held at minimum
6 three events of over two hundred people per year; now, therefore be it

7 RESOLVED, that the American Osteopathic Association (AOA) will make efforts to make
8 events "green" and sustainable such as: choosing eco-friendly venues (IACC Green Star
9 certified, i.e.), using compostable or reusable cups and glasses, fabric napkins, going
10 paperless, limiting food waste, reducing transportation footprints, choosing virtual
11 meeting options as appropriate, etc.; and, be it further

12 RESOLVED, that the AOA will report to the House of Delegates annually on these
13 improvements, starting in 2021.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Based on Finance Committee's estimate, the Committee believes the costs to implement is prohibitive and could result in a negative fiscal impact. In times of a pandemic, there is potential that use of reusable items could contribute to spread.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $250,000 in additional expenses annually.
The staff estimates that providing sustainable options regarding cups, plates, utensils, etc. for meals and breaks at AOA sponsored events would cost an addition $250,000 annually. Presently, due to COVID-19 venues are not offering or providing a sustainable option; additionally, virtual meetings are the current option for the foreseeable future, therefore under these circumstances a direct fiscal impact cannot be accurately determined at this time.

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H357-A/19 NUTRITION AND LEADING BY EXAMPLE

SUBMITTED BY: Osteopathic Physicians and Surgeons of Oregon

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, at the 2018 American Osteopathic Association (AOA) House of Delegates,
2 resolution H-365 was approved resolving that the AOA consider meal nutritional
3 content when planning events; and

4 WHEREAS, the preponderance of evidence shows negative health outcomes associated with
5 the consumption of sugar sweetened beverages and processed meats and;

6 WHEREAS, the World Health Organization, International Agency for Research on Cancer has
7 classified processed meat as carcinogenic to humans (Group 1); and

8 WHEREAS, nudges, defined as a subtle environment cues designed to make healthy food
9 choices the easy choice have been shown to increase consumption of healthy foods; and

10 WHEREAS, the AOA has the opportunity to lead by example - recognizing the impact that
11 nutrition has on human health when providing meals; and

12 RESOLVED, that sugar sweetened beverages and processed meats be excluded from all
13 American Osteopathic Association (AOA) sponsored events where a meal is served;
14 and, be it further

15 RESOLVED, that the AOA encourage osteopathic medical schools, residency programs, and
16 hospitals to offer plant-based meals and eliminate sugar sweetened beverages and
17 processed meats when meals are served.

Explanatory Statement: Submitted by Finance Committee.
The staff determined an additional annual cost for breakfast, lunch and breaks of $135,000 in Food & Beverage expenses. This would only be incurred if offsets were not taken from other components of the Food & Beverage order for events. However, as meeting staff will strictly remain within their overall individual event budgets, the appropriate reductions would be made in other areas to offset the increased expenses associated with the "healthier" menu options thus no direct fiscal impact. The Committee recognizes that there could be an indirect fiscal impact that cannot be predicted.

Explanatory Statement: Reference Committee
Based on Finance Committee's estimate, the Committee believes the costs to implement is prohibitive and could result in a negative fiscal impact.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H324-A/14 USE OF THE TERM "PHYSICIAN" "DOCTOR" AND "PROVIDER"

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H324-A/14 USE OF THE TERM "PHYSICIAN" "DOCTOR" AND "PROVIDER"
The American Osteopathic Association (AOA) adopts as policy: (1) that AOA members are encouraged to use the terms "physician" or **"**doctor**"** to describe themselves, leaving other terms such as "practitioner," "clinician," or "provider" to be used by non-physician clinicians or to categorize health care professionals as a whole; (2) supports the appropriate use of credentials and professional degrees in advertisements; (3) SUPPORTS providing a mechanism for physicians to report advertisements related to medical care that are false or deceptive; (4) opposes non-physician clinicians' use of the title "physician," AS WELL AS USE OF THE TITLE~~or~~ "doctor" WITHOUT SPECIFYING THE TYPE OF DOCTORATE RECEIVED, because such communication is likely to ~~deceive~~ CONFUSE the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine; (5) opposes legislation that would expand the use of the term "physician" to persons other than US-trained DOs, and MDs; AND (6) supports a policy that physicians and non-physician clinicians SHOULD identify themselves to their patients ~~noting~~ USING their degree in both a verbal ~~description~~ INTRODUCTION as well as BY~~a~~ OTHER IDENTIFICATION CLEARLY VISIBLE DURING PATIENT ENCOUNTERS ~~visual identification by use of a nametag; (7) will not support legislation, which would allow non-physician clinicians to be called "physician;" (8) supports a policy reserving the title "physician" for US-trained DOs, and MDs who have established the integrity of their education, training, examination and regulations for the unlimited practice of medicine; and (9) opposes the misuse of the title "doctor" by non-physician clinicians, in all communications and clinical settings because such use deceives the public by implying the non-physician clinician's education, training or credentialing is equivalent to a DO or MD~~. 2009; reaffirmed as amended 2014

Explanatory Statement: Submitted by Author
Per the directive of the 2019 AOA House of Delegates, the BSGA convened a workgroup to discuss updates to this policy, specifically regarding use of the term "doctor" by non-DOs/MDs. The amended policy takes into account the fact that many types of healthcare professionals now undergo additional years of education and training in pursuit of a doctorate, and as of 2015, the doctorate is now the qualifying degree for physical therapists. Beginning in 2027, a doctorate will be required of occupational therapists as well. The revised policy balances patient safety by ensuring that patients are aware of who is providing their care, while appropriately recognizing doctoral degrees earned by non-physicians. In addition, the term "provider" is still commonly used among healthcare and governmental organizations to refer to healthcare professionals (including physicians) as a whole, and the revised policy reflects that fact.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, WHEREAS, in 2016 the United States Centers for Disease Control and Prevention (CDC) released its *"Guideline for Prescribing Opioids for Chronic Pain — United States, 2016"* [1] (Guidelines); and

WHEREAS, following its release, many legislatures and regulatory bodies adopted the Guidelines as standards of practice, enacted rules, and have taken action against prescribers who failed to rigidly follow the guidelines; and

WHEREAS these actions led the CDC to issue a statement warning against the misapplication of the Guideline [2]; and

WHEREAS in an article published in the New England Journal of Medicine, Deborah Dowell, MD, MPH, Chief Medical Officer, National Center for Injury Prevention and Control further stated, "*Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice.*" [3]; and

WHEREAS the misapplication of the Guidelines has a high potential for patient harm and may impose needless suffering on patients and bring unwarranted sanctions against physicians; and

WHEREAS through its participation in the American Medical Association's Opioid Task Force, the American Osteopathic Association (AOA) has developed and published recommendations [4] to assist physicians in reversing the opioid epidemic in the US; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) opposes the misuse and inflexible application of the United States Centers for Disease Control and Prevention (CDC) ~~released its~~ "Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, (Guidelines) by law makers and regulators; and be it further,

RESOLVED the AOA opposes the codification of the Guidelines into law or regulation and their use as a measure of the appropriateness of physicians prescribing; and be it further

RESOLVED the AOA recommends physicians read and consider the use of the 2019 AMA Opioid Task Force 2019 Guidelines[4] **4** in patients being treated for non-malignant chronic pain conditions.

Explanatory Statement: Submitted by Author
2019 AMA Opioid Task Force 2019 Guidelines attached

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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

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SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Public Affairs (400 series)
  This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Action
H400	Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents (H400-15)	BSAPH / BSA	ADOPTED
H401	Osteopathic Name and Identity (H401-A/15)	BOE	ADOPTED *(for sunset)*
H402	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (H402-A/15)	BSAPH	ADOPTED
H403	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (H403-A/15)	BSAPH	ADOPTED
H404	Vaccination Rates – Daycare Notification to Parents (H404-A/15)	BSGA	ADOPTED
H405	Protection of Safe Water Supply (H405-A/15)	BFHP / BSAPH	ADOPTED
H406	Antibiotic Stewardship (H407-A/15)	BSAPH	ADOPTED
H407	Vaccines for Children Program (H408-A/15)	BSAPH	ADOPTED
H408	Seat Belt Laws – Primary Enforcement (H409-A/15)	BSGA	ADOPTED
H409	Intrauterine Fetal Demise Awareness (H410-A/15)	BSAPH	ADOPTED
H410	Antifreeze Poisoning (H411-A/15)	BSAPH	NOT ADOPTED
H411	Aircraft Emergency Medical Supplies (H412-A/15)	BFHP	ADOPTED
H412	Animals in Medical Research (H413-A/15)	BSAPH	ADOPTED
H413	Cancer (H415-A/15)	BSAPH	ADOPTED
H414	Cardiopulmonary Resuscitation, Training (H416-A/15)	BSAPH	ADOPTED
H415	Children's Safety Seats (H418-A/15)	BSAPH	ADOPTED
H416	Death – Right to Die (H419-A/15)	BSGA	ADOPTED
H417	Environmental Responsibility--Waste Materials (H420-A/15)	BSAPH	ADOPTED
H418	Firearms and Non-Powdered Guns - Education for Users (H421-A/15)	BFHP	ADOPTED
H419	Genetic Manipulation of Food Products – Consumers Right to Know (H422-A/15)	BSAPH	ADOPTED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H420	Condom Usage – Health Education (H423-A/15)	BSAPH	ADOPTED
H421	Support of Literacy Programs (H424-A/15)	BSAPH	ADOPTED
H422	Tanning Devices (H425-A/15)	BSGA	ADOPTED
H423	Tobacco Settlement Funds (H426-A/15)	BSGA	ADOPTED
H424	Healthy Family, Support of (H428-A/15)	BSAPH	ADOPTED
H425	Immunization of 9 to 26 Year Old Male and Females with Human Papilloma Virus Vaccine (H429-A/15)	BSAPH	ADOPTED as AMENDED
H426	Drugs, Curbing Counterfeit (H430-A/15)	BFHP	ADOPTED
H427	Sleep Disorders – Promoting the Understanding and Prevention of (H432-A/15)	BSAPH	ADOPTED
H428	Minority Health Disparities (H433-A/15)	BSAPH	ADOPTED as AMENDED
H429	Infant Walker (Mobile) – Ban on the Manufacture, Sale and Use of (H434-A/15)	BSAPH	ADOPTED
H430	Develop In-Vitro Fertilization Standards of Care (H435-A/15)	BSAPH	ADOPTED as AMENDED
H431	Complementary and Alternative Medicine by Non-Physicians (H436-A/15)	BSGA	REFERRED
H432	Continued Support OF Combating Bio-Terrorism Activities (H437-A/15)	BFHP	ADOPTED as AMENDED
H433	Childhood Obesity – Worsening Epidemic in the American Society (H438-A/15)	BSAPH	ADOPTED
H434	Immunizations – Mainstay of Preventive Medical Practice (H439-A/15)	BSAPH	ADOPTED
H435	Texting While Driving (H440-A/15)	BSAPH	ADOPTED
H436	Silver Alert System (H442-A/15)	BFHP	ADOPTED
H437	National Institutes of Health Grants (H443-A/15)	BFHP	ADOPTED as AMENDED
H438	Screening for Breast Cancer (H444-A/15)	BSAPH	ADOPTED
H439	Gender Identity Non-Discrimination (H445-A/15)	BSAPH	ADOPTED
H440	Traumatic Brain Injury Awareness (H446-A/15)	BSAPH	ADOPTED as AMENDED
H441	Support for Family Caregivers (H448-A/15)	BSAPH	ADOPTED
H442	Firearm Violence (H450-A/15)	BFHP	ADOPTED as AMENDED
H443	Addressing Police Use of Disproportionate Force…	SOMA	REFERRED

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SPECIAL SESSION OF THE
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OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H444	Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders	SOMA	ADOPTED
H445	AOA Response to Novel Public Health Threats	MOA	ADOPTED
H446	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase	BFHP	ADOPTED
H447	Fentanyl Testing Strips	AOAAM	ADOPTED as AMENDED
H448	Firearms Policy	BFHP	REFERRED
H449	Homeless Support	OPSC	ADOPTED as AMENDED
H450	Medical Amnesty for Underage Consumption of Alcohol	AOAAM	REFERRED
H451	Opposition to Abstinence-Only Sex Education	SOMA	WITHDRAWN
H452	REFERRED RESOLUTION: Breastfeeding While on Medication Assisted Treatment (MAT)	BSAPH	ADOPTED
H453	REFERRED SUNSET RESOLUTION: H-411 - A/2019: H413-A/14 Epidemic Terrorist Attack Victims, Government Responsibility of Health Care	BFHP	ADOPTED as AMENDED
H454	REFERRED SUNSET RESOLUTION: H429 A/14 Minorities, Underrepresented (URM) – Increasing Numbers of Applicants…	BSAPH	ADOPTED as AMENDED
H455	REFERRED RESOLUTION: Regulation of E-Cigarettes and Nicotine Vaping	BSAPH	ADOPTED as AMENDED
H456	Recognizing Health Care as a Human Right	MOA	NOT ADOPTED
H457	Support a Culture of Patient Safety and Speaking Up from Medical Students and Preceptors in Healthcare Settings	SOMA	WITHDRAWN
H458	WITHDRAWN	IOMA	WITHDRAWN

SUBJECT: H400-A/15 INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGENTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health / Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health and Bureau of
2 Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H400-A/15 INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP**
5 **BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER**
6 **AGENTS**
7 The American Osteopathic Association opposes any interference in the physician-patient
8 relationship by persons with financial and business interests regarding a personal injury incident.
9 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H401-A/15 OSTEOPATHIC NAME AND IDENTITY

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be SUNSET.

3 **H401-A/15 OSTEOPATHIC NAME AND IDENTITY**
4 The American Osteopathic Association will advise the Accreditation Council for Graduate
5 Medical Education that MDs who complete osteopathic-recognized residencies should describe
6 themselves as "MDs who have been trained in Osteopathic Manipulative Medicine" and not as
7 Osteopathic Physicians or DOs. 2015.

Explanatory Statement: Submitted by Author
The BOE recommends this policy be sunset because the AOA no longer separately accredits graduate medical education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 14, 2020**

SUBJECT: H402-A/15 PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H402-A/15 PUBLIC EDUCATION REGARDING THE IMPORTANCE AND**
5 **SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS**
6 The American Osteopathic Association supports the widespread use and high compliance rate
7 of the Health and Human Services National Vaccine Implementation Plan for infants, children,
8 and adults through education of the public using media and marketing tools available to its
9 organization. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H403-A/15 SUPPORT FOR THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H403-A/15 SUPPORT FOR THE ADVISORY COMMITTEE ON**
5 **IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS**
6 The AOA encourages osteopathic physicians consider the vaccination history as an integral part
7 of their patient's health record and should counsel their patients on appropriate vaccinations for
8 their age and health conditions. Osteopathic physicians should take all reasonable steps to
9 ensure their patients of all ages are fully immunized against vaccine preventable illnesses and
10 make vaccine recommendations to their patients according to the recommendations of the
11 Advisory Committee on Immunization Practices (ACIP) and published in the Morbidity and
12 Mortality Weekly Report (MMWR) and should not advocate alternative schedules. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H404-A/15 VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H404-A/15 VACCINATION RATES – DAYCARE NOTIFICATION TO**
5 **PARENTS**
6 The American Osteopathic Association (AOA) supports legislation at the state level that
7 requires daycare facilities to notify parents (in compliance with Health Insurance Portability and
8 Accountability Act (HIPAA) regulations and state regulations where applicable) that their
9 facility has in its care unvaccinated children who may pose a health risk to high risk populations.
10 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H405-A/15 PROTECTION OF SAFE WATER SUPPLY

SUBMITTED BY: Bureau on Federal Health Programs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs and the Bureau on Scientific Affairs
2 recommends that the following policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H405-A/15 PROTECTION OF SAFE WATER SUPPLY**
5 The American Osteopathic Association (AOA) ~~will~~ encourageS the oil industry and the
6 Environmental Protection Agency (EPA) to seek out new technologies for safer disposal of
7 waste well water and the protection of our water supply. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H407-A/15 ANTIBIOTIC STEWARDSHIP

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H407-A/15 ANTIBIOTIC STEWARDSHIP**
5 The American Osteopathic Association (AOA), supports the five core actions outlined in the
6 National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic
7 physicians to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which
8 is a commitment to ~~always~~ use antibiotics only when they are MEDICALLY necessary ~~to treat,~~
9 ~~and in some cases prevent, disease; to choose the right antibiotics; and to administer~~
10 ~~appropriately~~. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H408-A/15 VACCINES FOR CHILDREN PROGRAM

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H408-A/15 VACCINES FOR CHILDREN PROGRAM**
5 The American Osteopathic Association supports the expansion of the Vaccines for Children
6 (VFC) Program to include all Advisory Committee on Immunizations Practices (ACIP) age
7 appropriate vaccines for all underinsured children, in keeping with the original goals of the
8 program. 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H409-A/15 SEAT BELT LAWS – PRIMARY ENFORCEMENT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H409-A/15 SEAT BELT LAWS – PRIMARY ENFORCEMENT**
5 The American Osteopathic Association ~~endorses~~ SUPPORTS the ~~passage of~~ primary
6 enforcement seat belt laws in every state. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H410-A/15 INTRAUTERINE FETAL DEMISE AWARENESS

SUBMITTED BY: Bureau on Scientific Affairs and Public Heath

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H410-A/15 INTRAUTERINE FETAL DEMISE AWARENESS**
5 The American Osteopathic Association supports increasing public awareness of the risk for
6 intrauterine fetal demise and encourages the director of the National Institutes of Health to
7 allocate more resources to intrauterine fetal demise research. 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H411-A/15 ANTIFREEZE POISONING

SUBMITTED BY: Bureau on Scientific Affairs and Public Heath

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H411-A/15 ANTIFREEZE POISONING**
5 The American Osteopathic Association supports the addition of a bittering agent to antifreeze
6 to lessen the likelihood of accidental ingestion. 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The addition of a bittering agent to antifreeze is now the law in all 50 states so this policy is no longer needed.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H412-A/15 AIRCRAFT EMERGENCY MEDICAL SUPPLIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H412-A/15 AIRCRAFT EMERGENCY MEDICAL SUPPLIES**
5 The American Osteopathic Association supports the concept that airlines, under the control of
6 the Federal Aviation Administration, maintain a policy for adequately equipping commercial
7 aircraft of greater than 19 seats with at least minimal diagnostic and emergency medical supplies
8 and supports legislation and regulation that any physician providing emergency service while on
9 board aircraft be immune from any liability or legal action. 1984; revised 1989, 1995; reaffirmed
10 2000, revised 2005, reaffirmed 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H413-A/15 ANIMALS IN MEDICAL RESEARCH

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H413-A/15 ANIMALS IN MEDICAL RESEARCH**
5 The American Osteopathic Association (AOA) supports the use of animals for valid medical
6 research projects and the humane handling and treatment of such animals, and their ready
7 availability from legitimate sources. The AOA supports eventual elimination of the use of
8 animals in medical research as better techniques become available. 1990; reaffirmed 1995;
9 revised 2000, revised 2005; reaffirmed 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H415-A/15 CANCER

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H415-A/15 CANCER**
5 The American Osteopathic Association recognizes, endorses, and approves the continuing
6 efforts of the National Cancer Institute to develop means to significantly reduce the incidence
7 of cancer and the suffering and death resulting from cancer. THE AOA ~~and~~ will disseminate to
8 the medical community and the public ~~it serves~~, information gained from osteopathic and other
9 research activities on the applications of the latest advances in cancer prevention, detection,
10 early diagnosis and treatment. 1974; reaffirmed 1980, 1985; revised 1990, 1995, reaffirmed 2000,
11 revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H416-A/15 CARDIOPULMONARY RESUSCITATION, TRAINING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H416-A/15 CARDIOPULMONARY RESUSCITATION~~,~~ AND AUTOMATED**
5 **EXTERNAL DEFIBRILLATOR TRAINING**
6 The American Osteopathic Association strongly supports instruction in cardiopulmonary
7 resuscitation (CPR) AND AUTOMATED EXETERNAL DEFIBRILLATOR (AED)
8 TRAINING to the general public; and encourages member physicians to qualify as instructors
9 in basic life support so as to enable them to teach cardiopulmonary resuscitation AND AED
10 courses on a voluntary basis. 1980; revised 1985, 1990, 1995, 2000, reaffirmed 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H418-A/15 CHILDREN'S SAFETY SEATS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H418-A/15 CHILDREN'S SAFETY SEATS**
5 The American Osteopathic Association supports the ADIPTION AND enforcement of child
6 safety seat statutes in accordance with the National Highway Traffic Safety Administration
7 Guidelines. 1985; revised 1990; reaffirmed 1995; revised 2000, 2005; revised 2010; reaffirmed
8 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H419-A/15 DEATH - RIGHT TO DIE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H419-A/15 ~~DEATH - RIGHT TO DIE~~ END OF LIFE**
5 The AOA believes that the decision to withhold or withdraw treatment from a patient whose
6 prognosis is terminal, or when death is imminent, shall be based upon the wishes of the patient
7 or THEIR ~~his/her~~ family or legal representative if the patient lacks capacity to act on THEIR
8 ~~his/her~~ own behalf as mandated by applicable law. 1979; revised 1984, 1989, 1995, 2000, 2005;
9 revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H420-A/15 ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H420-A/15 ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS**
5 The American Osteopathic Association supports ~~the~~ recycling ~~of all recyclables~~. 1995; revised
6 2000, revised 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H421-A/15 FIREARMS AND NON-POWDERED GUNS - EDUCATION FOR USERS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H421-A/15 FIREARMS AND NON-POWDERED GUNS - EDUCATION FOR**
5 **USERS**
6 The American Osteopathic Association supports education involving firearm and non-
7 powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990;
8 reaffirmed 1995, 2000, 2005; revised 2010; revised 2015 [Editor's Note: Non-Powdered Guns
9 are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard
10 plastic) through the force **OF COMPRESSED AIR OR GAS, ELECTRICITY,** ~~**of air**~~
11 ~~**pressure, CO2 pressure,**~~ or spring action. Non-powder guns are distinguished from firearms,
12 which use gunpowder to generate energy to launch a projectile.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H422-A/15 GENETIC MANIPULATION OF FOOD PRODUCTS – CONSUMERS RIGHT TO KNOW

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H422-A/15 GENETIC MANIPULATION OF FOOD PRODUCTS –**
5 **CONSUMERS RIGHT TO KNOW**
6 The American Osteopathic Association supports efforts that require clear identification of any
7 genetically manipulated food products so that consumers may be properly informed as they
8 make food choices. 2000, revised 2005, reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H423-A/15 CONDOM USAGE – HEALTH EDUCATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H423-A/15 CONDOM USAGE – HEALTH EDUCATION**
5 The American Osteopathic Association supports full disclosure of the risks and benefits of
6 condom usage and the data on condom failure rates and causes of failure, whenever condom
7 usage is taught. 1995; revised 2000, 2005, reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H424-A/15 SUPPORT OF LITERACY PROGRAMS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H424-A/15 SUPPORT OF LITERACY PROGRAMS**
5 The American Osteopathic Association supports programs that promote literacy in the United
6 States. 1990; revised 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H425-A/15 TANNING DEVICES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H425-A/15 TANNING DEVICES**
5 The American Osteopathic Association SUPPORTS EDUCATION AND LEGISLATION
6 TO REDUCE THE use of tanning devices EXCEPT WHERE MEDICALLY INDICATED.
7 1990; revised 1995, 2000, reaffirmed 2005; revised 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H426-A/15 TOBACCO SETTLEMENT FUNDS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H426-A/15 TOBACCO SETTLEMENT FUNDS**
5 The American Osteopathic Association supports the use of the tobacco settlement fund
6 EXCLUSIVELY for health care services, education and research. 2000, revised 2005;
7 reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H428-A/15 HEALTHY FAMILY, SUPPORT OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H428-A/15 HEALTHY FAMILY, SUPPORT OF

The American Osteopathic Association recommends that their members support healthy families by encouraging families to do the following: (1) try to eat at least one meal per day together, using healthful nutritional guidelines; (2) a set time be spent together as a family to help with school work and include reading to and with children; (3) ENCOURAGING MEDIA-FREE TIME ~~limiting non-educational use of television, computer, texting / telephones and video game to no more than 2 hours per day~~; (4) limiting exposure to violence; and (5) engaging in a healthy lifestyle that includes exercise. 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H429-A/15 IMMUNIZATION OF 9 TO 26 YEAR OLD MALE AND FEMALES WITH HUMAN PAPILLOMA VIRUS VACCINE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H429-A/15 IMMUNIZATION ~~OF 9 TO 26 YEAR OLD MALE AND FEMALES~~ WITH HUMAN PAPILLOMA VIRUS VACCINE

The American Osteopathic Association ~~recommends~~ SUPPORTS EDUCATION AND IMMUNIZATION for Human Papilloma Virus (HPV) ~~immunization for both females and males, 9 – 26 45 years of age~~. 2010; reaffirmed 2015

Explanatory Statement

Overview:

Human Papillomavirus is a human-specific class of sexually transmitted viruses with over 200 types associated with multiple diseases in humans. These include benign conditions such as genital and nongenital warts and malignant conditions such as cervical, anal, oropharyngeal, vaginal, and vulvar cancer(4).There are approximately 33,700 cases of cancer caused by HPV diagnosed annually(1). Furthermore, the incidence of cervical cancer worldwide is predicted to increase by 50% with the current rate of vaccination (3). Risk factors for developing these malignant conditions include exposure to and infection with associated strains of the HPV Virus (4,5). A recombinant vaccine has been developed including 9 strains associated with malignancy, including types 16 and 18 which are responsible for 70-80% of all cases of Cervical Cancer and 90% of Anal Cancer(6). Based on recent data from the CDC and clinical trials (7,8,9), the FDA has recommended that the recombinant vaccine be administered in both women and men until the age of 45(1,2).

Background:

The HPV recombinant vaccines that have been Bivalent, or targeting 2 strains, have been available since 2006. These initial vaccines targeted 2 strains most commonly associated with Cervical Cancer: strains 16 and 18. In 2017, the Gardasil 9 vaccine was released targeting 9 strains of the virus: 6, 11, 16, 18, 31, 33, 45, 52, and 58 (6). Although 2 of these strains (strains 6 and 11) are more likely to be associated with the development of non-cancerous genital and nongenital warts, the link between presence of warts and development of cancerous lesions is currently being studied (5).

The vaccine was recommended to be administered to women and men ages 9-25(2) as evidence demonstrated that the vaccine is most effective in those who have not previously been exposed to the HPV virus (1,8,9).

Since 1999, there has been a decrease in the incidence of HPV related cervical carcinoma by 1.6%, however there has been an increase in HPV related Cancer of the Mouth and Throat, known as Oropharyngeal Squamous Cell Carcinoma by 2.7% in men and 0.8% in women (7). A study conducted in 2016 revealed that there was a decrease in infection rates and development of Cervical Intraepithelial Neoplasia (a precancerous lesions which can develop into Cervical Carcinoma) in women over 25 who had received the HPV recombinant vaccine and had no previous exposure to HPV over a 7 year period (8,9). In 2018, the FDA revised the Prescribing Information for Gardasil to allow the vaccine to be administered to both women and men until the age of 45 if there was no previous history of HPV infection (2).

Recommendations:

Clinical trials (8,9) have proven that the vaccine is just as effective in both Males and Females over the age of 25 who do not have a history of HPV, the policy should be updated in conjunction with the Prescriber Information and the FDA recommendations - any male without a history of HPV associated warts (genital and nongenital) between the ages of 25-45 and any female between the ages of 25-45 with no history of HPV related warts (genital and nongenital) or negative HPV test with Pap Smear be eligible for 9-valent HPV recombinant vaccine if not previously administered.

In conjunction with current guidelines, regular pap smears should include HPV testing for women above the age of 18, extending the age limit in guidelines beyond the age of 26 (1,6,7).

Sources:

1. ACIP Evidence to Recommendations for HPV Vaccine
https://www.cdc.gov/vaccines/acip/recs/grade/HPV-adults-etr.html

2. Gardasil 9 Prescribing Information

https://www.merck.com/product/usa/pi_circulars/g/gardasil_9/gardasil_9_pi.pdf

3. WHO Call to Action to Eradicate Cervical Cancer

https://www.who.int/reproductivehealth/DG_Call-to-Action.pdf?ua=1

4. UpToDate HPV https://www.uptodate.com/contents/human-papillomavirus-infections-epidemiology-and-disease-associations?search=hpv&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

5. Virology of HPV Infections and Link to Cancer

https://www.uptodate.com/contents/virology-of-human-papillomavirus-infections-and-the-link-to-

cancer?search=hpv&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3

6. HPV Vaccination

https://www.uptodate.com/contents/human-papillomavirus-vaccination?search=hpv&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

7. Trends in HPV Related Cancers 1999-2015

https://www.cdc.gov/mmwr/volumes/67/wr/mm6733a2.htm?s_cid=mm6733a2_w%20%5Bcdc.gov%5D

8. Efficacy, Safety, and Immunogenicity of HPV 16/18 ASOV-adjuvanted vaccine in women over 25 years

https://www.ncbi.nlm.nih.gov/pubmed?term=27373900

9. FUTURE Trial for HPV Vaccination

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4636904/#S5title

10. AOA 2019 Policy Compendium

https://osteopathic.org/wp-content/uploads/2019-Policy-Compendium.pdf

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H430-A/15 DRUGS, CURBING COUNTERFEIT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H430-A/15 DRUGS, CURBING COUNTERFEIT**
5 The American Osteopathic Association supports the Food and Drug Administration's (FDA)
6 efforts to educate osteopathic physicians on how to identify counterfeit drugs. 2005; revised
7 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H432-A/15 SLEEP DISORDERS – PROMOTING THE UNDERSTANDING AND PREVENTION OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H432-A/15 SLEEP DISORDERS – PROMOTING THE UNDERSTANDING**
5 **AND PREVENTION OF**
6 The American Osteopathic Association supports programs that promote education and
7 understanding of sleep and its impact on health and encourages osteopathic physicians to
8 educate their patients about sleep disorders and the importance of sleep and its impact on
9 health. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H433-A/15 MINORITY HEALTH DISPARITIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H433-A/15 MINORITY HEALTH DISPARITIES

The American Osteopathic Association adopts the following Position Statement on Minority Health Disparities (2005; reaffirmed 2010; 2015):

POSITION STATEMENT ON MINORITY HEALTH DISPARITIES

The minority healthcare crisis in America stems from a multitude of factors. In particular, healthcare disparities most greatly affect underrepresented minorities, which include African-Americans, Hispanic-Americans, Asian-Americans, Native Americans and Pacific Islanders. In order to effectively create positive change, certain questions must be addressed. These include, but are not limited to**:** Which minorities are most affected by disease-specific illness? Why do these disparities exist? What can be done to eliminate them? Will a concerted effort to increase awareness and education about health-care disparities result in improved delivery of quality healthcare?

There is a need for the osteopathic profession and all of organized medicine to develop strategies which address health care disparities among minorities and prepare culturally competent physicians. Guidance should be offered to educate practicing physicians and trainees to better resolve known disparities and serve diverse populations. Efforts must be made to assure cultural competency and to identify and overcome language and other barriers to delivering health care to minorities.

Healthcare disparities include differences in health coverage, health access and quality of care. Health disparities result in morbidity and mortality experienced by one population group in relation to another.

Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high quality care.

Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.

The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify

and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities.

The identified areas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) **INFECTIOUS DISEASES (I.E., COVID-19, INFLUENZA, HIV/AIDS);** ~~HIV/AIDS;~~ and 6) child and adult immunizations. In addition, serious disparities exist in the provision of care for mental health problems, substance abuse and suicide prevention.

The American Osteopathic Association calls for the following actions to be taken to address minority health disparities and to improve cultural competency of its physician members:

1. ~~The creation of a forum~~ **THE** EDUCATION OF PHYSICIANS **REGARDING** ~~ABOUT to increase physician knowledge on~~ racial and ethnic healthcare needs, including disparities in the areas listed above;
2. ~~The elimination of provider stereotypical beliefs BIASES AMONG HEALTH CARE PROFESSIONALS~~ **THE PROMOTION OF EDUCATION REGARDING IMPLICIT OR EXPLICIT BIASES AMONG HEALTHCARE PROFESSIONALS** that may play a role in clinical decision-making;
3. The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk;
4. The identification of new methods to involve physician members in the communities in which they serve;
5. The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government;
6. The inclusion of cultural competency training throughout the continuum of osteopathic education;
7. The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties;
8. The development of approaches to encourage all physicians to provide care to underserved minority populations;
9. The adoption of strategies to assist physicians to effectively communicate with their patients, addressing translation and other barriers to patient understanding.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H434-A/15 INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE, SALE AND USE OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H434-A/15 INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE,**
5 **SALE AND USE OF**
6 The American Osteopathic Association supports the ban on the manufacture, sale and use of
7 mobile infant walkers; and urges osteopathic physicians to educate parents and other caregivers
8 on the risks associated with the use of these devices. 2003; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
Infant Walker–Related Injuries in the United States Ariel Sims, Thitphalak Chounthirath, Jingzhen Yang, Nichole L. Hodges and Gary A. Smith Pediatrics October 2018, 142 (4) e20174332; DOI: https://doi.org/10.1542/peds.2017-4332

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H435-A/15 DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H435-A/15 DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE**
5 The American Osteopathic Association supports the appropriate and evidenced based use of
6 in-vitro fertilization in a manner that promotes the health and safety of both the mother and
7 embryo; and supports the ethical guidelines for the practice of in-vitro fertilization ~~set by the~~
8 ~~American Society of Reproductive medicine~~ that include, but are not limited to, the appropriate
9 number of embryos implanted per patient. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H436-A/15 COMPLEMENTARY AND ALTERNATIVE MEDICINE BY NON-PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H436-A/15 COMPLEMENTARY AND ALTERNATIVE MEDICINE ~~BY~~ – CULTURAL SENSITIVITY TO AND AWARENESS OF

The American Osteopathic Association (1) encourages its members to become knowledgeable about complementary and alternative medicine; (2) encourages its members to discuss the use of complementary and alternative medicine with their patients in a respectful and culturally sensitive manner~~; AND~~ (3) encourages the continued performance of well-designed, evidence-based research on the efficacy and safety of complementary and alternative medicine. ~~; and (4) opposes all attempts to permit non-physicians to gain practice rights or expand their scope of practice to include complementary and alternative medicine practices.~~ **AND (4) OPPOSES ALL ATTEMPTS TO PERMIT NON-DO/MD PHYSICIANS TO GAIN ADDITIONAL PRACTICE RIGHTS OR EXPAND THEIR SCOPE OF PRACTICE TO INCLUDE COMPLEMENTARY AND ALTERNATIVE MEDICINE PRACTICES.** 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
This statement was added back into H431 because AOA should strongly oppose any expansion of scope of practice from non-physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau of Osteopathic Research and Public Health)*

DATE: **October 14, 2020**

SUBJECT: H437-A/15 CONTINUED SUPPORT OF COMBATING BIO-TERRORISM ACTIVITIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H437-A/15 CONTINUED SUPPORT OF COMBATING BIO-TERRORISM**
5 **ACTIVITIES**
6 The American Osteopathic Association ~~recommends the continued~~ supportS ~~of~~ any and all
7 constitutionally legal efforts to prevent and respond to future acts of bio-terrorism in the
8 United States. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H438-A/15 CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H438-A/15 CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY

The American Osteopathic Association ENCOURAGES ~~will makes efforts to educate~~ schools and vending machine suppliers TO INCLUDE ~~of the need of~~ healthy choice snacks IN VENDING MACHINES; and supports the limited use of vending machines in schools to avoid unnecessary caloric intake. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H439-A/15 IMMUNIZATIONS – MAINSTAY OF PREVENTIVE MEDICAL PRACTICE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H439-A/15 IMMUNIZATIONS – MAINSTAY OF PREVENTIVE MEDICAL**
5 **PRACTICE**
6 The American Osteopathic Association will create stronger ties with pro-immunization groups
7 within and outside the osteopathic profession; and whenever possible, will assist these pro-
8 immunization groups with appropriate evidence-based information regarding the safety of
9 immunizations and significant positive effects of the proper use of immunizations relative to
10 the overall public safety. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H440-A/15 TEXTING WHILE DRIVING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H440-A/15 TEXTING WHILE DRIVING**
5 The American Osteopathic Association supports efforts to educate all drivers concerning the
6 dangers of texting and driving and supports efforts to ban the use of texting while driving.
7 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H442-A/15 SILVER ALERT SYSTEM

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H442-A/15 SILVER ALERT SYSTEM**
5 The American Osteopathic Association supports the formation of a "Silver Alert" System on a
6 national level to notify communities of missing persons with mental disabilities, particularly
7 seniors with cognitive or developmental impairments. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H443-A/15 NATIONAL INSTITUTES OF HEALTH GRANTS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H443-A/15 NATIONAL INSTITUTES OF HEALTH (NIH) - GRANTS
The American Osteopathic Association encourages osteopathic physicians, osteopathic medical schools, and their affiliated institutions to pursue NIH funding for biomedical research; and requests that the NIH include osteopathic medical schools in the overall United States medical school funding reports and also to include a category specific to O~~o~~steopathic MANIPULATIVE TREATMENT **(OMT)** IN THE ESTIMATES OF FUNDING FOR VARIOUS RESEARCH, CONDITION, AND DISEASE CATEGORIES (RCDC) ~~among the Research Condition and Disease Categories~~ reported each year to Congress and the American public. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H444-A/15 SCREENING FOR BREAST CANCER

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H444-A/15 SCREENING FOR BREAST CANCER**
5 The American Osteopathic Association recognizes and promotes the importance of the
6 integrity of the patient-physician relationship and recommends that breast cancer clinical
7 preventive screenings and coverage be individualized to the extent possible for every patient.
8 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H445-A/15 GENDER IDENTITY NON-DISCRIMINATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H445-A/15 GENDER IDENTITY NON-DISCRIMINATION**
5 The American Osteopathic Association supports the provision of adequate and medically
6 necessary treatment for transgender and gender-variant people and opposes discrimination on
7 the basis of gender identity. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H446-A/15 TRAUMATIC BRAIN INJURY AWARENESS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H446-A/15 TRAUMATIC BRAIN INJURY AWARENESS**
5 The American Osteopathic Association **(AOA)** believes that osteopathic physicians should be
6 aware of and utilize "best practices" when caring for victims of civil or military conflicts, or
7 natural or man-made disasters, including civilians, returning veterans and their families,
8 particularly those with traumatic brain injury (TBI); and the AOA will work in conjunction with
9 state, specialty and regional societies to provide educational programs to advance this goal.
10 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H448-A/15 SUPPORT FOR FAMILY CAREGIVERS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H448-A/15 SUPPORT FOR FAMILY CAREGIVERS**
5 The American Osteopathic Association, recognizing a growing number of family caregivers
6 have unaddressed needs related to personal health and wellbeing, supports caregivers by
7 participating in the developing public debate regarding health care policy to include family
8 caregivers and encourages its members to gain education in caregiver illnesses, resources in their
9 area and treat and/ refer when appropriate. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H450-A/15 FIREARM VIOLENCE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be ~~**SUNSET**~~ **REAFFIRMED**.

(Old language is crossed out and new language is in CAPS)

H450-A/15 FIREARM VIOLENCE

The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;" (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015

AOA Policy Statement – Firearm Violence

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. The AOA supports the Administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

1 Improving access to mental health services and resources is essential to reducing firearm violence. The
2 AOA supports promotion of policies that will increase access to mental health services and for the
3 appropriate coverage of mental health services by public and private health care programs. Access to
4 mental health services and resources for young adults should be a priority. The early identification of
5 diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

Explanatory Statement: Submitted by Author
As per H437-A/19 FIREARM VIOLENCE The American Osteopathic Association (AOA) will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates. 2019

Explanatory Statement: Reference Committee
H448/2020 FIREARMS POLICY requires that all firearms policies "should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis." Therefore, H442 should be reaffirmed.

Background Information: Provided by AOA Staff
Current AOA Policy: H437-A/19 FIREARM VIOLENCE

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: ADDRESSING POLICE USE OF DISPROPORTIONATE FORCE AGAINST AFRICAN AMERICANS AND OTHER MARGINALIZED POPULATIONS AS AN EMERGING NATIONAL PUBLIC HEALTH ISSUE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, according to the study published April 2019 by The Proceedings of the National
2 Academies of Sciences, in the U.S., police violence is a leading cause of death for
3 minority populations such as African American, American Indian and Alaskan Natives;
4 with African American males having the highest incidence rate, facing a 1 in 1,000-
5 lifetime risk of being killed during a police encounter, which is 2.5 times higher than
6 their white male counterparts[3]; and

7 WHEREAS, deficiencies in internal policies and training[4], coupled with lack of adherence to
8 force continuum, requiring officers to prevent excessive force and de-escalate
9 encounters, has created a window to limit the accountability of police force, resulting in
10 increased mortality within already marginalized people of color [3,5]; and

11 WHEREAS, the American Public Health Association (AHPA) passed a policy in 2018
12 acknowledging the current law enforcement system mediates the physical and
13 psychological violence directed against marginalized populations that results in the
14 disproportionate death, injuries and trauma of these marginalized populations, with
15 these law-enforcement related deaths amounting to 54,754 years of life lost[2]; and

16 WHEREAS, the AOA approved policy H439-A/16 which states the AOA's support of "the
17 protection of [LGBTQ] individuals from discriminating practices and harassment[1]; and
18 reaffirmation of the equal rights and protections for all patient populations; and

19 WHEREAS, an AOA policy that specifically acknowledges gun-violence against marginalized
20 populations wound be concordant with the previously approved resolution H630-A/18
21 resolving that the AOA joins like-minded organizations in the call for congressional
22 legislation that labels gun violence as a national public health issue[1]; now, therefore be it

23 RESOLVED, that the American Osteopathic Association (AOA) acknowledges the
24 disproportionate use of force by law enforcement against African Americans and other
25 marginalized groups and its physical and mental health effects on communities.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. AOA Policy Search. (n.d.). Retrieved from https://osteopathic.org/about/leadership/policy-search/.

2. AHPA, (2019, January 29). Addressing Law Enforcement Violence as a Public Health Issue. (n.d.). Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence
3. Edwards, F., Lee, H., & Esposito, M. (2019, August 20). Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. Retrieved from https://www.pnas.org/content/116/34/16793.
4. Jackman, T. (2015, October 15). De-escalation training to reduce police shootings facing mixed reviews at launch. Available at: https://www.washingtonpost.com/local/public-safety/de-escalation-training-to-reduce-police-shootings-facing-mixed-reviews-at-launch/2016/10/14/d6d96c74-9159-11e6-9c85-ac42097b8cc0_story.html
5. Obasogie, O. K., & Newman, Z. (2017, December 18). Police Violence, Use of Force Policies, and Public Health. Retrieved from https://journals.sagepub.com/doi/full/10.1177/0098858817723665

Explanatory Statement: Reference Committee
Refer back to SOMA to rewrite the Resolve statement to include the health implications of this policy.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ADOPTING AND PROMOTING NON-STIGMATIZING LANGUAGE FOR SUBSTANCE USE DISORDERS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, in a cross-cultural study on 18 of the most stigmatized conditions across 14
2 countries, the World Health Organization determined substance use disorder to be the
3 most stigmatized condition in the world[1]; and

4 WHEREAS, there are 20.8 million people in the United States struggling with a substance use
5 disorder, yet only 10% receive help[2] despite the high prevalence of 14,500 treatment
6 facilities[3] and 100,000 recovery support meetings across the nation[4]; and

7 WHEREAS, stigma is a commonly cited reason for not seeking treatment and recovery[5]; and

8 WHEREAS, research shows that stigmatizing language causes clinicians to have more
9 pejorative attitudes and even to recommend punishment instead of treatments for this
10 medical condition[6]; and

11 WHEREAS, the International Society of Addiction Journal Editors recommends against the
12 use of terminology that can stigmatize people with substance abuse disorders[7]; and

13 WHEREAS, the Office of National Drug Control Policy issued a memorandum to the Heads
14 of Executive Departments and Agencies about the importance of changing federal
15 terminology related to substance use disorders[8]; and

16 WHEREAS, the American Osteopathic Association (AOA) has not yet issued a resolution to
17 adopt and education members on the importance of non-stigmatizing language related
18 to substance use disorders; and

19 WHEREAS, the AOA has shown a commitment to addressing substance use disorders through
20 outreach, education modules[9], and policy efforts[10];

21 WHEREAS, the AOA's 2019 policy compendium contained the word "abuse" in the context
22 of substance use disorders 36 times throughout the written policies, not including
23 language in citations or organizational names such as the National Institute of Drug
24 Abuse – situations in which this word would have been reasonable[10]; now, therefore be
25 it

26 RESOLVED, that the American Osteopathic Association (AOA) commit to the use of
27 clinically- accurate, non-stigmatizing, person-first language ("substance use disorder,"
28 "recovery," "substance misuse," "positive or negative urine screen," and "person with a
29 substance use disorder") and discourage the use of stigmatizing terminology ("substance
30 abuse," "substance abuser," "addict," "alcoholic," and "clean/dirty") in future

publications, resolutions, and educational materials both in print and online; and, be it further

RESOLVED, that the AOA encourages its members and organizational partners to incorporate clinically-accurate, non-stigmatizing, person first language into their clinical practice.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Room, R., Rehm, J,, Trotter, R.T., Paglia, A., & Üstün, T.B. (2001). Cross-cultural views on stigma valuation parity and societal attitudes towards disability. Üstün, T.B. (Ed.). Seattle, WA: Hofgrebe & Huber.
2. United States Department of Health and Human Services. (2016). Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC.
3. National Institute on Drug Abuse. (2018). Principles of Drug Abuse Treatment: A Research Based Guide (Third Edition). Washington, DC.
4. Kelly, J.F. (2016, September). Addiction, Stigma, Treatment, Recovery. Talk presented at Massachusetts General Hospital Recovery Month; September 2016; Boston, Massachusetts.
5. Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
6. Kelly, J.F., Westerhoff, C.M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy, 21(3), 202-207.
7. International Society of Addiction Journal Editors website. (2015). Statements and Guidelines: Addiction Terminology. Retrieved October 5, 2019 from http://www.isaje.net/addiction-terminology.html.
8. Botticelli, M.P. Executive Office of the President of the United States. Memorandum to Heads of Executive Departments and Agencies: Changing Federal Terminology Regarding Substance Use and Substance Use Disorders. Washington, DC.
9. American Osteopathic Association website. (n.d.). Preventing Drug and Substance Use Disorders. Retrieved on October 5, 2019 from https://osteopathic.org/practicing-medicine/providing-care/preventing-drug-use-disorders
10. American Osteopathic Association website. (2019, September). American Osteopathic Association Policy Compendium 2019. Retrieved October 5, 2019 from https://osteopathic.org/wp-content/uploads/2019-Policy-Compendium.pdf.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA RESPONSE TO NOVEL PUBLIC HEALTH THREATS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the United States Center for Disease Control and Prevention has attributed more
2 than two million cases and one hundred and twenty thousand deaths in the U.S. as of
3 June 2020 due to the COVID-19 pandemic, with more than nine million cases and
4 nearly five hundred thousand deaths globally attributed to COVID-19 according to the
5 World Health Organization; and

6 WHEREAS, more than twenty-eight thousand people were infected during the 2014-2016
7 Ebola epidemic, with over eleven thousand deaths; and

8 WHEREAS, healthcare workers may be at a higher risk than the general population for
9 infection to novel public health threats[1]; and

10 WHEREAS, medical providers around the world have experienced shortages of the equipment
11 needed to properly test for, protect themselves and treat recent infectious disease; now,
12 therefore be it

13 RESOLVED, that the American Osteopathic Association (AOA) will continue to serve as a
14 trusted source of information and education for physicians, health professionals and the
15 public relative to urgent, emergent and novel public health threats; and, be it further

16 RESOLVED, that the AOA will advocate for and support those responding to urgent,
17 emergent and novel public health threats, including all healthcare workers and
18 volunteers; and, be it further

19 RESOLVED that the AOA will advocate for proactive planning, improved public health
20 infrastructure, disease threat surveillance and evidence-based responses to novel public
21 health threats affecting the U.S. population.

Explanatory Statement: Submitted by Author

The following bibliography is the citation referenced in WHEREAS statements above.

[1] Epidemiology of and Risk Factors for Coronavirus Infection in Health Care Workers: A Living Rapid Review. Ann Intern Med 2020;May 5:[Epub ahead of print]

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, firearm-related deaths in the United States have increased to a twenty year high[1];
2 and

3 WHEREAS, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides,
4 and accidents in the United States, the highest rate among industrialized countries[2,3]; and

5 WHEREAS, intentional suicide by discharge of firearms in the United States increased in 2017,
6 totaling 23,854, compared to 22,938 in 2016[4]; and

7 WHEREAS, firearms are the third-leading cause of death due to injury after poisoning and
8 motor vehicle accidents[5,6]; and

9 WHEREAS, 109 firearm deaths occur each day due to firearm-related homicides, suicides, and
10 unintentional deaths[7]; and

11 WHEREAS, firearm-related violence in the United States had a total societal cost of $229
12 billion in 2015[8]; and

13 WHEREAS, in 2017, of the 25 million individuals who submitted to a background check to
14 purchase or transfer possession of a firearm, 103,985 were by prohibited purchasers and
15 were blocked from making a purchase[9]; an estimated 6.6 million firearms are sold
16 annually with no background checks[10]; now, therefore, be it

17 RESOLVED, that the American Osteopathic Association (AOA) recognizes public health data
18 demonstrating the impact of firearms on mortality and wellness in the United States and
19 will support federal legislation requiring comprehensive background checks for all
20 firearm purchases, including sales by gun dealers, sales at gun shows, and online sales
21 for purchase, which does not extend to firearms transfers between family members or
22 firearms attained through inheritance; and, be it further

23 RESOLVED, that the AOA will support efforts to require firearms safety training, including
24 military or law enforcement training, as a condition to purchase any class of firearms;
25 and be it further

26 RESOLVED, that H421-A/15 is superseded by this resolution.

Explanatory Statement: Submitted by Author
The intent of this policy is to supplement the following existing policies:
H630-A/18 Comprehensive Gun Violence Reform
H318-A/16 Firearms--Commission Of A Crime While Using A Firearm
H340-A/16 Physician Gag Rules--Opposition To
H450-A/15 Firearm Violence
H424-A/19 Firearm Safety

References
[1] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[2] Id.
[3] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.
[4] National Vital Statistics Reports Volume 68, Number 9 June 24, 2019 Deaths: Final Data for 2017 Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf
[5] Centers for Disease Control and Prevention. Injury Prevention & Control: Data & Statistics (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention; 2014.
[6] Centers for Disease Control and Prevention. Deaths: Final Data for 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2018.
[7] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[8] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.
[9] Federal Bureau of Investigation. National Instant Criminal Background Check System (NICS) Operations. 2017. Accessed at https://www.fbi.gov/file-repository/2017-nics-operations-report.pdf/view
[10] Cook PJ, Ludwig J. Guns in America: National Survey on Private Ownership and Use of Firearms. Washington, DC: U.S. Department of Justice, National Institute of Justice Research in Brief; May 1997.

Background Information: Provided by AOA Staff
Current AOA Policy: H425-A/19 FIREARM SAFETY

Prior HOD action on similar or same topic: Policy reaffirmed as amended n 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: FENTANYL TESTING STRIPS

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the American Osteopathic Association (AOA) has in place a broad policy
2 supporting harm reduction for people who use drugs (PWUD) and/or patients with
3 Substance Use Disorder (SUD); and

4 WHEREAS, the AOA makes no specific mention in their harm reduction policy of the benefits
5 of fentanyl testing strips; and

6 WHEREAS, fentanyl testing strips have been demonstrated to be an inexpensive and effective
7 method of harm reduction; and

8 WHEREAS, fentanyl testing strips are illegal to possess, often under "drug paraphernalia"
9 statues in various states; now, therefore be it

10 RESOLVED, that the American Osteopathic Association (AOA) will ~~explicitly~~ support the
11 universal legalization of fentanyl testing strips, both for Public Health initiatives, as well
12 as personal use; and, be it further

13 RESOLVED, that the AOA strongly encourage the American Osteopathic Academy of
14 Addiction Medicine (AOAAM) to maintain the above position.

Explanatory Statement: Submitted by Author

In 2016 overdose deaths involving illicitly manufactured fentanyl surpassed heroin and prescription opioid deaths in the US; the number grows. Fentanyl test strips may be an effective overdose prevention tool when included with other evidence-based treatments to prevent opioid overdoses.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: FIREARMS POLICY

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the AOA House of Delegates adopted H437-A/19, Firearm Violence, which
2 requires the American Osteopathic Association (AOA) to develop a comprehensive
3 policy that consolidates all current firearm violence policies into a single unified policy
4 and present it for consideration by the 2020 AOA House of Delegates; and

5 WHEREAS, consolidated, unified policies can have the unintended consequence of disrupting
6 continuity of AOA policy; and

7 WHEREAS, background and history on a given topic can be lost through the consolidation and
8 elimination of multiple policies into a single policy, making additions or changes to
9 future policy more difficult; and

10 WHEREAS, having a broad array of policies on a given topic allows the AOA to accurately
11 respond to federal and state legislative and regulatory concerns with nuanced and
12 specific policy to reference; and

13 WHEREAS, the AOA risks having no policy relating to firearm violence should a portion of a
14 single, consolidated policy on firearms be found to be no longer germane in future
15 years; now, therefore, be it

16 RESOLVED, that the American Osteopathic Association (AOA) will develop a comprehensive
17 white paper, which will include all current AOA policies relating to firearm violence,
18 into a single, unified document which will be presented for review and consideration by
19 the Bureau on Federal Health Policy (BFHP). This unifying white paper will be
20 presented in lieu of a developing a single firearm violence policy resolution; and

21 RESOLVED, that H437-A/19 is superseded by this resolution; and

22 RESOLVED, that the AOA House of Delegates adopt the attached white paper which includes
23 all current AOA policies relating to firearm violence.

24

AOA Policy White Paper – Firearm Policy

Introduction

The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.

Much of the AOA policy is predicated on an understanding of the role of firearms on public health in the United States. According to the Centers for Disease Control and Prevention (CDC), firearm-related deaths in the U.S. have increased to a twenty year high[i]. Additionally, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides, and accidents in the U.S., the highest rate among industrialized countries[iiiii]. Firearms are also the third-leading cause of death due to injury after poisoning and motor vehicle accidents[ivv]. CDC data also shows that 109 firearm deaths occur each day due to firearm-related homicides, suicides, and unintentional deaths[vi]. Beyond the impact on the health and well-being of Americans, there is an economic impact with gun violence in the U.S. costing $229 billion in 2015[vii].

Background

H437-A/19 FIREARM VIOLENCE was adopted at the 2019 AOA House of Delegates meeting, which states that the *"American Osteopathic Association (AOA) will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates."* This resolution was then referred to the Bureau on Federal Health Policy (BFHP) for development. After consideration of the request, the BFHP came to the conclusion that developing a single unifying policy sets a potentially problematic precedent in which background and history of a topic can be lost, and makes additions or changes to future policy more difficult.

Beyond setting a precedent, if part of the policy in future years is no longer germane, the full resolution could be in jeopardy, potentially effecting any and all related policies, which in this case could impact more than a half-dozen separate policies relating to firearms. Having a broad array of policies on a given topic allows AOA staff to accurately respond to federal and regulatory concerns with nuanced policy to reference.

With these concerns in mind, the BFHP thought it best that the AOA develop a comprehensive white paper, in lieu of a single firearm violence policy resolution, which includes all current AOA policies relating to firearm violence.

This white paper is intended to provide a complete and cohesive representation of current AOA policy relating to firearm violence and safety as of the 2019 AOA House of Delegates. This document is broken down by *Education, Research, and Miscellaneous.*

Policies Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death, as a result of firearms is critical. Physicians play

an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services.

Current Resolutions on Firearm Education:

- **H425-A/19 FIREARM SAFETY**

  The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians to educate families in the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014; reaffirmed as amended 2019

- **H421-A/15 FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS**

  The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015 ***[Editor's Note: Non-Powdered Guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]***

- **H340-A/16 PHYSICIAN GAG RULES – OPPOSITION TO**

  The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights. 2016

- **H428-A/19 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE**

  While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. 2013; reaffirmed 2019

<u>Policies on Advancing Research to Reduce Firearm Violence</u>

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities, to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Current Resolutions on Firearm Research:

- **H450-A/15 FIREARM VIOLENCE**
  The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;" (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015
- **H630-A/18 COMPREHENSIVE GUN VIOLENCE REFORM**
  The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that:
  1. Labels gun violence as a national public health issue.
  2. Funds appropriate research on gun violence as part of future federal budgets.
  3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. 2018

Current Miscellaneous Resolutions:

- **Safety- H318-A/16 FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM**
  The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011; reaffirmed 2016

<u>Conclusion</u>

As noted above, the AOA House of Delegates adopted a policy that calls for the identification of all current firearm violence policies in a single document. This paper reflects that policy and highlights wide range of issues addressed in AOA firearm policies, with seven individual policies identified for inclusion in this paper. At least two resolutions (H425-A/19 and H421-A/15) support education and recommend safety precautions for gun owners. One (H340-A/16) opposes any governmental action that would limit the right of physicians to discuss gun owners and safe storage with their patients. Another (H428-A/19) opposes any mandated reporting of patient gun ownership. Two policies (H450-A/15 and H630-A/18) support federal funding for research on firearm violence. H630-A/18 also labels gun violence as a national public health issue and supports federal legislation that would establish constitutionally appropriate restrictions on the manufacturing and sale of certain classes of firearms.

There is a separate and distinct focus in most of these policies, with focus ranging from education, to protecting the rights of physicians, to support for research, and support for certain restrictions on sales.

1 As such, these policies, as well as any future firearm-related policies, should be maintained and taken up
2 for review and reconsideration by the House of Delegates on an individual basis.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H437-A/19 FIREARM VIOLENCE

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau on Federal Health Programs)*

DATE: **October 14, 2020**

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[i] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[ii] Id.
[iii] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.
[iv] Centers for Disease Control and Prevention. Injury Prevention & Control: Data & Statistics (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention; 2014.
[v] Centers for Disease Control and Prevention. Deaths: Final Data for 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2018.
[vi] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[vii] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.

SUBJECT: HOMELESS SUPPORT

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Public Affairs

~~WHEREAS, the state of California has a disproportionate share of homeless in the country; and~~

WHEREAS, many people in the homeless community have experienced social, racial, and economic inequalities that contribute to medical, mental, and alcohol/drug addiction illnesses, which are often left untreated due to lack of access to health care resources; and

WHEREAS, as osteopathic physicians, we are trained in approaching population health and public health holistically, including addressing access to proper nutrition, hydration, thermal protection, shelter, and hygiene; and

~~WHEREAS, the public health and population health issues of the entire homeless population are providing a public health and population hazard to the community at large; and~~

~~WHEREAS, the lack of affordable and available housing for the homeless during and after implementation of comprehensive treatment programs has contributed to the unprecedented rise in the nation's homelessness; and~~

WHEREAS, there are ~~current~~ ONGOING debates regarding cost effective housing programs which MAY include dormitory, group, and individual housing; and

WHEREAS, the lack of a comprehensive state ~~and~~ OR national strategy to address the homeless issues as ~~a~~ comprehensive population health and public health problemS and ~~medical problem~~ has resulted in significant numbers of those affected to have ~~essentially~~ LITTLE OR no medical care and little community support to treat their medical and psychiatric issues; and

WHEREAS, the American Osteopathic Association has previously stated their support of efforts aimed at addressing the root causes of homelessness in House resolution H-428 – A/2018; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) reaffirm support for ~~all~~ state and federal efforts, including efforts by private organizations, as well as those enumerated in the 2018 House of Delegates resolution number H-428 – A/2018, and that those efforts include addressing social determinants ~~of~~ AFFECTING health, substance abuse programs, mental health resources, clinical care programs and provision of stable housing for all homeless individuals that are seeking temporary or permanent shelter~~; and, be it further~~

~~RESOLVED, that the AOA, with the guidance of the Department of Educational Affairs and any other relevant department(s), develop recommendations for curriculum and submit them to the Commission on Osteopathic College Accreditation (COCA), American Association of Colleges of Osteopathic Medicine (AACOM), National Board of Osteopathic Medical Examiners(NBOME), Accreditation Council for Graduate Medical Education (ACGME), and other educational entities at all levels of osteopathic medical education, including undergraduate, postgraduate, and osteopathic continuing medical education, in order to address healthcare issues related to clinical and social aspects of homelessness and report to the AOA House of Delegates at its July 2021 meeting~~.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: MEDICAL AMNESTY FOR UNDERAGE CONSUMPTION OF ALCOHOL

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, state laws prohibit the consumption of alcohol below the age of twenty-one (21)
2 years; and

3 WHEREAS, people aged 12 to 20 years drink 11% of all alcohol consumed in the United
4 States; and

5 WHEREAS, underage drinkers and associated social contacts are often reticent to seek medical
6 help for themselves or their ill peers for fear of legal reprisal, resulting in tragic and
7 unnecessary deaths; now, therefore be it

8 RESOLVED, that legal immunity for the underage consumption of alcohol for those who
9 consume alcohol underage and seek medical attention, as well as any "Good
10 Samaritans" who aid in their seeking of medical attention, should be the *de jure* standard
11 in each state, enacted into law by state legislatures; and, be it further

12 RESOLVED, that this legal immunity applies specifically and exclusively to the consumption of
13 alcohol before the legal age, but *not* for any infractions or crimes committed while under
14 the influence of alcohol or as a result of the consumption of alcohol (e.g. driving under
15 the influence, physical altercations, etc.); and, be it further

16 RESOLVED, that the American Osteopathic Association (AOA) supports full legal immunity
17 for these individuals, and urge state and national lawmakers to enact "Good Samaritan"
18 laws to increase access to life-saving medical care for underage consumers of alcohol.

Explanatory Statement: Submitted by Author
Instances of excessive drinking involving the death of minors could be avoided if minors can seek medical assistance without fear of criminal charges, including manslaughter.

Explanatory Statement: Reference Committee
Refer back to the American Osteopathic Academy of Addiction Medicine for clarification.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to American Osteopathic Academy of Addiction Medicine)*

DATE: **October 14, 2020**

SUBJECT: BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT) (Response to RES. NO. H-415 - A/2019, Referencing H-417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-415 - A/2019, titled "BREASTFEEDING WHILE ON METHADONE MAINTENANCE", was referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to evaluate breastfeeding and other forms of medication assisted treatment (MAT) for opioid addiction, not just methadone; now therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the attached white paper, titled, "BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT)", and the recommendations within be adopted as policy.

Breastfeeding While on Medication Assisted Therapy

Introduction

Opioid use among pregnant women is a growing public health concern. In 2014, the Centers for Disease Control and Prevention (CDC) recorded a 333% national increase in opioid use disorder (OUD) among pregnant women, with 6.5 cases of opioid abuse per 1,000 hospital deliveries, compared to 1.5 cases in 1999.[1] Opioid use during pregnancy is not uncommon; as many as 1 in 5 pregnant women enrolled in Medicaid filled an opioid prescription during their pregnancy.[2] Prenatal opioid exposure has been directly linked to adverse health outcomes for mothers and babies across the nation. These adverse health outcomes include increased maternal mortality and morbidity, poor fetal development, preterm births, still births, birth defects, and increased incidence of Neonatal Abstinence Syndrome (NAS).[3]

Studies have found that breastfeeding among women being treated for OUD offers many benefits that can mitigate the impacts of OUD for the mother and infant. Benefits include, but are not limited to, reduced hospital stays and decreased need for morphine treatment in infants born with NAS.[4]

Opioid Use Disorder Treatment

Medication Assisted Treatment, or MAT, is defined as the use of medications in combination with counseling and behavioral therapies to treat OUD and aid patients in sustaining their recovery.[5] MAT may be utilized with pregnant women to treat opioid use disorder and avoid the severe consequences associated with untreated opioid use disorder or stopping opioid usage too quickly. The U.S. Food and Drug Administration has approved three medications, buprenorphine, methadone, and naltrexone for OUD treatment.[5]

Naltrexone is the newest therapy approved by the U.S. Food and Drug Administration to treat opioid use disorder in pregnant women. Since it is also the least studied therapy, there is a research gap regarding the safety and effectiveness of naltrexone during pregnancy.[6] As a result, MAT for pregnant women commonly entails the use of methadone or buprenorphine with naloxone, in conjunction with coordinated care among behavioral therapists, OB-GYNs, and addiction specialists.[7] Both methadone and buprenorphine treatment

are endorsed by the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine as best practices for addressing opioid use during pregnancy.[4]

Methadone, a long-acting opioid agonist that decreases the desire to take opioids, was established as the standard of care in 1998 for treating OUD in pregnant women. The Substance Abuse and Mental Health Service Administration (SAMHSA) identified methadone as a safe drug to take while pregnant or preparing for pregnancy, along with counseling and participation in social support programs.[8]

Recently, The American Society of Addiction Medicine (ASAM) recognized Buprenorphine combined with Naloxone as the standard of care for the treatment of women who are pregnant or breastfeeding with OUD. The American Osteopathic Academy of Addiction Medicine (AOAAM) supports ASAM consensus that the combination of Buprenorphine and Naloxone is regularly used, safe, and effective.[9] Buprenorphine is the first medication to treat opioid use disorder that was authorized to be administered in physician offices, resulting in improved access to treatment.[10] Studies indicate that buprenorphine reduces fluctuations in fetal levels of opioids, minimizes repeated prenatal withdrawal, decreases overdoses, and limits drug interactions.[10]

Neonatal withdrawal, also called neonatal abstinence syndrome (NAS), is an anticipated and treatable condition caused by perinatal exposure to opioids, including methadone and the combination of buprenorphine with naloxone.[11] Although NAS may still occur in infants whose mothers receive MAT, the symptoms are milder than they would be without treatment.[4]

Postpartum, both infants and women on maintenance therapies can experience greater benefits through breast feeding. Although trace amounts of both methadone and buprenorphine have been found to seep into breast milk, research has shown that the benefits of breastfeeding outweigh the negligible risk associated with the medication that enters breast milk.[8, 10]

Breastfeeding

Because of the associated benefits, exclusive breastfeeding, without other supplementation, is recommended for healthy women by both the American Academy of Pediatrics and the World Health Organization for the first 6 months of life.[12,13] Breastfeeding contributes to attachment between a woman and her infant, encourages skin-to-skin contact.[11] The antibodies and hormones found in breast milk defend the infant's immune system against illness and lower the risk of asthma, leukemia, childhood obesity, lower respiratory infections, eczema, diarrhea, vomiting, and Sudden Infant Death Syndrome.[14] Breastfeeding also improves the health of mothers post-delivery, simultaneously, lowering potential risk for diabetes, breast cancer, and ovarian cancer. Breast milk is also easier for infants to digest and cost efficient for parents.[14]

The American Academy of Pediatrics (AAP) recommendation applies to women who take methadone or buprenorphine as well, without regard for dosage.[15] Breastfeeding among women who are opioid dependent is also encouraged by both, the American College of Obstetricians and Gynecologists (ACOG) and the American College of Osteopathic Obstetricians and Gynecologists (ACOOG), as long as the women are taking methadone or buprenorphine consistently, abstaining from illicit drugs, and have no underlying complexities or conditions, such as human immunodeficiency virus (HIV) and or Hepatitis C with open/bleeding and cracked nipples.[11] Additionally, The ACOOG supports the ACOG committee review that women in the post-partum period who return to using street drugs and are not on stable OUD therapy should restrain from breastfeeding.[16] After 6 months, the AAP recommends continuation of breastfeeding, alongside introduction of complementary foods during the first year of life.[12]

In spite of these endorsements, less than 25% of mothers exclusively breastfeed for 6 months in the United States.[12] Formula supplementation of breast milk is commonly utilized. Supplementation is reportedly associated with many side effects that can lead to adverse infant and maternal outcomes. Formula supplements can negatively impact the "maternal milk supply, the duration of exclusive breastfeeding, and

the infant's gut microbiome; alteration of the neonatal gut environment can be responsible for mucosal inflammation and disease, autoimmunity disorders, and allergic conditions in both childhood and adulthood".[17]

The Centers for Disease Control and Prevention established the breastfeeding report card, which provides national data on breastfeeding rates, breastfeeding support indicators, and breastfeeding practices.[12] The breastfeeding report card indicates that, in 2015, 83.2% of infants were breastfed starting at birth, 57.6% were still breastfed at some level at 6 months, and 35.9% at 12 months.[12] This data suggests that "the early postpartum period is a critical time for establishing breastfeeding, but mothers may not be getting the support they need from health care providers, family members, and employers to meet their breastfeeding goals".[12]

Uptake of breastfeeding is likely even lower among women with OUD. National Institute on Drug Abuse (NIDA) states that the rate of breastfeeding is normally "low" among mothers with OUD. Increased formal breastfeeding education, direct support for mothers, health care providers training on breastfeeding techniques, and peer support are all effective interventions that promote the start and sustainability of breastfeeding among mothers.[18]

Conclusion

Increasing rates of maternal opioid use during pregnancy and NAS are public health concerns. The utilization of MAT with methadone or buprenorphine has been approved as a safe mechanism for combatting opioid use during pregnancy and while breastfeeding.

Breastfeeding improves maternal and infant morbidity and mortality and decreases the impact of adverse health conditions. Breastfeeding infants who were exposed to opioids prenatally have the added advantage of lessening the impact of other conditions, such as NAS. Encouraging breastfeeding among mothers with exposure to opioids, who are undergoing MAT, is a significant step toward addressing OUD and NAS and improving maternal and child health. It shall be noted that the ACOOG and AOAAM supports the content of this paper and the policy recommendations outlined to encourage exclusive breastfeeding among mothers with a history of OUD.

American Osteopathic Association Policy

Given the research surrounding the positive impact of breastfeeding, the American Osteopathic Association adopts the following policy statements as its official position on breastfeeding among mothers with exposure to opioid use disorder in the United States:

1. The American Osteopathic Association (AOA) acknowledges that exclusive breastfeeding significantly improves maternal and infant health outcomes.
2. The American Osteopathic Association supports methadone and buprenorphine/naloxone assisted treatment as standards of care for addressing opioid use disorder during pregnancy and in the postpartum period.
3. The American Osteopathic Association (AOA) encourages exclusive breastfeeding among mothers with a history of Opioid Use Disorder (OUD), who are under physician care, actively engaged in a recovery program, on appropriate opioid agonists (methadone or buprenorphine), abstaining from illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection and or Hepatitis C with open/bleeding and cracked nipples.
4. The American Osteopathic Association (AOA) recommends the use of counseling, coordination of care, and social support for mothers during pregnancy and breastfeeding in the postpartum period.

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Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy:
H428-A/17 BREASTFEEDING – PROMOTION, PROTECTION AND SUPPORT OF
H425-A/18 BREASTFEEDING EXCLUSIVITY

Prior HOD action on similar or same topic: H428-A/17 policy revised in 2017; H425-A/18 policy reaffirmed as amended 2018

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: REFERRED SUNSET RES. NO. H-411 - A/2019: H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, the AOA House of Delegates referred sunset resolution H-411-A/2019 titled H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE to the Bureau on Federal Health Programs for "clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H413-A/14 ~~EPIDEMIC~~ DOMESTIC OR FOREIGN TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

The American Osteopathic Association SUPPORTS **ALL HEALTHCARE PERSONNEL AND** FIRST RESPONDERS AND ~~believes that~~ victims of ~~an epidemic~~ DOMESTIC OR FOREIGN terrorist attackS ~~(e.g., anthrax) are victims of a new age conflict against America and as victims of an attack against America; they~~ IN THE UNITED STATES BEING~~ should be~~ eligible for healthcare TREATMENT STEMMING FROM THE ACT to be covered by the United States Government. 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H429 A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS sunset resolution. H-421 – A/2019 titled "MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE", was referred to the Bureau of Scientific Affairs and Public Health for an analysis of the statistics to determine if the target deadline should be extended; now, therefore be it

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED AS AMENDED:

H429 A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

The American Osteopathic Association encourages an increase in the total number of URM[1] graduates from colleges of osteopathic medicine by the year ~~**2020**~~ **2025** and encourages an increase in the total number of URM faculty by the year **2025** ~~2020~~. 2014

Explanatory Statement: Submitted by Author

INTRODUCTION

It is widely accepted that increasing racial and ethnic diversity among health professionals is associated with improved health outcomes for racial and ethnic minority patients, greater patient satisfaction, and better educational experiences for medical students.

Despite this widespread recognition, in 2017, the Health Resources and Services Administration (HRSA) Bureau of Health Workforce reported that "all minority groups, except Asians, are underrepresented in Health Diagnosis and Treating occupations."[2] Osteopathic physicians and faculty are included in these occupations.

PROGRESS

The American Osteopathic College of Osteopathic Medical Application Service (AOCOMAS) publication, titled, "AACOMAS Applicants to Osteopathic Medical Schools by Race and Ethnicity", tabulated the number and percentage of Underrepresented Minorities (URM). The report states that in academic year 2013-14, 11.7% and 2019-20, 17.0% identified as URM. Thus, there was an absolute increase of 5.3% in the applications submitted from URM over 6 years.[3]

While there was an improvement in the application rate of URM to osteopathic colleges, the same was not observed in the graduation rate. The American Association of Colleges of Osteopathic Medicine

(AACOM) publication, "Graduates of US Osteopathic Medical School by Race/Ethnicity", reported that for the academic year 2011-12, 8.4% of graduates identified as Hispanic/Latino; American Indian and Alaskan Native, non-Hispanic; Black/African American, non-Hispanic; Pacific Islander, non-Hispanic. In 2017-18, the most recent data, 8.2% of graduates identified as the same ethnic and racial groups. In other words, over a 6-year period, the proportion of medical school graduates, who identified as belonging to an URM group, had an absolute decline of 0.2%.[4]

Additionally, according to the most recent AACOM reports titled, "2012-13 Osteopathic Medical College Faculty by Race/Ethnicity"[5] and "2016-17 Osteopathic Medical College Faculty by Race/Ethnicity"[6], there were 1,164 of a total 37,197 (3.1%) faculty in academic year 2012-13, and 1,710 of a total 46,848.39 (3.6%) faculty in academic year 2016-17 who identified as Hispanic, American Indian/Alaskan Native, non-Hispanic; Black/African American, non-Hispanic; and Pacific Islander, non-Hispanic. Thus, the absolute change in faculty employed at an osteopathic college was 0.5% over the 4-year period.

CONCLUSION/RECOMMENDATIONS

There has been modest progress in increasing the proportion of applicants and faculty at osteopathic medical schools who identify as URM, current statistics are far from that of the general population. There has been little improvement in the graduation rate among URM. Given that the proportion of racial and ethnic minorities in the United States exceeded 18% at the most recent Census and is progressively climbing, it is recommended that the AOA and the AACOM continue to prioritize the development of an osteopathic workforce that more closely represents the people served by the profession.

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Background Information: Provided by AOA Staff
Current AOA Policy:
H433-A/15 MINORITY HEALTH DISPARITIES
H323-A/19 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

Prior HOD action on similar or same topic: 433-A/15 policy reaffirmed in 2015; H323-A/19 policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: REGULATION OF E-CIGARETTES AND NICOTINE VAPING
(Response to RES. NO. H - 424 - A/2019 referencing H - 435 - A/2014)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, RES. NO. H-424 - A/2019 was referred to the Bureaus of Scientific Affairs and Public Health to update the white paper; now, therefore be it

RESOLVED, that the following policy paper and the recommendations provided within be adopted as the amended policy of the AOA.

REGULATION OF E-CIGARETTES AND NICOTINE VAPING

BACKGROUND

The adverse health effects associated with tobacco use are well documented public health concerns. Smoking can damage every human organ, and it can lead to death from heart disease, cancers or strokes. According to the World Health Organization (WHO), 1 in 10 deaths each year, or nearly 8 million deaths around the world, are caused by tobacco use.[1,2] More than 7 million of those deaths are the result of direct tobacco use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke.[2] In the United States, this translates to 480,000 deaths per year from cigarette smoking and second-hand smoke exposure.[3]

In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the past 4 decades.[4] The use of electronic nicotine delivery systems (ENDS), such as electronic cigarettes (e-cigarettes), has reached a rapidly expanding consumer base.[5] E-cigarettes are often used or promoted to reduce consumption of tobacco products.[6] Alternative strategies for reaching smoking cessation goals include switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.[7]

In the US, e-cigarettes are the most frequently utilized tobacco product among youth, who are also more likely than adults to use them. In 2019, over 5 million US middle and high school students had used e-cigarettes in the past 30 days.[8] In 2018, 3.2% of US adults were current e-cigarette users.[9]

The name e-cigarette is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-hookahs, but could potentially be referred to by other terms. Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 460 brands.[10] E-cigarettes are a 2.5 billion dollar business in the United States.[11] The attraction to e-cigarettes crosses many segments of the population, appealing to tobacco cigarette smokers trying to quit as well as non-smokers who want to try nicotine without the harmful additives.[12] Though some states and municipalities have started to ban e-cigarettes, tobacco cigarette smokers can use e-cigarettes as a source of nicotine in some venues where conventional cigarettes are banned.

Costs associated with smoking-related illnesses continue to escalate. In 2014, smoking-related illness costs in the United States were more than $300 billion each year, including approximately $170 billion for direct medical care for adults, and more than $156 billion in lost productivity. Nearly $5.6 billion of the lost productivity cost was due to secondhand smoke exposure.[13]

Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death.[14] However, the effect of long term consumption of nicotine and associated aerosols remains unclear. Studies have shown that e-cigarette vapors may be harmful, particularly in places with limited ventilation and for people with compromised health. Furthermore, e-juice liquids have been found to increase accidental poisonings in children. The full scale of health and safety hazards of vaping for users and secondhand users is undetermined.[15]

ANALYSIS

Regulation of e-cigarettes by the Food and Drug Administration (FDA) only began in earnest in 2016. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) provided the FDA authority to regulate the manufacture, marketing and distribution of tobacco products.[16] However, e-cigarettes were not initially included in the FDA's regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes have enjoyed the ability to advertise on television and radio.[17] This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.[18] However, some manufacturers have voluntarily begun to limit their advertising in an attempt to avoid federally imposed restrictions on advertising.

The Composition of E-Cigarettes

The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation.[19] Using an e-cigarette may also be referred to as "vaping", or as "juuling", the branded form of flavored e-cigarettes popular among younger consumers. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients.[20] It is primarily composed of a nicotine cartridge, atomizer, and a battery.[21] The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element.[22] When screwed onto the cartridge, the nicotine liquid from the cartridge, which could also include flavoring, comes into contact with the atomizer unit and is carried to the metal coil heating element.[23] A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[24] E-cigarettes can also be used to deliver marijuana and other drugs.[25]

While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens, lipsticks, and other everyday items.[26] Often, they can be legally used where traditional tobacco products are banned.

Federal Efforts to Regulate

In 2016, the FDA finalized a rule extending regulatory authority to cover all tobacco products, including electronic nicotine delivery systems (ENDS) that meet the definition of a tobacco product.[27] The FDA now regulates the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ENDS. Prior to this rule, the FDA could regulate e-cigarettes only if the manufacturer made a therapeutic claim, such as the product was being marketed as a cessation device.[28]

The rule established restrictions on youth access to newly regulated tobacco products by: (1) banning their sale to individuals younger than 18 years of age (federal legislation raised this to 21 years in 2019)

and requiring age verification via photo ID; and (2) prohibiting the sale of tobacco products in vending machines (unless in an adult-only facility).[29]

The Federal Food, Drug, and Cosmetic Act was signed into law on December 20, 2019, and raised the federal minimum age of sale for tobacco products from 18 to 21 years.[30] Retailers are now prohibited from selling tobacco products to anyone under the age of 21.

Further, in January 2020, the FDA banned all mint- and fruit-flavored e-cigarettes, but exempted menthol- and tobacco-flavored products, in an effort to target products widely used by minors while preserving an "off-ramp" for adults who are trying to quit smoking.[31]

Tobacco is a major threat to public health, and one of the goals of the FDA is to protect Americans from tobacco-related diseases and death. This rule allows the FDA to protect youth by restricting their access to tobacco products, helps consumers better understand the risks of using these products, prohibits false and misleading product claims, and prevents new tobacco products from being marketed unless a manufacturer demonstrates that the product meets relevant public health standards.

State Efforts to Regulate

Various states and municipalities have also enacted laws restricting the sale of e-cigarettes.[32] Twenty-seven states, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and 1,107 municipalities have passed laws that ban smoking in all non-hospitality workplaces, restaurants, and bars; of these, 22 states and 929 municipalities also restrict e-cigarette use in 100% smoke-free venues.[33]

In November 2019, **Massachusetts** became the first state to restrict the sale of *all* flavored tobacco products, including e-cigarettes and menthol cigarettes.[34] **New Jersey** prohibited the use of e-cigarettes in all enclosed indoor places of public access as well as in working places, and in January 2020, the state enacted legislation banning the sale of *all* flavored e-cigarettes.[35,36] In March 2020, **Rhode Island** also announced a permanent ban on the sale of flavored e-cigarettes.[37] Six other states (Michigan, Montana, New York, Oregon, Utah and Washington) temporarily banned the sale of flavored e-cigarettes in 2019, but of those, only Montana's and Washington's bans are currently in effect while the others are facing various legal challenges.[38]

As of 2019, twenty-three (23) states and the District of Columbia have enacted statutes which require licenses for retail sales of e-cigarettes.[39]

Arguments for E-Cigarettes

Proponents of e-cigarettes consider e-cigarettes to be less harmful than traditional tobacco products and believe they increase adult smoking cessation.[40] While it has been established that e-cigarettes contain fewer carcinogenic elements than traditional tobacco cigarettes, the long-term health effects of e-cigarette use are unknown.[41] According to the American Lung Association there are approximately 600 ingredients in cigarettes.[42] When burned, they create more than 7,000 chemicals.[43] At least 69 of these chemicals are known to cause cancer, and many are poisonous.[44] While e-cigarettes may have fewer component chemicals, a study found that the usage of e-cigarettes contributes to indoor air contamination.[45] A 2016 report from the WHO determined that second-hand aerosols from e-cigarettes are a new source of pollution for hazardous particulate matter (PM). The levels of nickel, chromium, and other metals found in second-hand aerosols are higher than ambient air and higher than second-hand tobacco smoke.[46]

The greatest appeal of e-cigarettes for smoking cessation is that they deliver nicotine to alleviate nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking because of its shape and the familiar behavior aspect of smoking.[47] A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking.[48] Another survey of 3,037 e-cigarette users revealed that 77% of respondents used e-cigarettes to quit smoking or to avoid relapse.[49] None said they used them to reduce consumption of tobacco with no intent to quit smoking.[50] However, the overall effectiveness of e-cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.[51]

Consequences of E-Cigarettes

Advocates of e-cigarettes contend that e-cigarettes are less risky than traditional tobacco products and can serve as a mode of harm reduction by reducing smoking or serving as a smoking cessation strategy.[52] While there is limited evidence that suggests that adult smokers could benefit from e-cigarette use instead of combustible tobacco products, smokers would need to fully switch to e-cigarettes and stop smoking cigarettes and other tobacco products completely to achieve any meaningful health benefits from e-cigarettes. Experts who serve on the US Preventive Services Task Force have resolved that there is insufficient evidence to recommend e-cigarettes for smoking cessation in adults, including pregnant women. Thus, e-cigarettes are not currently approved by the FDA as an aid to quit smoking.[53]

Another major concern is that e-cigarettes appeal to youth by being flavorful, trendy and a convenient accessory.[54] The flavorings being used, such as candy and other sweet flavorings are particularly attractive to younger populations. For this reason, these flavorings are banned in traditional cigarettes.[55] Despite a downturn prior to 2017, e-cigarette use among youth has drastically increased. From 2017 to 2018, the percent of middle school students who used e-cigarettes increased 48%, resulting in 570,000 middle school students, or 4.9%, who were current e-cigarette users. Among high school students during the same period, current e-cigarette use, defined as use at least one day in the past 30 days, increased by 78%, from 11.7% to 20.8%, the equivalent of 3.05 million high school students using e-cigarettes in 2018. Current e-cigarette users in high school who reported use on 20 days or more in the past 30-day period increased from 20% to 27.7%. During the same timeframe, use of flavored e-cigarettes increased among high school students who currently used e-cigarettes as well. Use of any flavored e-cigarette went up among current users from 60.9% to 67.8%, and menthol use increased from 42.3% to 51.2% among all current e-cigarette users, including consumers of multiple products, and from 21.4% to 38.1% among those using only e-cigarettes. From 2018 to 2019, the number of middle school and high school students who reportedly used e-cigarettes in the past 30 days increased from a total of 3.6 million to 5.4 million youth.[56]

In addition to exposure to the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine.[57] Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).[58] E-cigarette cartridges can contain up to 20 times the nicotine of a single cigarette, and the process of vaping lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.[59]

Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues.[60] E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or nicotine cartridge.

Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.[61]

E-cigarettes can cause other inadvertent injuries as well. The CDC, the US Food and Drug Administration (FDA), state and local health departments, and other clinical and public health organizations have investigated a national outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI).[62] EVALI is an inflammatory response in the lungs triggered by inhaled substances. EVALI has been found to vary due to the substantial variety of products and ingredients used. It may present as pneumonia or an inflammatory condition known as fibrinous pneumonitis.[63] As of February 2020, 2,807 hospitalized EVALI cases or deaths were reported to CDC from all 50 states, the District of Columbia, Puerto Rico and U.S. Virgin Islands. Sixty-eight (68) deaths were confirmed in 29 states and the District of Columbia. Vitamin E acetate, an additive in some THC-containing e-cigarette products, was found to be strongly associated with the EVALI outbreak.[64]

Additionally, e-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions.[65] Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries. Lithium-ion batteries have reportedly overheated, caught fire or exploded, an event known as thermal runaway. From 2015 to 2017, an estimated 2,035 e-cigarette explosions and burn injuries presented to hospital emergency departments. Although the explosions are relatively rare, they can cause severe injuries.[66]

CONCLUSION

The AOA supports FDA and state regulation of the ingredients in all electronic cigarette cartridges, requiring ingredient labels and warnings, and eliminating the use of flavors that are banned in traditional cigarettes.

The AOA supports FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 21. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.

The AOA further encourages federal, state and local government action to ban the use of electronic cigarette devices in all spaces where traditional cigarettes are currently barred from use.

The AOA promotes tobacco and nicotine cessation treatment, and the use of any such treatment that has been proven safe and effective by the FDA.

The AOA supports research by the FDA and other organizations into the health and safety impact of e-cigarettes and liquid nicotine.

The AOA encourages physicians to ~~consider the health risks when recommending e-cigarettes to patients, to~~ educate patients about the risks of e-cigarette use, and to counsel patients to submit voluntary reports to the US Department of Health and Human Services Safety Reporting Portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.

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Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: RECOGNIZING HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, there are many components that contribute to good health, including the ability to
2 respond to sickness, disease and injury; and
3 WHEREAS, achieving the goal of living a healthy life is impossible without the ability to access
4 health care; and

5 WHEREAS, health care should be available to everyone; and

6 WHEREAS, the lack of available health care is a barrier to opportunity, success and quality of
7 life; and

8 WHEREAS, Osteopathic physicians and their patients' should not be divided between those
9 who can afford to be healthy and those who cannot; and

10 WHEREAS, Osteopathic physicians and their patients' should not be divided between those
11 who have hopes and dreams and those whose sickness, disease or injury robs them of
12 their hopes and dreams; and,

13 WHEREAS, the World Health Organization recognizes "the highest attainable standard of
14 health as a fundamental right of every human being," and "the right to health includes
15 access to timely, acceptable, and affordable health care of appropriate quality [i]," and

16 WHEREAS, the United States ranks 33th out of 34 countries in the Organization for
17 Economic Co-operation and Development (OECD) in percentage of insured
18 population (with 88.5%), with nearly every other country at > 98% [ii], and

19 WHEREAS, 25-30 million Americans are still uninsured after implementation of the
20 Affordable Care Act (ACA), and the non-partisan Congressional Budget Office
21 estimates that this number would increase to 48 million, and continue to increase
22 annually, with an ACA repeal [iii]; now, therefore be it

23 RESOLVED, that the American Osteopathic Association (AOA) recognizes that health care is
24 a human right for every person [1], not a privilege as an official policy statement to inform
25 and guide ongoing work of the AOA as a tenet of our osteopathic profession.

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Explanatory Statement: Submitted by Author

Resolution H431 – A/2019 was referred back to the Michigan Osteopathic Association, with a request "for clarity and direction". It has been revised and re-submitted for consideration by the AOA HOD.

Explanatory Statement: Reference Committee

The resolution was referred back to Michigan at the 2019 HOD meeting for "clarity and direction." However, the Committee believes that the resolution does not adequately define "healthcare as a human right" versus "health as a human right" and does not address the legal implications of defining healthcare as a human right.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **November 7, 2020**

SUBJECT: RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the World Health Organization recognizes "the highest attainable standard of
2 health as a fundamental right of every human being," and states "the right to health
3 includes access to timely, acceptable, and affordable health care of appropriate quality"[1];
4 and

5 WHEREAS, the United States ranks 33rd out of 34 countries in the Organization for
6 Economic Co-operation and Development (OECD) in percentage of insured
7 population (with 88.5%), with nearly every other country at > 98%[2]; and

8 WHEREAS, 25-30 million Americans are still uninsured after implementation of the
9 Affordable Care Act (ACA), and the non-partisan Congressional Budget Office
10 estimates that this number would increase to 48 million, and continue to increase
11 annually, with an ACA repeal[3]; now, therefore, be it

12 RESOLVED, that the American Osteopathic Association recognizes that health care is a
13 human right for every person[4], not a privilege.

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15 1. World Health Organization Media Center. "Health and Human Rights." Fact Sheet N°232, Dec
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22 http://jamanetwork.com/journals/jama/fullarticle/2595503 - Journal of the American Medical
23 Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional
24 societies will "speak with a single voice and say that health care is a basic right for every person, and
25 not a privilege to be available and affordable only for a majority."

Reference Committee Explanatory Statement:
The committee believes that the resolution, as written, lacks clarity and direction.

ACTION TAKEN **REFERRED** *(to the Michigan Osteopathic Medical Association)*

DATE **July 27, 2019**

AMERICAN OSTEOPATHIC ASSOCIATION

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SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
CONSTITUION & BYLAWS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Constitution and Bylaws (500 series)
  This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Action
H500	Amendment to the American Osteopathic Association Bylaws – Implement Changes to Governance Structure	BOT	ADOPTED
H501	Amendments to the American Osteopathic Association Bylaws – Update to Bureau of Membership	BOT	ADOPTED
H502	Amendments to the American Osteopathic Association Bylaws – Procedure for Notice of Proposed Changes to Bylaws	BOT	ADOPTED

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – IMPLEMENT CHANGES TO GOVERNANCE STRUCTURE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Board of Trustees, on recommendation of the Committee on AOA Governance & Organizational Structure, has approved a resolution that calls for changes to the names by which some of the AOA's Departments are known to better identify their function within the AOA's governance structure; and

WHEREAS, it is necessary to amend the AOA's Constitution and Bylaws to reflect these changes to the Department names; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

<u>Article IX - Departments, Bureaus, and Committees</u>

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association's departments shall include the Departments of Affiliate~~d~~ RELATIONS ~~Affairs~~, FINANCE ~~Business Affairs~~, EDUCATION ~~Educational Affairs~~, Governmental Affairs, MEMBERSHIP ~~Professional Affairs~~, and Research~~, Quality &~~ AND Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

<u>Explanatory Statement: Submitted by Author</u>

The AOA Board of Trustees approved changes to the organizational structure at its midyear meeting in February 2020, including renaming the six Departments as follows:

1. Affiliate Affairs to become Affiliate Relations
2. Business Affairs to become Finance
3. Educational Affairs to become Education
4. Governmental Affairs – no change
5. Professional Affairs to become Membership
6. Research Quality & Public Health to become Research and Public Health

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – UPDATE TO BUREAU OF MEMBERSHIP

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA's Committee on AOA Governance & Organizational Structure has reviewed the AOA's Constitution and Bylaws; and

WHEREAS, the AOA's Bylaws refer to the "Committee on Membership" which is now called the "Bureau of Membership"; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

<u>Article II (Membership), Section 2-Membership Requirements</u>

a. Applicants for Regular Membership . . . Such information and application shall be carefully reviewed by the BUREAU OF ~~Committee on~~ Membership, which shall make an appropriate recommendation for reinstatement to the Board of Trustees. An applicant whose license to practice is revoked or suspended, or who is currently serving a sentence for conviction of a felony offense, shall not be considered eligible for membership in this Association.

b. Honorary Life Member . . . Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the BUREAU OF ~~Committee on~~ Membership. Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.

c. Life Member . . . The BUREAU OF ~~Committee on~~ Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year AOA Constitution & Bylaws 6 in which the age of 70 is attained.

<u>Explanatory Statement: Submitted by Author</u>
This amendment, if approved, will change references in the AOA's Bylaws from "Committee on Membership" to "Bureau of Membership."

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – PROCEDURE FOR NOTICE OF PROPOSED CHANGES TO BYLAWS

SUBMITTED BY: Committee on AOA Governance & Organizational Structure

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the current procedure for amending the AOA's Bylaws calls for providing notice to members through publication in the JAOA and notice to affiliated organizations represented in the House of Delegates by U.S. mail; and

WHEREAS, the JAOA is transitioning to on-line publication and notice by electronic mail is more efficient and cost-effective than notice by U.S. mail; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

<u>Article XI - Amendments Section 1—Bylaws</u>
These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by US MAIL OR ELECTRONIC ~~first class~~ mail, ~~postage paid,~~ to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in THE ON-LINE EDITION OF The Journal of the American Osteopathic Association at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

<u>Explanatory Statement: Submitted by Author</u>
None provided.

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: None

Prior HOD action on similar or same topic: None

<u>FISCAL IMPACT</u>: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
WITHACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Action
H600	Dissemination of Publications in Osteopathic Research (H600-A/15)	BOCER	ADOPTED
H601	Reduction of Osteopathic Training Positions in Post-Graduate Medical Education (H601-A/15)	BOE	ADOPTED *(for sunset)*
H602	Reimbursement for Physician Time Spent Obtaining Pre-Certification and Pre-Authorization (H602-A/15)	BSA	ADOPTED *(for sunset)*
H603	Pay for Performance (H604-A/15)	BSA	ADOPTED as AMENDED
H604	Proper Badge Identification of Employees in a Hospital Setting (H606-A/15)	BSAPH	ADOPTED
H605	Interoperability of Health Information Technology (H607-A/15)	BSA	ADOPTED
H606	Gifts to Physicians from Industry (H612-A/15)	Ethics	ADOPTED
H607	Physician Competency Retesting (H614-A/15)	BOS	ADOPTED as AMENDED
H608	Health Plan Coverage of Tobacco Cessation Treatment (H615-A/15)	BSA	ADOPTED
H609	Encouraging Patient Participation in Their Health Care (H616-A/15)	BSAPH	ADOPTED
H610	Frivolous Liability Lawsuits (H617-A/15)	BFHP	ADOPTED *(for sunset)*
H611	Provider Tax (H618-A/15)	BSGA	ADOPTED
H612	Medicaid Payment (H619-A/15)	BSGA	ADOPTED as AMENDED
H613	Lay Midwives (H620-A/15)	BSGA	ADOPTED
H614	Medical Malpractice Judgments Requiring Reimbursement of Medicare Payments (H621-A/15)	BSA	REFERRED
H615	Electronic Health Records – Physician Assistance Programs for Transition to (H622-A/15)	BSA	ADOPTED as AMENDED
H616	Prescription Medications -- Overrides for (H624-A/15)	BSGA	NOT ADOPTED

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AD HOC - RESOLUTION ROSTER
WITHACTION

Res. No.	Resolution Title	Submitted By	Action
H617	Pediatric Psychiatric Care Health Records (H625-A/15)	BSA / BSAPH	ADOPTED
H618	Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (H626-A/15)	BSA	ADOPTED
H619	Medicare Recovery Audit Contractors (H628-A/15)	BSA	REFERRED
H620	Medicare Law and Rules (H629-A/15)	BFHP	REFERRED
H621	Veterans Administration Credentialing of Non-Physician Providers Health Records (H630-A/15)	BFHP	ADOPTED
H622	Tax Credits for Health Profession Shortage Areas (H631-A/15)	BFHP	ADOPTED
H623	Osteopathic Manipulative Treatment (OMT) in a Pre-Paid Environment –Payment Policies for (H632-A/15)	BSA	ADOPTED
H624	Prescription of Drugs for Off Label Uses (H633-A/15)	BFHP	ADOPTED
H625	Newborn and Infant Hearing Screens (H635-A/15)	BSAPH	ADOPTED
H626	Medicare Preventive Medical Screening (H636-A/15)	BFHP	ADOPTED
H627	Confidentiality of Patient Records (H637-A/15)	Ethics	ADOPTED
H628	Diabetics Confined to Correctional Institutions (H638-A/15)	BSAPH	ADOPTED
H629	Discrimination by Insurers (H639-A/15)	BSA	ADOPTED
H630	Executions in Capital Crimes Criminal Cases (H640-A/15)	Ethics	ADOPTED
H631	Managed Care – All Products Clauses (H642-A/15)	BSGA	ADOPTED
H632	Medical Procedure Patents (H643-A/15)	BFHP	ADOPTED
H633	Medicare Contractor Denial Letters (H644-A/15)	BSA	ADOPTED as AMENDED
H634	Osteopathic Medical Student, Resident, and Physician Mental Health (H646-A/15)	BEL	ADOPTED
H635	American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance (H647-A/15)	BSA	ADOPTED
H636	Access to Care – Network Adequacy and Coverage	BSGA	ADOPTED as AMENDED
H637	Addressing Fears and Barriers to Telemedicine Implementation and Alignment	MOA	ADOPTED as AMENDED
H638	Addressing Social Determinants of Health Through Data Collection and Improved Access to Social Services	SOMA	REFERRED

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OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
WITHACTION

Res. No.	Resolution Title	Submitted By	Action
H639	Elimination of Prior Authorization and Step Therapy	MOA	NOT ADOPTED
H640	H623-A/18 Non-Physician Clinicians	BSGA	ADOPTED as AMENDED
H641	Marketing AOA Board Certification	AOCOPM	NOT ADOPTED
H642	Prior Authorization	BSA	ADOPTED
H643	Professional Liability Insurance Reform	BSGA	ADOPTED
H644	Re-Establishment of the Bureau of Osteopathic Specialty Societies (BOSS)	AOCOPM	NOT ADOPTED
H645	REFERRED RESOLUTION: H636-A/2019 Obesity Treatment Reimbursement in Primary Care	BSA	ADOPTED as AMENDED
H646	REFERRED RESOLUTION: H-615: Postpartum Depression	BSAPH	ADOPTED
H647	REFERRED SUNSET RESOLUTION: H-619 - A/2019: H624-A/14 Managed Care Plans – Service, Access and Costs in	BSA	ADOPTED
H648	Researching Patient Safety and Provider Qualifications	SOMA	ADOPTED as AMENDED
H649	Support the Bolstering of Veteran Health Administration Resources Through Provider Pay Reform	SOMA	ADOPTED
H650	Telemedicine; Reimbursement for	NYSOMS	ADOPTED as AMENDED

SUBJECT: H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommends
2 that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC**
5 **RESEARCH**
6 The American Osteopathic Association will widely disseminate publications, research, and
7 evidence based medicine regarding Osteopathic Medicine and Osteopathic Manipulative
8 Treatment (OMT) and its anatomical and physiological basis to the greater public via
9 prominent, designated public information sites, social networking, public information releases,
10 websites, and other media. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H601-A/15 REDUCTION OF OSTEOPATHIC TRAINING POSITIONS IN POST-GRADUATE MEDICAL EDUCATION

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy
2 be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H601-A/15 REDUCTION OF OSTEOPATHIC TRAINING POSITIONS IN**
5 **POST-GRADUATE MEDICAL EDUCATION**
6 The American Osteopathic Association will work to create parity in reimbursement from the
7 Centers for Medicare and Medicaid Services (CMS) for all osteopathic training to be equivalent
8 to allopathic programs. 2015.

Explanatory Statement: Submitted by Author
The AOA no longer separately accredits graduate medical education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING**
5 **PRE-CERTIFICATION AND PRE-AUTHORIZATION**
6 The American Osteopathic Association will include in its work plan investigation and
7 recommendations for a framework for diagnostic and procedure coding, along with associated
8 payment policies, for physician time spent obtaining required Medicare pre-certifications or pre-
9 authorizations for those designated services or prescriptions and provide a template for use by
10 state affiliates for third party payers within the jurisdiction of their state. 2015

Explanatory Statement: Submitted by Author:
The Bureau of Socioeconomic Affairs has submitted a resolution for consideration by the 2020 HOD which will merge this policy with several other existing policies to create one comprehensive policy addressing Prior Authorization.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H604-A/15 PAY FOR PERFORMANCE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H604-A/15 PAY FOR PERFORMANCE

In an effort to support the establishment of REASONABLE PAYMENT ~~appropriate pay-for-performance methodology~~ that will reflect the quality of care provided by physicians and improve patient health outcomes, the AOA adopts the following principles on quality reporting and pay-for-performance (2006; reaffirmed 2011; revised 2015).

1. THE AOA SUPPORTS THE ESTABLISHMENT OF QUALITY REPORTING AND/OR PAY-FOR-PERFORMANCE SYSTEMS WHOSE PRIMARY GOALS ARE TO IMPROVE THE HEALTH CARE AND HEALTH OUTCOMES OF PATIENTS. THE AOA BELIEVES THAT SUCH PROGRAMS SHOULD NOT BE BUDGET NEUTRAL. APPROPRIATE ADDITIONAL RESOURCES SHOULD SUPPORT IMPLEMENTATION AND REWARD PHYSICIANS WHO PARTICIPATE IN THE PROGRAMS AND DEMONSTRATE IMPROVEMENTS. THE AOA RECOMMENDS THAT ADDITIONAL FUNDING BE USED TO ESTABLISH BONUS PAYMENTS.

2. THE AOA BELIEVES THAT TO THE EXTENT POSSIBLE, PARTICIPATION IN QUALITY REPORTING AND PAY-FOR-PERFORMANCE PROGRAMS SHOULD BE VOLUNTARY AND PHASED-IN OVER AN APPROPRIATE TIME PERIOD. THE AOA ACKNOWLEDGES THAT FAILURE TO PARTICIPATE MAY DECREASE ELIGIBILITY FOR BONUS OR INCENTIVE-BASED PAYMENTS BUT FEELS STRONGLY THAT PHYSICIANS MUST BE AFFORDED THE OPTION OF NOT PARTICIPATING.

3. THE AOA RECOMMENDS THAT PHYSICIANS HAVE A CENTRAL ROLE IN THE ESTABLISHMENT AND DEVELOPMENT OF QUALITY STANDARDS. A SINGLE SET OF STANDARDS APPLICABLE TO ALL PHYSICIANS IS NOT ADVISABLE. INSTEAD, STANDARDS SHOULD BE DEVELOPED ON A SPECIALTY-BY-SPECIALTY BASIS, APPLYING THE APPROPRIATE RISK ADJUSTMENTS AND TAKING INTO ACCOUNT PATIENT COMPLIANCE. ADDITIONALLY, QUALITY STANDARDS SHOULD NOT BE ESTABLISHED OR UNNECESSARILY INFLUENCED BY PUBLIC AGENCIES OR PRIVATE SPECIAL INTEREST GROUPS WHO COULD GAIN BY THE ADOPTION OF CERTAIN STANDARDS. HOWEVER, THE AOA DOES SUPPORT THE ABILITY OF APPROPRIATE OUTSIDE GROUPS WITH ACKNOWLEDGED EXPERTISE TO ENDORSE DEVELOPED STANDARDS THAT MAY BE USED.

4. THE AOA DOES NOT SUPPORT THE EXCLUSIVE USE OF CLAIMS-BASED DATA IN QUALITY EVALUATION. INSTEAD, THE AOA SUPPORTS THE DIRECT AGGREGATION OF CLINICAL DATA BY PHYSICIANS. PHYSICIANS OR THEIR DESIGNATED ENTITY WOULD REPORT THIS DATA TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AND/OR OTHER PAYERS.

5. THE FEDERAL GOVERNMENT MUST ADOPT STANDARDS PRIOR TO THE IMPLEMENTATION OF ANY NEW HEALTH INFORMATION SYSTEM. SUCH STANDARDS MUST ENSURE INTEROPERABILITY BETWEEN PUBLIC AND PRIVATE SYSTEMS AND PROTECT AGAINST EXCLUSION OF CERTAIN SYSTEMS. INTEROPERABILITY MUST APPLY TO ALL PROVIDERS IN THE HEALTH CARE DELIVERY SYSTEM, INCLUDING PHYSICIANS, HOSPITALS, NURSING HOMES, PHARMACIES, PUBLIC HEALTH SYSTEMS, AND ANY OTHER ENTITIES PROVIDING HEALTH CARE OR HEALTH CARE RELATED SERVICES. THESE STANDARDS SHOULD BE ESTABLISHED AND IN PLACE PRIOR TO ANY COMPLIANCE REQUIREMENTS.

6. THE AOA ENCOURAGES THE FEDERAL GOVERNMENT TO REFORM EXISTING STARK LAWS IN ORDER TO ALLOW PHYSICIANS TO COLLABORATE WITH HOSPITALS AND OTHER PHYSICIANS IN THE PURSUIT OF ELECTRONIC HEALTH RECORDS (EHR) SYSTEMS WITHOUT FEAR OF PROSECUTION. THIS WILL PROMOTE WIDESPREAD ADOPTION OF EHR, EASE THE FINANCIAL BURDEN ON PHYSICIANS, AND ENHANCE THE EXCHANGE OF INFORMATION BETWEEN PHYSICIANS AND HOSPITALS LOCATED IN THE SAME COMMUNITY OR GEOGRAPHIC REGION.

7. THE AOA SUPPORTS THE ESTABLISHMENT OF PROGRAMS TO ASSIST ALL PHYSICIANS IN PURCHASING HEALTH INFORMATION TECHNOLOGY (HIT). THESE PROGRAMS MAY INCLUDE GRANTS, TAX-BASED INCENTIVES, AND BONUS PAYMENTS THROUGH THE MEDICARE PHYSICIAN PAYMENT FORMULA AS A WAY TO PROMOTE ADOPTION OF HIT IN PHYSICIAN PRACTICES. WHILE SMALL GROUPS AND SOLO PRACTICE PHYSICIANS SHOULD BE ASSISTED, PROGRAMS SHOULD NOT EXPRESSLY EXCLUDE LARGE GROUPS FROM PARTICIPATION.

8. THE AOA SUPPORTS THE ESTABLISHMENT OF PROGRAMS THAT ALLOW PHYSICIANS TO BE COMPENSATED FOR PROVIDING CHRONIC CARE MANAGEMENT SERVICES. FURTHERMORE, THE AOA DOES NOT SUPPORT THE ABILITY OF OUTSIDE VENDORS INDEPENDENT OF PHYSICIANS TO PROVIDE SUCH SERVICES.

9. THE AOA BELIEVES THAT PHYSICIANS WHO PARTICIPATE IN PAY FOR PERFORMANCE PROGRAMS HAVE THE RIGHT TO REVIEW, COMMENT, AND APPEAL ANY PERFORMANCE DATA.

10. THE AOA BELIEVES THAT PAY FOR PERFORMANCE PROGRAMS SHOULD INCLUDE MONITORING AND EVALUATION BY BOTH PAYORS AND PHYSICIAN ORGANIZATIONS TO IDENTIFY ELEMENTS THAT POSITIVELY AFFECT OUTCOMES.

1 11. THE AOA BELIEVES THAT PATIENT SATISFACTION MEASURES SHOULD BE
2 LIMITED TO EASILY DEFINABLE MEASURES.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee inserted the Principles from the original policy H604-A/15 so they could be viewed during review by the House.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H606-A/15 PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad HOC Committee

1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H606-A/15 PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A**
5 **HOSPITAL SETTING**
6 The American Osteopathic Association encourages all healthcare providers and hospital
7 employees to wear hospital-issued identification badges with clear delineation of their
8 professional role and that they verbally introduce and identify themselves and their role in the
9 patient's treatment process, with the overall goal of improving patient safety and patient
10 communication. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

The American Osteopathic Association (AOA) supports A NEW RISK-BASED OVERSIGHT FRAMEWORK FOR CLINICAL SOFTWARE, DEVELOPED THROUGH A MULTI-STAKEHOLDER CONCENSUS-BASED PROCESS. THE FRAMEWORK SHOULD TAKE INTO ACCOUNT RISK RELATIVE TO INTENDED USE, COST/BENEFIT OF PROPOSED OVERSIGHT, AND THE PRINCIPLE OF SHARED RESPONSIBILITY. PATIENT SAFETY AND APPROPRIATE IMPROVEMENTS IN QUALITY, EFFECTIVENESS, AND EFFICIENCY OF CARE DELIVERY SHOULD BE PARAMOUNT. THIS FRAMEWORK SHOULD NOT CONFLICT WITH OR DUPLICATE THE MEDICAL DEVICE REGULATION FRAMEWORK. THE AOA DOES NOT SUPPORT DATA BE TREATED AS A MEDICAL DEVICE, REGARDLESS OF THE CATEGORY OF HEALTH IT ASSOCIATED WITH THE DATA. THE AOA SUPPORTS A NATIONAL NETWORK FOR REPORTING PATIENT SAFETY EVENTS AND OTHER INFORMATION VITAL TO PUBLIC HEALTH, WHERE DATA CAN BE ACCESSED, ANALYZED, AND COMMUNICATED IN A TIMELY MANNER. THE REGULATORY FRAMEWORK SHOULD PROMOTE ~~An open~~ interoperability ~~platform for health care delivery~~, in order for clinical information systems to capture and share quality, outcome, cost, AND PATIENT HEALTHCARE data. TO SUPPORT COORDINATED HEALTH CARE AND DATA ANALYTICS TO PROMOTE TRANSITION TO A VALUE-BASED HEALTHCARE SYSTEM. THE AOA SUPPORTS A COMMON DATA STRUCTURE THAT WILL ENABLE INTEROPERABILITY, SETTING A CLEAR COURSE OF ACTION, FEDERAL SUPPORT FOR AN EXCHANGE INFRASTRUCTURE, AND STANDARDS WHICH WILL MAKE IT EASIER TO SHARE INFORMATION SO PHYSICIANS AND PATIENTS CAN MAKE INFORMED DECISIONS.

The AOA will encourage public and private sector stakeholders to develop clinically driven, standardized products that are interoperable by design, do not require costly and time-consuming customization, and for which any upgrades or future needs can be integrated seamlessly without burdensome costs or system modifications. The AOA also supports standardization of prior authorization attachments to alleviate burden and reduce delays to care.

The AOA opposes vendors blocking health care professionals' ability to access, view, share, or transfer data.

1 The AOA supports policies and technologies that facilitate person-centered health care~~, not~~
2 ~~technology-centered healthcare and policies that include adequate positive incentives for the~~
3 ~~adoption of health information technology.~~

4 The AOA will remain vigilant about mitigating the level of administrative burden posed by
5 existing and new government policies. 2015

Explanatory Statement: Submitted by Author
This policy merges with H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE and includes content provided by the Michigan Osteopathic Association. Upon approval of this resolution policy H603-19 will be sunset.

Background Information: Provided by AOA Staff
Current AOA Policy: H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Ethics Subcommittee recommends that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY**
5 The American Osteopathic Association has adopted the following "Guide to Section 17 of the
6 AOA Code of Ethics" as follows, and will distribute this information to students of osteopathic
7 medicine and osteopathic physicians (1991, revised 1994, 1999, 2003; 2008; reaffirmed as
8 amended 2015).

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H614-A/15 PHYSICIAN COMPETENCY RETESTING

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Osteopathic Specialists recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H614-A/15 PHYSICIAN COMPETENCY RETESTING**
5 The American Osteopathic Association: (1) supports the mission of physician competency, the
6 quality movement and patient safety through self-regulation mechanisms rather than through
7 government mandated retesting for purposes of obtaining relicensure or for receiving payment
8 under a health benefits program. (2) continue its voluntary efforts to address and promote
9 physician competency through the teaching of core competencies at the predoctoral and
10 postdoctoral levels, physician assessment through osteopathic continuous certification ~~**and its**~~
11 ~~**AOA Clinical Assessment Program (CAP)**~~. 1988; reaffirmed 1993; revised 1998, 2003;
12 revised 2008; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H615-A/15 HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H615-A/15** HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT
5 The American Osteopathic Association encourages all health plans to follow tobacco cessation
6 recommendations of the Centers for Disease Control and Prevention (CDC) and encourages all
7 health care plans to accept CPT, ~~ICD-9~~ and ICD-10 codes for tobacco use as legitimate codes
8 for payment for services provided for these codes. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH**
5 **CARE**
6 The American Osteopathic Association recommends that all insurance companies consider the
7 establishment of a system for rewarding those patients who are trying to stay health as a means
8 of decreasing the amount of money spent on health care. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H617-A/15 FRIVOLOUS LIABILITY LAWSUITS

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Federal Health Programs recommends that the following
2 policy be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H617-A/15 - FRIVOLOUS LIABILITY LAWSUITS**
5 The American Osteopathic Association (AOA) supports, as a component of comprehensive
6 tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of
7 pocket expenses and lost income. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
A resolution is being submitted that combines this policy with H333-A/18. It will read as follows:

H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM
The American Osteopathic Association continues support of professional liability insurance reform that includes the following ~~eight~~ principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting "loss of chance", (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; ~~and~~ (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I'm sorry clauses; **AND (9) REIMBUSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS**. 1985, revised 1990, 1993, 1998, 2003, revised 2008; reaffirmed 2013, reaffirmed as amended 2018

Background Information: Provided by AOA Staff
Current AOA Policy: H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H618-A/15 PROVIDER TAX

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H618-A/15 PROVIDER TAX**
5 The American Osteopathic Association opposes any effort by a state or the federal government
6 to impose a provider tax of any type. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H619-A/15 MEDICAID PAYMENT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H619-A/15 MEDICAID PAYMENT**
5 The American Osteopathic Association supports ~~**legislation to ESTABLISH MEDICAID-**~~
6 ~~**MEDICARE PAYMENT PARITY**~~ **THE EFFORTS IN EACH STATE TO UPHOLD**
7 **THEIR OBLIGATION TO PAY PHYSICIANS AND HOSPITALS AT A FAIR AND**
8 **EQUITABLE RATE FOR PROVIDING QUALITY CARE TO THE STATE'S**
9 **MEDICAID RECIPIENTS**. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The resolution submitted to the Committee did not contain the original language. Once obtained the Committee felt the original language better conveyed the intent of the resolution. Editorial comment reimburse was changed to pay to align with AOA policy on not using the word reimburse.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H620-A/15 LAY MIDWIVES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H620-A/15 – LAY MIDWIVES**
5 The American Osteopathic Association opposes the licensing of lay midwives and will continue
6 providing support to affiliate societies in opposing state's efforts to license lay midwives. 2010;
7 reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING REIMBURSEMENT OF MEDICARE PAYMENTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING**
5 **REIMBURSEMENT OF MEDICARE PAYMENTS**
6 The American Osteopathic Association will seek an immediate reversal of the policy of the
7 Centers of Medicare and Medicaid (CMS) requiring a payback of medical care rendered by a
8 provider who has agreed to a malpractice settlement or received a judgment in a malpractice
9 court. 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back on what steps have been taken since adoption of this resolution and the outcome to determine this policy's relevance.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on Economic and Regulatory Affairs)*

DATE: **October 13, 2020**

SUBJECT: H622-A/15 ELECTRONIC HEALTH RECORDS – PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H622-A/15 **HEALTH INFORMATION TECHNOLOGY PHYSICIAN ~~ASSISTANCE PROGRAMS FOR TRANSITION TO ELECTRONIC HEALTH RECORDS~~ SUPPORT FOR ADOPTING INNOVATIVE ~~HEALTH INFORMATION TECHNOLOGY~~**

The American Osteopathic Association will continue ~~to work with state osteopathic associations~~ to ~~assist~~ SUPPORT solo practice physicians and small-group practices in the adoption of health information technology (HIT). THE AOA SUPPORTS INCENTIVES OR ENHANCED PAYMENTS FOR ADOPTION OF INNOVATIVE HIT THAT IMPROVES CARE DELIVERY, COORDINATION, AND VALUE. 2005; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author:
This policy was combined with H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT for broader HIT interoperability. Approval of this resolution would sunset H616-A/19.

Background Information: Provided by AOA Staff
Current AOA Policy: H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

Prior HOD action on similar or same topic: Policy reaffirmed in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be SUNSET.

3 (Old language is crossed out and new language is in CAPS)

4 **H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR**
5 The American Osteopathic Association support legislative efforts to: (1) decrease the hold time
6 for physicians and staff for requesting approval from insurance pharmacy plans, (2) require
7 insurance pharmacy plans to allow patients to continue receiving the medications for which
8 they are prescribed and are in good control; and (3) make it easier for a physician to request an
9 approval. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author:
Submitted a new resolution for consideration by 2020 HOD titled PRIOR AUTHORIZATION which includes content that covers this topic.

Explanatory Statement: Reference Committee
The Committee believes this policy needs to remain active since the policy the Bureau of Socioeconomic Affairs/Council on Economic and Regulatory Affairs submitted for consideration for 2020 HOD (H642), which incorporated this policy, was not approved by the Committee.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H625-A/15 PEDIATRIC PSYCHIATRIC CARE HEALTH RECORDS

SUBMITTED BY: Bureau of Socioeconomic Affairs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs and Bureau on Scientific Affairs and
2 Public recommends that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H625-A/15 PEDIATRIC PSYCHIATRIC CARE ~~HEALTH RECORDS~~**
5 The American Osteopathic Association supports the development of educational programs to
6 assist primary care physicians to identify and initiate appropriate support of pediatric psychiatric
7 care and encourages insurance providers to adequately reimburse counseling and psychiatric
8 care deemed necessary by the patient's primary care physician. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT**
5 **HYPERACTIVITY DISORDER (ADD / ADHD)**
6 The American Osteopathic Association urges insurance carriers to provide coverage for
7 attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by
8 primary care physicians. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS**
5 The American Osteopathic Association will communicate to the Centers for Medicare &
6 Medicaid Services (CMS) its concern about the Medicare Recovery Audit Contractors (RAC)
7 payment methodology. 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back on what steps have been taken regarding this policy and the outcome.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on Economic and Regulatory Affairs)*

DATE: **October 13, 2020**

SUBJECT: H629-A/15 MEDICARE LAW AND RULES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Program recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H629-A/15 MEDICARE LAW AND RULES**
5 The American Osteopathic Association recommends that Medicare regulations that restrict a
6 patient's freedom, as well as assess punitive damages to physicians, be challenged and that
7 administrative burdens placed on both the patient and physician be reduced. 1995; revised 2000,
8 2005; reaffirmed 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back with examples and steps that have been taken to address.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau on Federal Health Programs)*

DATE: **October 13, 2020**

SUBJECT: H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS HEALTH RECORDS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-**
5 **PHYSICIAN PROVIDERS ~~HEALTH RECORDS~~**
6 The American Osteopathic Association **(AOA)** supports the establishment of well-defined
7 credentialing and privileging criteria within the Veterans Administration (VA) that prohibits
8 non-physician providers with expanded scope of practice rights in a minority of states from
9 demanding such privileges in the VA system and supports the establishment of a consistent
10 requirement for the privileging of non-physician providers in the VA system. 2005; reaffirmed
11 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H631-A/15 TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H631-A/15 TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS**
5 The American Osteopathic Association (AOA) supports the establishment of tax credits for
6 physicians who practice full time in federally designated health professions shortage areas
7 (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated
8 underserved areas and urges that these tax credits be available, on a sliding scale, to-physicians
9 who provide services on a part-time basis in these communities. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H632-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT –PAYMENT POLICIES FOR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H632-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-**
5 **PAID ENVIRONMENT –PAYMENT POLICIES FOR**
6 The American Osteopathic Association will work to ensure that: (1) osteopathic manipulative
7 treatment in any prepaid compensation model be recognized as a separate procedure; (2)
8 osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and
9 surgeons be considered unique; and (3) osteopathic manipulative treatment in any prepaid
10 compensation model be compensated as a special separate procedure, either by payment of
11 additional capitation or on a fee-for-service basis without the need for prior authorization. 1995;
12 revised 2000, 2005, 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Federal Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES**
5 The American Osteopathic Association believes it is appropriate for physicians to prescribe
6 approved drugs for uses not included in their official labeling when they can be supported as
7 accepted medical practice. 1995; reaffirmed 2000, 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H635-A/15 NEWBORN AND INFANT HEARING SCREENS

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H635-A/15 NEWBORN AND INFANT HEARING SCREENS**
5 The American Osteopathic Association supports adequate funding for universal hearing
6 screening and intervention for newborns and infants. 1995; revised 2000, 2005; reaffirmed 2010;
7 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H636-A/15 MEDICARE PREVENTIVE MEDICAL SCREENING

SUBMITTED BY: Bureau of Federal and Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Federal and Health Programs recommends that the following
2 policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H636-A/15 MEDICARE PREVENTIVE MEDICAL SCREENING**
5 The American Osteopathic Association supports coverage of Medicare recipients for routine
6 preventive medical services. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Ethics Subcommittee recommends that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS**
5 The American Osteopathic Association opposes invasion of privacy of the patient record by
6 any unauthorized person or agency; and endorses reasonable programs which seek to protect
7 patient/physician relationships and guarantee confidentiality of patient records. 1980; revised
8 1985, 1990, 1995; 2000, 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H638-A/15 DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
2 following policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H638-A/15 ~~DIABETICS~~ PERSONS WITH DIABETES CONFINED TO**
5 **CORRECTIONAL INSTITUTIONS**
6 The American Osteopathic Association supports the availability of American Diabetes
7 Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA
8 guidelines for all ~~diabetic inmates~~ IMPRISONED PERSONS WITH DIABETES, who are
9 under the care of a licensed physician, and confined in correctional institutions. 2000, revised
10 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H639-A/15 DISCRIMINATION BY INSURERS

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Socioeconomic Affairs and Council on AOA Policy
2 recommends that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H639-A/15 DISCRIMINATION BY INSURERS**
5 The American Osteopathic Association will actively pursue all reasonable avenues in support of
6 its members who are discriminated against by insurance companies and excluded from
7 participating in insurance programs; and in those instances where there is no due process to
8 discuss and mediate the exclusions, the AOA will petition organizations to present their
9 credentialing criteria and deselection criteria, and will use those resources at its disposal to help
10 obtain a fair and equitable solution to the problem and to include due process in all cases. 1995;
11 revised 2000, 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Ethics Subcommittee recommends that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES**
5 The American Osteopathic Association deems it an unethical act for any osteopathic physician
6 to deliver or be required to deliver a lethal injection for the purpose of execution in capital
7 crimes. 1995; revised 2000, reaffirmed 2005; 2010; [Editor's note: In 2015 this policy was
8 referred to the Ethics Subcommittee].

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H642-A/15 MANAGED CARE – ALL PRODUCTS CLAUSES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of State Government Affairs recommends that the following
2 policy be REAFFIRM as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

4 **H642-A/15 MANAGED CARE – ALL PRODUCTS CLAUSES**
5 The American Osteopathic Association and state osteopathic societies oppose the use of "all
6 products/all products developed in the future" clauses in physician managed care contracts;
7 actively opposes the use of any other clauses that may limit the ability of the physician to
8 choose the plans in which he or she participates; ~~will educate its members on the potential risks~~
9 ~~of "all products/all products developed in the future" clauses and the importance of identifying~~
10 ~~such clauses in contracts prior to their signing~~; and supports both state and federal legislation as
11 well as regulatory agency regulations and rulings to prohibit the use of "all products/all
12 products developed in the future" clauses in physician managed care contracts. 2000, revised
13 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H643-A/15 MEDICAL PROCEDURE PATENTS

SUBMITTED BY: Bureau of Federal Health Program

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Federal Health Program recommends that the following
2 policy be REAFFIRM.

3 (Old language is crossed out and new language is in CAPS)

4 **H643-A/15 MEDICAL PROCEDURE PATENTS**
5 The American Osteopathic Association (AOA) supports measures that restrict medical
6 procedure patents. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H644-A/15 MEDICARE CONTRACTOR DENIAL LETTERS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H644-A/15 MEDICARE CONTRACTOR DENIAL OF SERVICE LETTERS**
5 The American Osteopathic Association calls upon the Centers for Medicare and Medicaid
6 Services (CMS) to continue to involve osteopathic physicians in the development of screening
7 parameters **FOR DENIAL OF SERVICES FOR** ~~**including**~~ osteopathic structural diagnoses
8 and **OSTEOPATHIC** manipulative treatments. 1990; revised 1995, 2000, 2005; revised 2010;
9 reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN MENTAL HEALTH

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Emerging Leaders recommends that the following policy be
2 REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND**
5 **PHYSICIAN MENTAL HEALTH**
6 The American Osteopathic Association (AOA) will promote mental health awareness and
7 provide osteopathic medical students, residents, and physicians with educational information on
8 recognizing mental health issues among themselves and their colleagues. The AOA will work
9 with the American Association of Colleges of Osteopathic Medicine, AOA State Divisional
10 Societies, and Advocates for the American Osteopathic Association to reduce the stigma
11 associated with mental illness to eliminate barriers to treatment while advocating for increasing
12 the resources for care. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy
2 be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 **H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC**
5 **MANIPULATIVE TREATMENT (OMT) COVERAGE**
6 **DETERMINATION GUIDANCE**
7 The American Osteopathic Association (AOA) approves the attached policy as the standard
8 guidelines for OMT coverage and encourages all public and private payers to refer to the
9 AOA's policy when developing new policy or revising existing guidance for OMT coverage.
10 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, access to health care relies upon both the availability of providers and the patients' ability to cover the costs of health care services; and

WHEREAS, comprehensive, high-quality health care often involves services from multiple providers across different specialties, often working in collaboration; and

WHEREAS, government regulators and insurance companies have a responsibility to ensure that plan networks have adequate numbers of providers available in-person to provide all necessary services in the beneficiary's area; now, therefore be it

RESOLVED, American Osteopathic Association (AOA) will advocate to ensure plan coverage by public and private payors for all medically necessary services in-person, within a reasonable distance/wait time for all plan beneficiaries; and be it further

RESOLVED, the AOA support state insurance commissioners **AND/OR OTHER APPROPRIATE REGULATORY AGENCIES** as the primary enforcers of network adequacy requirements.

Explanatory Statement: Submitted by Author:
H317-A/15 PATIENT ACCESS IN RURAL AREAS has been reviewed by the Bureau of State Government Affairs and it was determined that the content could be merged into **H635-A/16** ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE to create a more comprehensive, streamlined policy. We suggest that both **H317-A/15** and **H635-A/16** be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

H317-A/15 PATIENT ACCESS IN RURAL AREAS
~~The American Osteopathic Association supports policy on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient.~~

H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE
The American Osteopathic Association (AOA) will advocate ~~for public and private payors~~ **TO** ensur**E**~~ing~~ plan coverage BY PUBLIC AND PRIVATE PAYORS for all medically necessary services **IN-PERSON, WITHIN A REASONABLE DISTANCE/WAIT TIME FOR ALL PLAN** ~~regardless of availability within the service area of its~~ beneficiaries, and support~~ing~~ state ~~regulators~~ **INSURANCE COMMISSIONERS** as the primary enforcer**S** of network adequacy requirements.

Background Information: Provided by AOA Staff
Current AOA Policy:
H309-A/16 PATIENT ACCESS IN RURAL AREAS
H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

Prior HOD action on similar or same topic: H309-A/16 policy reaffirmed in 2016; H635-A/16 policy approved in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: ADDRESSING FEARS AND BARRIERS TO TELEMEDICINE IMPLEMENTATION AND ALIGNMENT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, telemedicine is becoming a growing entity and option for healthcare services; and

2 WHEREAS, the potential convenience and lower costs of telemedicine may be highly attractive
3 to patients; and

4 WHEREAS, many physicians have expressed concern that telemedicine could adversely affect
5 the patient/physician relationship, quality of care, and/or patient safety; and

6 WHEREAS, appropriate oversight and regulations for telemedicine services are lacking; and

7 WHEREAS, inferior technology and network coverage can affect consistent services; and

8 WHEREAS, empowering a physician's ability to engage and implement telemedicine could
9 increase revenue, practice marketing options, and enhance relationships with physician's
10 existing patients; now, therefore, be it

11 RESOLVED, that the American Osteopathic Association (AOA) engage partner organizations
12 to support understanding, training and implementation of telemedicine in physician
13 offices; and, be it further

14 RESOLVED, that the AOA **BELIEVES THAT EVERY EFFORT SHOULD BE MADE**
15 **TO ALLOW TELEMEDICINE SERVICES TO BE PROVIDED BY THE**
16 **PATIENT'S ~~REGULAR~~ ATTENDING PHYSICIAN RATHER THAN BY**
17 **PROVIERS NOT AFFILIATED WITH OR TO WHOME THE PATIENT**
18 **HAS NOT BEEN REFERRED BY THE PATIENT'S PRIMARY CARE**
19 **PHYSICIAN ~~engage in evaluating processes that help our physicians implement~~**
20 **~~telemedicine in practices~~**.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H601-A/17 TELEMEDICINE – AOA POLICY ON

Prior HOD action on similar or same topic: Policy approved as amended in 2017.

FISCAL IMPACT: $0
Finance Committee Explanatory Statement – The general provisions included in this resolution may be incorporated into the AOA's existing processes without additional fiscal impact. Activities undertaken through the educational, legislative and legal realms currently address evolving telemedicine issues as

warranted. Additional efforts would require shifting of resources, but without an expectation of additional expenditures at this time.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH DATA COLLECTION AND IMPROVED ACCESS TO SOCIAL SERVICES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, equity in health and overall wellbeing is not simply determined by individual
2 choices but based on life chances and the resources provided in the environment one is
3 born into [1,2]; and

4 WHEREAS, consistent structural differences in social opportunities amongst the indigent
5 compared to the affluent is as important to life expectancy and health outcomes as
6 affordable access to medical treatment[1,2]; and

7 WHEREAS, the glaring inequality in freedom to live a thriving, healthy life can be balanced
8 through concerted effort to reverse structural drivers including policies, economics, and
9 living conditions to ensure a sustainable standard of health across all socioeconomic and
10 cultural backgrounds[1,2]; and

11 WHEREAS, there is widespread support for screening tools to measure social determinants of
12 health (SDoH) such as food insecurity, domestic violence, and housing quality that
13 currently exist in clinical practice[3,4]; and

14 WHEREAS, implementation of comprehensive screening with adequate linked cooperation to
15 local community resources was a noted barrier to practical use[3]; and

16 WHEREAS, the success of promising universal assessment tools, such as the Center for
17 Medicare and Medicaid Services' Accountable Health Communities (AHC) Model,
18 could be limited by inadequate funding, lack of hospital cooperation, and omission of
19 essential social and behavioral measures [4,5]; and

20 WHEREAS, American Osteopathic Association (AOA) aims to promote public health and
21 accentuate the distinctive philosophy of Osteopathic Medicine to treat the whole-person
22 as affirmed by AOA Policy H406-A/17 and H300-A/18; and

23 WHEREAS, private sector organizations are working with national medical organizations
24 through the Integrated Health Model Initiative (IHMI) to address the issue of SDoH
25 systematically through the process of creating relevant ICD-10 codes related to "critical
26 factors of patient well-being, such as employment, education, food, housing, access to
27 transportation, and many other factors" which will trigger social services referrals[7]; and

28 WHEREAS, ICD-10-CM is an international classification of diseases that plays a fundamental
29 role in health care delivery and payment policy, and it has recently been adapted in the
30 United States to include clinical modification (CM) which expands implications to
31 precise measuring, disease tracking, health care utilization, and quality of patient care

1 including codes "Z00-Z99" for factors influencing health status and contact with health
2 services [6]; and

3 WHEREAS, projects exist that aim to improve screening, diagnosis, treatment, and planning by
4 using technology to streamline data collection by defining a coded library of terms
5 related to SDoH and use interoperability of electronic health systems to address
6 individual patient needs more effectively[8]; now, therefore be it

7 RESOLVED, that the American Osteopathic Association (AOA) will adopt an official position
8 that supports the use of ICD-10-CM codes regarding social determinants of health that
9 mitigate challenges of physician referrals to social or government resources; and, be it
10 further

11 RESOLVED, that the AOA support legislation that improves interoperability of electronic
12 health records to reduce overall health care costs by improving communication between
13 members of a care team, including social services; and, be it further

14 RESOLVED, that the AOA support a validated screening tool to identify patients influenced
15 by social determinants of health.

Explanatory Statement: Submitted by Author:
Please note the use of "structural drivers" in line 7 refers to gender norms and values, economic participation, social exclusion, wealth distribution, education, civil rights, governance, public spending priorities, and macroeconomic conditions [1]. Further, note that the phrase "validated screening tool" referenced in line 51 indicates issuing a position of support for the creation of a standardized measurement of social determinants of health in individual patients that can be used across the nation, in any setting, and that has been authenticated to accurately assess patients at risk without any bias or skew towards certain demographics. This tool is indicated to be used at patient intake to identify individuals, such that the proper ICD-10 codes can be documented at the time of the encounter. Please be advised that the use of the term "support(s)" in the resolved statements is meant to indicate that SOMA and the AOA will use their judgement to promote the utilization of existing ICD-10 codes whether it be issuing a statement of support, lobbying for federal legislation relating to these codes, etc.

References

1. Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.
2. U.S. Department of Health and Human Services. Healthy People 2020: Social Determinants. Retrieved October 1, 2019, from: https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants
3. Davidson KW, McGinn T. Screening for Social Determinants of Health: The Known and Unknown. JAMA. Published online August 29, 2019. doi:10.1001/jama.2019.1091
4. Thomas-Henkel, Caitlin. Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Center for Health Care Strategies, Inc. October 2017, from https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf
5. Centers for Medicare and Medicaid Services. Accountable Health Communities Model. Retrieved March 1, 2020, from: https://innovation.cms.gov/initiatives/ahcm

6. Centers for Disease Control and Prevention: National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Retrieved March 1, 2020, from https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202020%20release%20of%20ICD-10-CM
7. American Medical Association. (2019, April 2). UNH and the AMA collaborate to address access to better health [Press release]. Retrieved from https://www.ama-assn.org/press-center/press-releases/unh-and-ama-collaborate-address-access-better-health
8. Health Level Seven® International (HL7®). (2019, August 20). New HL7® FHIR® Accelerator Project Aims to Improve Interoperability of Social Determinants of Health Data [Press release]. Retrieved from http://www.hl7.org/documentcenter/public_temp_E229E04C-1C23-BA17-0C76A643D1AFCAB7/pressreleases/HL7_PRESS_20190820.pdf

Explanatory Statement: Reference Committee
The Committee feels this needs to be restructured due to lack of clarity and overlap with existing policy.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 13, 2020**

SUBJECT: ELIMINATION OF PRIOR AUTHORIZATION AND STEP THERAPY

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, US healthcare spending is significantly greater for administrative costs than other
2 countries; and

3 WHEREAS, substantial costs to medical practices are required in order to process Prior
4 Authorizations (PAs); and

5 WHEREAS, administrative burdens to healthcare providers concerning PAs have substantially
6 increased thus leading to higher cost and delays to patient care and the related adverse
7 outcomes resulting from delays or denials of patient care; and

8 WHEREAS, legislative attempts to address PA issues have focused on transparency, rather than
9 addressing the barriers to timely patient care; and

10 WHEREAS, PA burdens in medical practice have increased significantly; and

11 WHEREAS, PA's and step therapy have been shown to lead to unnecessary hospitalizations
12 and overall health care, cost as well as increased patient morbidity and mortality; now,
13 therefore be it

14 RESOLVED, that the American Osteopathic Association advocate for elimination of prior
15 authorizations as a third payor pre-requisite for the provision of quality health care in
16 order to avoid harm and/or death due to delays in care.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Complete elimination of prior authorization and step therapy could result in improper utilization. The committee feels that H642, reviewed by this committee, can be used to help place guardrails on these practices.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H623-A/18 NON-PHYSICIAN CLINICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of State Government Affairs (BSGA) convened a workgroup to review the American Osteopathic Association's (AOA) Non-Physician Clinicians policy in light of the ongoing attempts by non-physician clinicians to independently practice medicine, despite wide variances in their education, training, and competency demonstration requirements (all of which fall short of the nationally standardized requirements for physicians); and,

WHEREAS, current AOA policy H623-A/18 NON-PHYSICIAN CLINICIANS~~,~~ supports either (undefined) "collaboration" or "supervision" by physicians, to ensure meaningful physician involvement and oversight in states that do not currently allow non-physician clinicians to practice independently; and

WHEREAS, it is the belief of the BSGA that the AOA should retain its current opposition to independent practice for non-physicians, **TO VOICE OPPOSITION TO THE ESTABLISHMENT OF EDUCATIONAL PROGRAMS TITLED "RESIDENCIES AND FELLOWSHIPS" FOR ADVANCED PRACTICE NURSES, PHYSICIAN ASSISTANTS, PHYSICAL THERAPISTS ~~AND OTHERS~~, AND** add support for regulating these professionals by state medical licensing boards in states that currently allow non-physician clinicians to practice independently by law, to ensure that they are being held to the same standards of care as physicians; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H623-A/18 NON-PHYSICIAN CLINICIANS The American Osteopathic Association has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, revised 2005; revised 2010; reaffirmed 2015; revised 2018

Policy Statement - 2018 NON-PHYSICIAN CLINICIANS

OVER THE COURSE OF THE PAST CENTURY, SCIENTIFIC AND TECHNOLOGICAL ADVANCEMENTS HAVE LED TO IMPROVEMENTS IN THE TREATMENT OF DISEASE AND STANDARDS OF PATIENT CARE. AS A RESULT, THE STANDARDIZED MEDICAL EDUCATION, SUPERVISED POSTGRADUATE ("RESIDENCY") TRAINING AND EXAMINATION SERIES THAT ~~The DO/MD~~ PHYSICIANS IN THE UNITED STATES ARE REQUIRED TO COMPLETE IN ORDER TO OBTAIN AN UNLIMITED MEDICAL LICENSE HAS INCREASED AS WELL. AT THE SAME TIME, HOWEVER, SOME STATES ARE CREATING LEGISLATIVE PATHWAYS TO INDEPENDENT MEDICAL PRACTICE FOR OTHER TYPES OF CLINICIANS, DESPITE THE ABSENCE

OF NATIONALLY STANDARDIZED EDUCATION, TRAINING AND TESTING PATHWAYS FOR THESE CLINICIAN GROUPS, OR EVIDENCE REGARDING PATIENT SAFETY OUTCOMES.

The current DO/MD medical model, IN WHICH MEDICAL STUDENTS AND RESIDENT PHYSICIANS ARE REQUIRED TO DEMONSTRATE THEIR ABILITY TO SAFELY PROVIDE CARE TO PATIENTS UNDER THE SUPERVISION OF FULLY LICENSED PHYSICIANS, LEADING TO GREATER AUTONOMY OVER TIME, has proven its ability to provide ~~professionals~~ PHYSICIANS with THE complete KNOWLEDGE AND SKILL BASE ~~medical education and training and testing~~ needed to ensure patient safety AND OPTIMIZE OUTCOMES. IN ADDITION, MOST STATES IMPOSE ADDITIONAL CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS, AND MANY PHYSICIANS ELECT TO UNDERGO RIGOROUS CERTIFYING BOARD EXAMINATIONS TO DEMONSTRATE EXCELLENCE IN A PARTICULAR SPECIALTY, WHICH HELPS TO ENSURE THAT PHYSICIANS REMAIN TRAINED TO PROVIDE THE CURRENT HIGHEST STANDARD OF PATIENT CARE OVER THE COURSE OF THEIR CAREERS.

Thus, it is appropriate that the practice of medicine and the quality of medical care ~~are~~ REMAIN the responsibility of ~~properly licensed~~ physicians, WHO ARE THE ONLY CLINICIAN GROUP PROPERLY TRAINED, LICENSED AND REGULATED ACCORDING TO UNIFORM LAWS GOVERNING MEDICAL LICENSURE IN THE UNITED STATES. The American Osteopathic Association (AOA) ~~further~~ VALUES THE UNIQUE TRAINING AND CONTRIBUTIONS OF ALL MEMBERS OF THE PATIENT CARE TEAM, AND supports the concept of uniform licensure pathways for ~~non-physician~~ALL clinician GROUPS, based upon scope of practice. THE AOA~~It~~ FURTHER SUPPORTS APPROPRIATE PHYSICIAN INVOLVEMENT IN PATIENT CARE PROVIDED BY NON-PHYSICIAN CLINICIANS, AND opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates THAT patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. **Patient Safety.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of ~~the~~ relevant state statutes.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established STATE-LEVEL SUPERVISORY protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates AND PATIENTS CAN REST ASSURED THAT PHYSICIAN INVOLVEMENT IN THEIR CARE WILL REMAIN THE SAME REGARDLESS OF PRACTICE SETTING WITHIN THE

STATE. ~~The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted.~~ FURTHER, a~~A~~ll non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality AND DEGREE of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians ~~acting~~ PROVIDING CARE IN INDEPENDENT PRACTICE STATES ~~autonomously of physicians~~ should be REGULATED AND DISCIPLINED BY THE ENTITIES RESPONSIBLE FOR REGULATING AND DISCIPLINING PHYSICIANS (I.E. STATE MEDICAL BOARDS), TO ENSURE THAT ALL CLINICIANS WHO ARE INDEPENDENTLY PRACTICING MEDICINE ARE held to the SAME STANDARD OF CARE AND THE equivalent degree of liability~~ as that of a physician~~. ~~Within this independent practice framework,~~TO THAT END, the AOA ~~further~~ ALSO believes that non-physician clinicians should be required to obtain EQUIVALENT malpractice insurance ~~in those states that currently require~~TO physicians IN STATES THAT CURRENTLY REQUIRE PHYSICIANS to possess malpractice insurance.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H623-A/18 NON-PHYSICIAN CLINICIANS

Prior HOD action on similar or same topic: Policy approved as amended in 2018.

Fiscal Impact: $0

ACTION TAKEN **ADOPTED as AMENDED**

DATE **October 13, 2020**

SUBJECT: H623-A/18 NON-PHYSICIAN CLINICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of State Government Affairs (BSGA) convened a workgroup to review the American Osteopathic Association's (AOA) Non-Physician Clinicians policy in light of the ongoing attempts by non-physician clinicians to independently practice medicine, despite wide variances in their education, training, and competency demonstration requirements (all of which fall short of the nationally standardized requirements for physicians); and,

WHEREAS, current AOA policy H623-A/18 NON-PHYSICIAN CLINICIANS~~,~~ supports either (undefined) "collaboration" or "supervision" by physicians, to ensure meaningful physician involvement and oversight in states that do not currently allow non-physician clinicians to practice independently; and

WHEREAS, it is the belief of the BSGA that the AOA should retain its current opposition to independent practice for non-physicians, **TO VOICE OPPOSITION TO THE ESTABLISHMENT OF EDUCATIONAL PROGRAMS TITLED "RESIDENCIES AND FELLOWSHIPS" FOR ADVANCED PRACTICE NURSES, PHYSICIAN ASSISTANTS, PHYSICAL THERAPISTS ~~AND OTHERS~~, AND** add support for regulating these professionals by state medical licensing boards in states that currently allow non-physician clinicians to practice independently by law, to ensure that they are being held to the same standards of care as physicians; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

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As non-physician clinicians continue to seek wider roles, public policy dictates THAT patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. **Patient Safety.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of ~~the~~ relevant state statutes.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established STATE-LEVEL SUPERVISORY protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates AND PATIENTS CAN REST ASSURED THAT PHYSICIAN INVOLVEMENT IN THEIR CARE WILL REMAIN THE SAME REGARDLESS OF PRACTICE SETTING WITHIN THE

STATE. ~~The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted.~~ FURTHER, a~~A~~ll non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality AND DEGREE of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians ~~acting~~ PROVIDING CARE IN INDEPENDENT PRACTICE STATES ~~autonomously of physicians~~ should be REGULATED AND DISCIPLINED BY THE ENTITIES RESPONSIBLE FOR REGULATING AND DISCIPLINING PHYSICIANS (I.E. STATE MEDICAL BOARDS), TO ENSURE THAT ALL CLINICIANS WHO ARE INDEPENDENTLY PRACTICING MEDICINE ARE held to the SAME STANDARD OF CARE AND THE equivalent degree of liability~~ as that of a physician~~. ~~Within this independent practice framework,~~TO THAT END, the AOA ~~further~~ ALSO believes that non-physician clinicians should be required to obtain EQUIVALENT malpractice insurance ~~in those states that currently require~~TO physicians IN STATES THAT CURRENTLY REQUIRE PHYSICIANS to possess malpractice insurance.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H623-A/18 NON-PHYSICIAN CLINICIANS

Prior HOD action on similar or same topic: Policy approved as amended in 2018.

Fiscal Impact: $0

ACTION TAKEN **ADOPTED as AMENDED**

DATE **October 13, 2020**

SUBJECT: MARKETING AOA BOARD CERTIFICATION

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, the American Osteopathic Association (AOA) has deeming authority from the
2 U.S. Department of Education to certify physicians; and

3 WHEREAS, AOA board certified physicians have historically been supportive and involved
4 members of the AOA and its divisional societies; and

5 WHEREAS, the AOA, and its state associations' and specialty colleges', collectively known as
6 divisional societies, health and viability will be strengthened by having many early career
7 physicians sit for AOA examinations; and

8 WHEREAS, graduates of Accreditation Council of Graduate Medical Education (ACGME)
9 programs must be informed of and provided reasons for pursuing AOA board
10 certification; and

11 WHEREAS, the eighteen (18) AOA certifying boards depend upon item-writers who are
12 overwhelmingly practicing physicians; and

13 WHEREAS, the AOA internally uses the tag line "*Practicing Physicians Certifying Practicing*
14 *Physicians*"; now, therefore be it

15 RESOLVED, that the American Osteopathic Association (AOA) implement a branding
16 campaign for its specialty certifying boards to include incorporating the tag line
17 "*Practicing Physicians Certifying Practicing Physicians*" on all AOA certifying boards webpages
18 and letterhead; and, be it further

19 RESOLVED, that the AOA develop and broadly distribute a one-page info sheet targeting
20 Graduate Medical Education (GME) sponsoring institutions, program directors,
21 postdoctoral trainees, and board-eligible physicians; and, be it further

22 RESOLVED that the info sheet shall incorporate the tag line "*Practicing Physicians Certifying*
23 *Practicing Physicians*" and discuss AOA certification in terms of relevance of exam to
24 practice, affordability, value, convenience and ease of maintenance.

Explanatory Statement: Submitted by Author:
Potential candidates must be provided with reasons for pursuing AOA Board Certification: distinctiveness, value, relevance of exam to practice, affordability, convenience and ease of maintenance.

With ease of electronic communication and website branding, this resolution can be implemented with low costs and may help to expand our customer base and thus drive revenues to the certifying boards, specialty colleges, and the AOA.

The following Divisional Societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Orthopedics
- American Osteopathic Academy of Sports Medicine
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Explanatory Statement: Reference Committee
This policy conflicts with marketing campaigns and efforts recently started by the AOA.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to $59,500 in additional expense.
The additional expenses incurred if the AOA pursued this resolution would consist of the cost of disposing current letterhead and business cards and the estimated costs of reprinting letterhead and business cards of $10,500, and estimated costs for rebranding between $16,500 and $49,000 at $165 per hour. Rebranding could be from 100 to 300 hours including 30-40 hours for content and design work by AOA staff. The range of additional expenses would be between $27,000 and $59,500.

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: PRIOR AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, prior authorization (PA) results in care delays and adverse events, with a recent American Medical Association survey finding that 91% of physicians report care delays associated with PA and 28% report that PA has led to serious adverse events for their patients[1]; and

WHEREAS, prior authorization increases administrative burden for physicians with 86% of physicians citing high level of burden associated with PA requirements; and

WHEREAS, the American Osteopathic Association has numerous policies relating to PA and the 2019 House of Delegates directed the Bureau of Socioeconomic Affairs to unify policies into a comprehensive policy statement; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization; and be it further

RESOLVED, the AOA will merge policies H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16.

Prior Authorization

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden[2]. In order to ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of PA by payers and pharmacy benefit managers should abide by the following principles.

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.
- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.
- Payors should appropriately compensate providers for complying with utilization review.
- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.
- Allow continuation of medications already being administered or prescribed when a patient changes health plans and not allow changes without discussion and approval of the ordering physician.

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[1] American Medical Association. "2018 AMA Prior Authorization (PA) Physician Survey".
[2] American Medical Association. "2018 AMA Prior Authorization (PA) Physician Survey".

- Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.
- Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.
- Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved
- There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians

As part of its efforts to advocate for these principles and ensure their incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers and pharmacy benefit managers to:

- Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being;
- Consider a physician's attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment;
- Include in contracts with healthcare providers hold harmless clauses that indemnify healthcare providers against financial loss due to injury to a patient as a result of the payor's failure or refusal to grant a prior authorization request in a timely manner;
- Provide appropriate notice to patients and physicians when formulary and benefit changes are made;
- Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including EMR templates;
- Publish and make available to the public all requirements for prior authorization and follow those published policies;
- Provide sufficient knowledgeable staff to ensure that healthcare providers are able to contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes;
- Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests; and
- To identify and hold accountable the payor's medical director/claim adjudicator for the results of their decisions.

Explanatory Statement: Submitted by Author

Upon approval of this resolution the policies noted in the last resolved statement will be sunset.

Background Information: Provided by AOA Staff

Current AOA Policy:

H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION

H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: PROFESSIONAL LIABILITY INSURANCE REFORM

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the current state of the legal system imposes great costs on the U.S. health care system and society in general by forcing physicians to maintain costly amounts of professional liability insurance; and

WHEREAS, these costs may ultimately be borne by patients through increased prices or through the loss of solo/small group practices in rural and underserved areas, where physicians may be unable to afford the cost of this insurance; and

WHEREAS, this legal system incentivizes physicians to practice defensive medicine to protect themselves from litigation, and discourages some physicians from pursuing riskier specialties such as obstetrics, even though specialists in these areas are needed; now, therefore be it

RESOLVED, that the American Osteopathic Association continues support of professional liability insurance reform that includes the following principles:

1) limitations on non-economic damages - including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;
2) prohibiting "loss of chance" liability;
3) periodic payment of future expenses or losses;
4) offsets for collateral sources;
5) joint and several liability reform;
6) limitations on attorney contingency fees;
7) establishment of uniform statutes of limitations;
8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and "I'm sorry" clauses; and
9) reimbursement of all out-of-pocket expenses and lost income for physicians who are victims of frivolous lawsuits.

and, be it further

RESOLVED, that upon approval, AOA policies H617-A/15 FRIVOLOUS LIABILITY LAWSUITS and H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM be sunset.

Explanatory Statement: Submitted by Author

H617-A/15 FRIVOLOUS LIABILITY LAWSUITS has been reviewed by the Bureau of State Government Affairs and it was determined that the content should be merged into **H333-A/18** PROFESSIONAL LIABILITY INSURANCE REFORM to create a more comprehensive, streamlined

policy. We suggest that both **H617-A/15** and **H333-A/18** be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

H617-A/15 FRIVOLOUS LIABILITY LAWSUITS
~~The American Osteopathic Association (AOA) supports, as a component of comprehensive tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of pocket expenses and lost income.~~

H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM
The American Osteopathic Association continues support of professional liability insurance reform that includes the following ~~eight~~ principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting "loss of chance", (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; ~~and~~ (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I'm sorry clauses**; AND (9) REIMBUSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS.**

Background Information: Provided by AOA Staff
Current AOA Policy:
H617-A/15 FRIVOLOUS LIABILITY LAWSUITS
H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

Prior HOD action on similar or same topic: H617-A/15 policy approved in 2015; H333-A/18 policy approved in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: RE-ESTABLISHMENT OF THE BUREAU OF OSTEOPATHIC SPECIALTY SOCIETIES (BOSS)

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, the American Osteopathic Association's (AOA) Bureau of Osteopathic Specialty
2 Societies (BOSS), existed to allow for elected representatives from each of the specialty
3 colleges to assemble to discuss AOA policy proposals and their impact on the Specialty
4 Colleges; and

5 WHEREAS, other AOA Bureaus, Councils and Committees were able to refer matters to the
6 BOSS for comment and refinement; and

7 WHEREAS, the BOSS was discontinued without provision of an alternative structure to ensure
8 that specialty college elected leaders continued to have a vehicle for collaborative
9 discernment on matters affecting their members; and

10 WHEREAS, the AOA Council on Osteopathic Continuing Medical Education (COCME),
11 recently asked the Bureau of Osteopathic Specialists (BOS), the Bureau representing the
12 AOA's Specialty Certifying Boards, to weigh in on proposed changes to CME
13 requirements, including the tracking of specialty credits; however, the specialty colleges
14 had no venue or opportunity to provide input; and

15 WHEREAS, sweeping changes to CME requirements and the tracking of specialty credits
16 impact CME attendance at specialty college events and have significant fiscal impact on
17 divisional societies, organized elements within the AOA structure should exist to solicit
18 debate and support among key constituent groups, including the specialty college
19 elected leaders; and

20 WHEREAS, since the disbandment of BOSS, the profession has gained additional expertise,
21 experience and competence meeting in a virtual environment, the BOSS can now be re-
22 implemented with very little fiscal impact to the AOA; now, therefore be it

23 RESOLVED, that the Bureau of Osteopathic Specialty Societies (BOSS) be re-established,
24 whose membership is comprised of one elected representative from each specialty
25 society; and, be it further

26 RESOLVED, that the American Osteopathic Association (AOA) host at least two meetings per
27 year: one prior to the AOA Mid-Year Board of Trustees meeting and the other prior to
28 the Annual Business Meeting; as well as other times as requested by the BOSS; and, be
29 it further

30 RESOLVED that the AOA can organize these meetings in a virtual or hybrid environment, in
31 conjunction with the AOA Mid-Year Board of Trustees meeting and the Annual
32 Business Meeting, to minimize the fiscal impact to the AOA and the specialty colleges.

Explanatory Statement: Submitted by Author

The Bureau of Osteopathic Specialty Societies (BOSS) enable elected leaders of the specialty colleges to come together to discuss a myriad of issues:

- Proposed AOA Board and House resolutions
- Joint responses to public comment periods from other AOA Bureaus, Councils and Committees
- Joint responses to public comment periods from the ACGME, COCA, and various federal government agencies (HRSA, MEDPAC, CMS, etc.)
- Advocacy for needed revisions to ACGME Common Program requirements
- Collaboration on common issues, such as student chapters, supporting of transitions from medical school to postdoctoral training
- Tracking of and service to postdoctoral trainees
- Joint CME programming and planning

The following divisional societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Emergency Physicians
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American College of Osteopathic Surgeons
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Sports Medicine
- American Osteopathic Association of Prolotherapy Regenerative Medicine
- American Osteopathic College of Anesthesiologists
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Explanatory Statement: Reference Committee

AOA has just completed a systematic review and restructuring of its bureaus, councils, and committees. The AOA has also updated affiliate agreements with their input. This policy would be counterproductive to the AOA's recent efforts that it has undertaken in collaboration with affiliates.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: REFERRED RESOLUTION: H636-A/2019 OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates (HOD) referred resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE submitted by the Michigan Osteopathic Association; and

WHEREAS, the HOD requested the Bureau of Socioeconomic Affairs "review the feasibility of obtaining payment for the treatment of obesity as a primary diagnosis and whether new CPT and diagnosis codes need to be created for payment purposes"; now, therefore be it

RESOLVED, that resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE, be ADOPTED as amended

RES. NO. H-636 - A/2019

SUBJECT: OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016[1]; and

WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death; and

WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to reduce morbidity and mortality of the population; and

WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this condition ~~**and obesity is not currently a payable diagnosis for primary care**~~; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) ~~publicly affirms and advocates that all diagnosis codes for obesity and morbid obesity be a billable and reimbursable diagnostic code for any and all practicing primary care physicians~~ IS COMMITTED TO EXPANDING PAYMENT FOR SERVICES RELATED TO OBESITY DIAGNOSIS AND TREATMENT, INCLUDING NON-PRIMARY CARE PHYSICIANS AND NON-PHYSICIANS WHO PROVIDE COUNSELING IN CONSULTATION WITH A PHYSICIAN; and, be it further

RESOLVED, that the AOA WILL work with ~~insurers,~~ payors, legislators, and other stakeholders to ensure access to treatment for obesity to address this public health epidemic.

References

1. Centers for Disease Control Overweight and Obesity, https://www.cdc.gov/obesity/data/adult.html; Accessed March 15, 2019.

Explanatory Statement: Submitted by Author:
None provided.

Explanatory Statement: Reference Committee
The Committee felt that the statement "obesity is not currently a payable diagnosis for primary care" may not always be the case and may vary from payor to payor. The change suggested would prevent the resolution from becoming obsolete and still convey the original intent.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: POST PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18 referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, on July 21, 2018, the House of Delegates (HOD) Ad Hoc Reference Committee
2 referred H615-A/13 POSTPARTUM DEPRESSION to the Bureau on Scientific
3 Affairs and Public Health (BSAPH) to produce a report on outcomes; and

4 WHEREAS, at the 2019 HOD the BSAPH requested and received additional time to collect
5 the requested data from AOA's internal sources as well external key stakeholders (e.g.,
6 COMS, osteopathic state, and specialty associates); and

7 WHEREAS, the BSAPH developed and administered a survey to its external stakeholders to
8 collect the requested information and provide a final report to the HOD in 2020; now,
9 therefore be it,

10 RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the
11 following policy be REAFFIRMED.

12 **H615-A/13 POSTPARTUM DEPRESSION**

13 The American Osteopathic Association encourages its members to participate in continuing
14 medical education programs on postpartum depression (PPD); urges colleges of osteopathic
15 medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part
16 of their educational offerings; and endorses the use of screening tools and encourage the
17 measurement of outcomes in their use. 2003; 2008; reaffirmed as amended 2013.

Explanatory Statement: Submitted by Author

Introduction

Postpartum depression is a type of depression that occurs after women give birth. Symptoms of postpartum depression are more severe and enduring than those of "baby blues," which describes the worry, sadness, and tiredness many women combat after having a baby. Postpartum depressive symptoms (PDS) are common, and they can impact the mother, infant and family. PDS have been linked to adverse maternal and infant outcomes, including low breastfeeding initiation and duration and poor maternal and infant bonding. (Ko JY, 2017)

Fathers may also experience depression during the first year of their child's life. According to the Centers for Disease Control and Prevention (CDC), about 1 out of 5 fathers will suffer one or more incidences of depression before their child reaches 12 years of age. Younger fathers, those with a history of depression, and those experiencing financial challenges were most susceptible. (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020)

Based on the Pregnancy Risk Assessment Monitoring System (PRAMS) data, the CDC estimates that 1 in 8 women nationally experience PDS. (America's Health Rankings, 2019). Estimates of the number of

women affected by postpartum depression vary by age and race/ethnicity. Additionally, postpartum depression estimates differ by state, and can be as high as 1 in 5 women (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020).

Postpartum depression may be prevented and/ or mitigated by ensuring women have supportive and psychological care following childbirth. This includes home visits, peer support and interpersonal therapy. (Donna E. Stewart, 2016) Additionally, Postpartum Depression (PPD) is treatable with social support, counseling, and/ or medication. Though most people recover with treatment of PPD, many are not screened or diagnosed (America's Health Rankings, 2019).

Studies indicate that 66 percent of past-year depression among pregnant women in the US were undiagnosed, and only half of pregnant women with depressive symptoms received treatment. Studies also uncovered several barriers to treatment among women with PPD, particularly among Latinx and African American women. Given the significant burden of PPD, and the fact that PPD is preventable and highly treatable, the US public health strategy, Healthy People 2020, includes an objective to reduce the number of women who experience postpartum depressive symptoms subsequent to a live birth. (America's Health Rankings, 2019)

Osteopathic CME Education on PPD

In 2020, the BSAPH distributed a survey to 150 osteopathic CME providers at colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to ascertain whether or not the affiliate groups offered continuing medical education programs on PPD, endorsed the use of screening tools, or encouraged outcomes measurement from 2014 through 2019.

Sixty-nine (46%) organizations responded to the survey. Nine respondents (13%) reported a total of 26 educational CME activities on PPD delivered to their constituents from 2014 through 2019. The majority of the activities were live events, and as many as 1200 learners participated. Three (4%) of the organizations also promoted screening tools and encouraged outcomes measurement.

Conclusions/ Recommendations

There has been some education in the osteopathic community on PPD. However, depression for many women across the country is still a very significant issue that is underdiagnosed and untreated. Therefore, it is recommended that the AOA continue to encourage the osteopathic community to provide and participate in continuing medical education on PPD and the best practices for screening, diagnosis, monitoring and treatment.

References

America's Health Rankings. (2019). *Health of Women and Children Report*. Retrieved April 28, 2020, from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/postpartum_depression/state/ALL

Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2020, May 4). *Depression Among Women*. Retrieved from Centers for Diseas Control and Prevention, Reproductive Health: https://www.cdc.gov/reproductivehealth/depression/index.htm

Donna E. Stewart, C. M. (2016). Postpartum Depression. *N Engl J Med* , 2177-2186.

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Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to approximately $130,000 in additional expense.
The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: REFERRED SUNSET RES. NO. H-619 - A/2019: H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates referred sunset resolution H-619-A/2019 titled H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN to the Bureau of Socioeconomic Affairs for "clarification on intent of the resolution, definition of "open access models", and relevance of the resolution"; now, therefore be it

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED:

H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

The American Osteopathic Association (AOA) supports efforts to ~~combine tiered formulary and open access models with~~ expand~~ed~~ THE use of variable co-pays ~~that reflect the total~~ THAT SUPPORT PROGRAM costs. ~~of these programs and~~ THE AOA ALSO supports efforts to design benefits that align consumer needs, ~~and~~ accountability and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement: Submitted by Author:
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: RESEARCHING PATIENT SAFETY AND PROVIDER QUALIFICATIONS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, mid-level practitioners, defined as, but not limited to, health-care providers such
2 as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and
3 physician assistants [1] have increasingly sought expanded scope of practice with success;
4 and

5 WHEREAS, nurse practitioners (NPs) now have full scope of practice in 24 states with
6 intention to continue expansion of scope efforts [2]; and

7 WHEREAS, NPs have introduced a new degree, DNP, or Doctor of Nursing Practice, that has
8 increased confusion for patients in clinical settings, where said DNPs refer to
9 themselves as doctors, and at times do not adequately inform patients that they are not
10 physicians; and

11 WHEREAS, The Code of Federal Regulations defines the term physician to include doctors of
12 medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists,
13 chiropractors, and osteopathic practitioners within the scope of their practice as defined
14 by State law[7]; and

15 WHEREAS, The Social Security Administration defines physician to mean means doctor of
16 medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental
17 surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, or a
18 chiropractor, legally authorized to practice by a State in which he/she performs this
19 functions [within given parameters][8]; and

20 WHEREAS, Florida, New York, Arizona, Delaware have proposed laws limiting the use of
21 doctor to persons with a Medical Doctor (MDs) or Doctor of Osteopathic Medicine
22 (DOs) degree; Six states have passed laws making it a felony for nurse practitioners to
23 refer to themselves as doctor; Nine states require nurse practitioners to follow their
24 introduction with a clarifying statement [9,10,11]; and

25 WHEREAS, American Osteopathic Association (AOA) House of Delegates resolution number
26 H324-A/14 states that the AOA opposes the misuse of the title "doctor" by non-
27 physician clinicians, in all communications and clinical settings because such use
28 deceived the public by implying that the non-physician clinician's education, training, or
29 credentialing is equivalent to a DO or MD[13]; and

30 WHEREAS, attempts at promoting mid-level practitioners to independent practice is done
31 without proper reverence to their important purpose in healthcare, as mid-level support
32 for physicians; and

WHEREAS, such attempts are often aided by a gross oversimplification of the crucial role belonging to the primary care specialties to which NPs are often assumed to enter; and

WHEREAS, one major justification for the expanded numbers of these practitioners and their scopes of practice is the physician shortage, which is projected that by 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000[3]; and

WHEREAS, we acknowledge that the physician shortage is a real and serious problem on the horizon, but we also cannot afford to sacrifice patient safety or care in the name of momentary expediency; and

WHEREAS, American physicians, Medical Doctors (MDs) or Doctor of Osteopathic Medicine (DOs), undergo one to two and a half additional years of schooling, three additional years of residency training, and fifteen to eighteen thousand more training hours than "Doctors of Nursing Practice"[4]; and

WHEREAS, physicians are trained to direct and lead care, while midlevel providers such as nurse practitioners are not, the DNP degree is administrative in nature and not an advanced clinical degree; and

WHEREAS, there is inadequate evidence to support a transition to midlevel independence; and

WHEREAS, we must applaud and support nurse practitioners stance that their educational model is "patient centered" and "holistic", we must interject that they are not unique in this view point and reject the accusation that the "medical model" is "disease focused"; and

WHEREAS, continually expanding midlevel provider scope of practice creates an opportunity for a two tiered healthcare system to develop, where rural and underserved populations have limited access to physician providers while those in larger cities have greater access to physician providers, further exacerbating existing disparities in healthcare; and

WHEREAS, the AOA has previously called for a review and validation of nonphysician credentials and standards of care and supported a position that patients should be made clearly aware at all times if they are being treated by a non-physician provider or clinician (H634-A/15)[6]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~supports~~ **ENCOURAGES** independent research on the qualification and outcomes of nurse practitioners and other midlevel providers that practice independently**; AND, BE IT FURTHER**

RESOLVED, THAT THE AOA RESEARCH & PUBLIC HEALTH STAFF PERFORM AN ~~META~~ ANALYSIS OF CURRENT, VALID AND PUBLISHED RESEARCH ON CLINICAL OUTCOMES, RESOURCE UTILIZATION AND MALPRACTICE EXPERIENCE FOR INDEPENDENTLY PRACTICING NPS AND PAS AND PROVIDE THIS INFORMATION TO OSTEOPATHIC PHYSICIANS.

Explanatory Statement: Submitted by Author

Commonly it is asserted that midlevel providers provide access to rural communities. Firstly, the data shows that midlevel providers such NPs and PAs do not practice in rural areas in a statistically meaningfully different pattern as compared to physicians. Second, it is unjust to reinforce a two-tiered health care system by creating policy that promotes rural community care that is highly dependent on midlevel providers. Instead the policy focus should be to attract and retain physicians in rural areas. To solve a physician shortage, we must focus on physician policy.

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11. D-35.992, AMA BOT Cong. (2016) (enacted)
12. H324-A/14, AOA HOD Cong. (2014) (enacted)

Background Information: Provided by AOA Staff

Current AOA Policy: H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING

Prior HOD action on similar or same topic: Policy reaffirmed in 2016.

FISCAL IMPACT: $102,500 in additional expenses over a two (2) year period.
The additional expense would be incurred if AOA sponsors the research. Additional expenses would include: Initiate/Manage Grant Award $1,500; Grant Reviewers $1,000; grant award of $100,000.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: SUPPORT THE BOLSTERING OF VETERAN HEALTH ADMINISTRATION RESOURCES THROUGH PROVIDER PAY REFORM

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, veterans represented 7% (approximately 22.6 million people) of the United States
2 population in 2016[1]; and

3 WHEREAS, the Veterans Administration (VA) pays private contractors up to $295-300 for
4 each authorization of private care per veteran[2]; and

5 WHEREAS, existing health services provided directly by the United States Department of
6 Veterans Affairs remain hindered by chronic staffing shortages including 138 of 140
7 facilities reporting shortages of physicians, especially primary care and psychiatry
8 specialties, and 108 of 140 facilities reporting shortages of nursing occupations[3]; and

9 WHEREAS, existing health services provided directly by the United States Department of
10 Veterans Affairs remain hindered by uncompetitive pay because of outdated Office of
11 Personnel Management (OPM) classifications preventing the ability to offer more
12 competitive salaries or advancement opportunities[4]; and

13 WHEREAS, existing health services provided directly by the United States Department of
14 Veterans Affairs remain hindered by personnel management issues including a lack of
15 data on contract physicians and physician trainees resulting in insufficient workforce
16 planning [5]; and

17 WHEREAS, VA physicians are more knowledgeable about the care for combat injuries, post-
18 traumatic stress disorder, and other health injuries the veteran population faces[6]; and

19 WHEREAS, American Osteopathic Association (AOA) Resolution H-614-A/18 reaffirms the
20 support of adequate healthcare funding and use of community physicians "when
21 Veterans' Health Administration facilities cannot provide adequate or timely access"[7];
22 now, therefore be it

23 RESOLVED, that the American Osteopathic Association support both staffing management
24 and competitive pay reform at the Veterans' Health Administration (VHA) to ensure
25 that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is
26 available to meet the health needs of the United States veteran population.

Explanatory Statement: Submitted by Author

Per Resolution H617-A/13, SOMA and the AOA already supports adequate federal funding for health care for veterans at all VHA facilities, as well as federal funding for services from community health providers when VHA facilities are unable to provide adequate or timely access. SOMA and the AOA should advocate for improvements to existing VHA health care services by overhauling staffing data and management; thus, better allowing the VHA to strengthen its current services and provider pool by offering more competitive pay. These issues have been ongoing for years. Not enough has been done to ensure the VHA, which provides care to millions of Americans, keeps a level of modernity adequate enough to meet estimated needs. Addressing these issues would help reduce the need to rely on private health services, which have not met expectations for timeliness.

The intention of this resolution is to provide broad language for SOMA and the AOA to tackle these positions in a manner they find appropriate, without limiting methodology.

References

1. Bialik, K. (2017, November 10). 5 facts about U.S. veterans. Retrieved from https://www.pewresearch.org/fact-tank/2017/11/10/the-changing-face-of-americas-veteran-population/
2. VA Office of Inspector General. (2017, January 17). Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System. https://www.va.gov/oig/pubs/VAOIG-15-03036-47.pdf
3. Veteran Health Administration. (2018, June 21). Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain. Retrieved from https://www.gao.gov/assets/700/692661.pdf
4. Daigh, J. D. (2018, June 14). OIG Determination of Veterans Health Administration's Occupational Staffing Shortages: FY 2018. Retrieved from https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf
5. Draper, D. A. (2018, June 21). Steps Taken Lab to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain. Retrieved from https://docs.house.gov/meetings/VR/VR03/20180621/108430/HHRG-115-VR03-Wstate-DraperD-20180621.pdf
6. Tanielian, T., Farmer, C.M., Burns, R.M., Duffy, E.L., Setodji, C.M. (2018). Ready or not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. https://www.rand.org/pubs/research_reports/RR2298.html
7. American Osteopathic Association 98th Annual House of Delegates Meeting. (2018). *https://osteopathic.org/wp-content/uploads/2018-HOD-Resolutions-with-action.pdf*

Background Information: Provided by AOA Staff

Current AOA Policy: H414-A/18 ENVIRONMENTAL HEALTH

Prior HOD action on similar or same topic: Policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: TELEMEDICINE; REIMBURSEMENT FOR

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, the world continues to face a global health crisis through the pandemic spread of the corona virus COVID-SARS-19; and

WHEREAS, the health and safety of the peoples throughout the United States is uncertain; and

WHEREAS, in 2018 the Directorate for Global Health Security and Biodefense was shut down thereby limiting the national ability to respond to an emerging infectious disease crisis; and

WHEREAS, school districts throughout the United States have cancelled classes and look to digital platforms for instruction and have revisited and redefined the need for face-to-face time in the classroom, including hybrid versions of in-person and virtual encounters; and

WHEREAS, the number of confirmed cases and deaths in the United States continues to rise; and

WHEREAS, the disease continues to pose a heightened risk to those with immunocompromised and other vulnerable populations including the elderly, those with chronic lung disease, heart disease, cancer, and/or diabetes; and,

WHEREAS, a number of states witnessed their governor declaring public health states of emergency; and

WHEREAS, there has been inconsistent responses in such states as to quarantining measures, prevention techniques including masking and social distancing, and

WHEREAS, currently there are a number of United States' residents under mandatory quarantine and a far greater number confined to voluntary home isolation; and

WHEREAS, emergency responders have adopted policies that are designed to limit potential spread of the virus and some departments have been directed not to respond to calls from individuals that are experiencing coughs with high fevers and to also cease efforts of life-support or avoid transportation to hospitals for more definitive care if stricken citizens are above a certain age and/or if there was an extended effort; and

WHEREAS, individuals are instructed NOT to go to their physicians' offices if experiencing cough with fever unless they are in a high risk situation or experiencing shortness of breath when they are told to present to the emergency department of a hospital; and

WHEREAS, individuals ill with other medical conditions may likewise avoid needed in-person medical evaluation and treatment for fear of infection exposure; and

WHEREAS, on March 4, 2020, Congress voted to approve an emergency COVID-SARS-19 spending bill of 8.3 billion dollars to address this growing health crisis; and

WHEREAS, the medical community and community health centers serve as vital role in the maintenance of health and prevention of disease; and

WHEREAS, after 9/11/2001, the country watched as St. Vincent Hospital and Medical Center of New York City took on the role of receiving hospital for 9/11 workers and sustained incredible financial losses from which the hospital did not recover and was forced to close, and identified the particular risk to those who selflessly put themselves and their institution in harm's way for the good of the peoples in their community; and

WHEREAS, the physicians and other medical providers in the private sector must be enabled to respond to the growing need for medical services including mandatory quarantine and voluntary isolation; and

WHEREAS, technology is available to patients and physicians alike to allow for personalized advice and management through various means including telephonic and video communications (telemedicine); and

WHEREAS, there is acceptance of the utilization telemedicine for geographic areas where access to physicians and other health care providers is not readily accessible; and

WHEREAS, there are means available for these situations and circumstances for these physicians and others to be paid for their services using such telemedicine technology that was enacted on a temporary emergency basis; and

WHEREAS, the COVID-19 pandemic has created situations where persons are instructed to limit personal access to their physicians in an effort to curtail the spread of the contagion; and

WHEREAS, it is essential to provide up-to-the-minute information and medical care as safely and efficiently as possible, and

WHEREAS, the guidelines that determine that combined audio-visual interaction is necessary for one level of payment versus strictly telephonic interaction at another fails to recognize that those who are of a certain age or economic status may not have the means to utilize other than verbal-auditory interaction; and

WHEREAS, Medicare's coverage of telemedicine is slated to end in the near future if no extension is enacted and especially when the coronavirus no longer poses a public health emergency, and

WHEREAS, private insurers, which followed the federal government's lead, could revert to paying doctors for virtual visits at a fraction of the cost for traditional visits, if anything at all; now, therefore be it

RESOLVED, that the American Osteopathic Association work with the American Medical Association to advocate for legislation or an Executive Order to mandate that all health insurance plans, including those issued by CMS (Medicaid and Medicare Services) and entities covered under ERISA Law continue to reimburse for such services at a level that is commensurate with a ~~**level 4**~~ face-to-face visit~~**; and be it further**~~

~~**RESOLVED that community health centers, physicians and other clinical practitioners be directed to submit claims for services to individuals who have no health insurance to their respective State Offices of Emergency Management so as to utilize emergency funds approved by Congress so as to be able to provide medical care to the widest population of at-risk individuals as possible**~~**.**

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy:
H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING

H601-A/17 TELEMEDICINE – AOA POLICY ON

H343-A/18 PHYSICIAN PAYMENT FOR ELECTRONIC ADVICE, COUNSELING AND TREATMENT PLANS

H630-A/19 COMMUNICATION TECHNOLOGY-BASED AND REMOTE EVALUATION SERVICES

Prior HOD action on similar or same topic: H613-A/16 policy reaffirmed as amended in 2016; H601-A/17 policy reaffirmed as amended in 2017; H348-A/18 policy reaffirmed in 2018; H630-A/19 policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: **A PROCLAMATION** REGARDING THE INACCURATE PORTRAYALS OF US TRAINED DOs IN MEDIA

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, 120,000 osteopathic physicians are currently working in the US Healthcare system, and

WHEREAS, more than half of the current DOs practice in primary care specialties, and

WHEREAS, DOs have served in many levels of healthcare including state Surgeon Generals, the Surgeon General of the Army, Physician to Vice President Biden, and Physician to President Donald Trump, among others, and

WHEREAS, U.S. trained DOs have practice parity with Allopathic Physicians in all 50 states, and in many foreign nations, and

WHEREAS, on October 5, 2020 Rachel Maddow, during her show televised on MSNBC, referred to a DO as an Osteopath and implied he was not qualified to render medical care, and

WHEREAS, other journalists have made similar comments in print and on social media, and

WHEREAS, the demeaning effects of these comments represent an ongoing detriment to the perception of the thousands of Osteopathic Physicians among the people and the communities they serve, and

WHEREAS, the American Osteopathic Association has advocated and educated news agencies and the general public through formal campaigns and social media, and

WHEREAS, these efforts have resulted in appropriate news articles in the Atlantic, the LA Times and other publications, and

WHEREAS, these efforts have resulted in over one half million engagements on social media within the first 72 hours of this issue developing, now therefore, be it

PROCLAIMED by the American Osteopathic Association House of Delegates on this day, November 7, 2020, that we are

RESOLVED that the leadership and members of the American Osteopathic Association (AOA) condemn the poorly researched and patently incorrect statements regarding the ~~limits~~ **SCOPE OF PRACTICE** of U.S. trained DOs made by journalists; and, be it further

PROCLAIMED, that the American Osteopathic Association will continue ongoing efforts using social media and other means to educate the public and dispel inaccuracies of U.S. trained DOs; and, be it further

PROCLAIMED, that the American Osteopathic Association encourages its members, affiliated organizations, our patients and our Allopathic colleagues to use social media and other means to accurately represent the profession of Osteopathic Medicine to the public; and, be it further

PROCLAIMED, that the American Osteopathic Association will continue to provide online resources and support to its members and advocates to develop a grassroots social media campaign to further the understanding of the profession of Osteopathic Medicine by the public; **AND, BE IT FURTHER**

PROCLAIMED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION ON BEHALF OF THE OSTEOPATHIC PROFESSION EXPRESSES APPRECIATION AND GRATITUDE TO THE JOURNALISTS, ORGANIZATIONS, AND OTHER PERSONS THAT SUPPORT AN ACCURATE PORTRAYAL OF OSTEOPATHIC MEDICINE AND OSTEOPATHIC PHYSICIANS IN THE MEDIA.

Explanatory Statement: Submitted by Author
None provided.

FISCAL IMPACT:

ACTION TAKEN **ADOPTED**

DATE **November 7, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

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99th ANNUAL AOA HOUSE OF DELEGATES MEETING

2019 MEETING
RESOLUTION ROSTER
As of August 9, 2024

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

- Committee on Educational Affairs (200 series)
  This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.
- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.
- Committee on Public Affairs (400 series)
  This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.
- Committee on Constitution and Bylaws (500 series)
  This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.
- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.
- Joint Board/House Budget Review Committee (700 series)
  This committee reviews the AOA Strategic Plan and Budget.
- Committee on Resolutions
  This committee drafts the resolutions expressive of the sense of the HOD meeting.
- Credentials Committee
  This Committee receives and validates the credentials of the delegates and alternates, maintains a continuous roll call, determines the presence of a quorum, supervises voting and election procedures and makes recommendations on the eligibility of delegates and alternates to a seat in the House when a seat is contested.

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Res. No.	Resolution Title	Submitted By	Reference Committee
H-200	Health Care Shortage in Rural America (H200-A/14)	BOE	Education
H-201	Graduate Medical Education – Increasing Opportunities (H201-A/14)	BOE	Education
H-202	Osteopathic Medical Education (H203-A/14)	BOE	Education
H-203	Assure GME Residency Positions to Graduates of U.S. Medical Schools H205-A/14)	BFHP	Education
H-204	Uniformed Services Physicians Requiring and Assigned to Civilian Residency Programs – AOA Support of All Osteopathically Trained (H208-A/14)	BOE	Education
H-205	Graduates of LCME-Accredited Colleges of Medicine - Admission to Osteopathic Residency Programs (H207-A/14)	BOE	Education
H-206	Clinical Rotations for International Medical Students (H209-A/14)	BSGA	Education
H-207	Inhalation of Volatile Substances (H210-A14)	BSAPH	Education
H-208	Integrity and Mission of COMs UHSC Granting the DO – Maintaining the (H211-A/14)	BOE	Education
H-209	Psychiatry Curriculum and Staffing (H212-A/14)	BOE	Education
H-210	Teenage Alcohol Abuse (H213-A/14)	BSAPH	Education
H-211	Mandatory CME Course Requirements (H214-A/14)	BSGA	Education
H-212	Community-Based Teaching Health Centers Residency Support (H217-A/14)	BOE	Education
H-213	Professional Liability Insurance – Trainee (H219-A/14)	BOE	Education
H-214	Influenza Vaccination Programs for Medical Schools (H308-A/14)	BOE	Education
H-215	Single Graduate Medical Education Accreditation System (H800-A/14)	BOT	Education
H-216	Statement of Support for the American Osteopathic Board of Neurology And Psychiatry	ACONP	Education
H-217	Board Certification Test Results	ACOFP	Education
H-218	Certification Component Development	ACOFP	Education
H-219	Osteopathic Manipulative Treatment Boot Camp	ACOFP	Education

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Res. No.	Resolution Title	Submitted By	Reference Committee
H-220	American Osteopathic Association Specialty Board Certification	ACOFP / et al	Education
H-221	American Osteopathic Association Specialty Board Certification Terminology	ACOP	Education
H-222	H204-A/13 Unified GME Accreditation System Under the ACGME – Proposed and H209-A/13 Osteopathic Focused Training Programs	BOE	Education
H-223	Education of Students and Faculty on Obtaining Permission Before All Student and Patient Encounters	MOA	Education
H-224	AOA Board Certification Terminology	MOS	Education
H-225	Osteopathic Certification	MOS	Education
H-226	Osteopathic Content and Certification Standards	MOS	Education
H-227	Osteopathic Specialty Colleges And Certification	MOS	Education
H-228	Parental Leave Policies for Accreditation Council for Graduate Medical Education Residency	OOA	Education
H-229	Commendation of AMA Policy (AMA 955) on Equal Acceptance of COMLEX-USA for DO Students in all US Residency Programs	OPSC	Education
H-230	Classification of Osteopathic Medical Graduates as US Medical Graduates in Electron Residency Application Service	SOMA	Education
H-231	Recognition of COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs	MAOP	Education
H-232	Addiction Medicine CAQ	FC	Education

Res. No.	Resolution Title	Submitted By	Reference Committee
H-300	Training – Extended Release-Long Acting (ER/LA) Opioid Risk Evaluation And Mitigation Strategy (REMS) (H300-A/14)	BSAPH	Professional
H-301	Medical Websites and Smartphones/Tablet Computer Apps to Diagnose Illness – Use of (H301-A/14)	BSAPHG	Professional
H-302	Flu Pandemic – Osteopathic Treatment of (H305-A14)	BOCER	Professional
H-303	Direct-to-Consumer Marketing of Health Screening and Testing (H306-A/14)	BSAPH	Professional
H-304	New Born HIV Testing (H307-A/14)	BSAPH	Professional
H-305	CDC – HIV Proposed Rule Change (H313-A/14)	BSAPH	Professional

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H-306	Influenza Immunization for Health Care Workers and Educators (H314-A/14)	BSAPH	Professional
H-307	Due Process for Alleged Impaired Physicians (H316-A/14)	BOM	Professional

Res. No.	Resolution Title	Submitted By	Reference Committee
H-308	Drug Formularies (H317-A/14)	BFHP	Professional
H-309	Home-Based Care for Frail Elderly (H318-A/14)	BOCER	Professional
H-310	Health Care Costs in Long Term Services and Support (H319-A/2014)	BOCER	Professional
H-311	Immunization Registries (H320-A/14)	BSA	Professional
H-312	National Practitioner Data Bank – Membership Action (H321-A/14)	BOM	Professional
H-313	Importation of Medications (H322-A/14)	BFHP	Professional
H-314	Any Willing Provider Legislation (H323-A/14)	BSGA	Professional
H-315	Use of the Term "Phtysician" Doctor" and "Provider" (H324-A14)	BSGA	Professional
H-316	Physically Active Video Games – (Exergaming Health) Benefits (H325-A/14)	BSAPH	Professional
H-317	Medicare – Prescription Assistance for Medicare Patients (H326-A/14)	BSA	Professional
H-318	Electronic Prescribing (H327-A/14)	BSGA	Professional
H-319	Cardiovascular Disease and Women (H328-A/14)	BSAPH	Professional
H-320	Healthy Weight for Families (H329-A/14)	BSAPH	Professional
H-321	Administrative Fees (H330-A/14)	BSA	Professional
H-322	End-of-Life Care – Use of Placebos In (H331-A/14)	BOCER	Professional
H-323	Minorities in the Osteopathic Profession – Collecting Data (H332-A/14)	BOCER	Professional
H-324	Osteopathic Manipulative Treatment (OMT) of the Cervical Spine (H332-A/14)	BOCER	Professional
H-325	Right to Privately Contract (H334-A/14)	BSGA	Professional
H-326	Promoting Diversity in AOA Membership and Leadership (H334-A/14)	BOM	Professional
H-327	Abuse of Performance Enhancing Substances and Procedures (H337-A/14)	BSAPH	Professional
H-328	Diversity In Leadership Positions (H338-A/14)	BOM	Professional
H-329	Tobacco Use Status – Reporting in the Medical Record (H339-A/14)	BSAPH	Professional
H-330	Medical Costs Incurred by Patients for Services not	BSA	Professional

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	Covered by their Insurance (H344-A/14)		
H-331	Electronic Medical Record (EMR) – Student Access And Use (H345-A/14)	BOE	Professional

Res. No.	Resolution Title	Submitted By	Reference Committee
H-332	Testosterone Therapy: Long Term Effect On Health (H346-A/14)P	BOCER	Professional
H-333	Compensation Tied to Patient Satisfaction Surveys – Osteopathic Physician (H348-A/14)	BSA	Professional
H-334	Availability of Biosimilar Products	BSA	Professional
H-335	Maternal Mortality	ACOOG	Professional
H-336	Extending Medicaid to 12 Months Postpartum	ACOOG	Professional
H-337	New Physician in Practice Definition	BEL	Professional
H-338	Hospital Consolidation – Opposition to	BFHP	Professional
H-339	Pharmacy Benefit Managers-Increased Regulation of	BSGA/BFHP	Professional
H-340	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase	BFHP	Professional
H-341	Referred Sunset Res. No. H-315 - A/2018: H316-A/13 Human Cloning	BSAPH	Professional
H-342	Misaligned Incentives in Medicare Plans	FOMA	Professional
H-343	White Papers - Updating	IOMA	Professional
H-344	Development of a National Immunization Information Registry	IOMS	Professional
H-345	Consultant Reports Accessibility/ Availability- American Osteopathic Association	KOMA	Professional
H-346	Whistleblower Policy – American Osteopathic Association	KOMA	Professional
H-347	American Osteopathic Association – Organizational Health, Viability & Transparency	KOMA	Professional
H-348	Expansion of Medicaid in all States	MOA	Professional
H-349	Support for OMT Privileges	OPSC	Professional
H-350	Anti-Intimidation Standards Among Physicians	POMA	Professional
H-351	Advocating for Women's Right to Reproductive Healthcare Access and Support of Roe v. Wade	SOMA	Professional
H-352	Advocating for More DO Representation Within Medical TV Shows and Movies	SOMA	Professional
H-353	Decriminalization of Self-Induced Abortion	SOMA	Professional
H-354	De-Stigmatization of Mental Illness in Physicians	SOMA	Professional
H-355	Opposing Targeted Regulation of Abortion Providers	SOMA	Professional

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	(Trap Laws)		
H-356	Physician Psychological Trauma and Mental Health	MOA	Professional
H-357	Nutrition and Leading By Example	OPSO	Professional
H-358	Referred Resolution - H305-A/18 Interference Laws	BFHP/BSGA	Professional
H-359	Referred Resolution H306-A/18 - State Graduate Medical Education Funding Alternatives	BSGA	Professional
H-360	Referred Resolution H426-A/18 – Office Based Surgery	BSGA	Professional
H-361	Referred Resolution H340-A/13 – Uniform Pathway of Licensing of Osteopathic Physicians	BSGA	Professional
Res. No.	**Resolution Title**	**Submitted By**	**Reference Committee**
H-400	Patient Safety and use for Patients with Pain Conditions (H400-A/14)	BOCER	Public
H-401	Human Trafficking – Awareness as a Global Health Problem (H401-A/14)	BSAPH	Public
H-402	Same-Sex Relationships and Healthy Families (H403-A/14)	BSAPH	Public
H-403	Public Information – Correction of, About the Osteopathic Profession (H404-A/14)	BIOM	Public
H-404	Alert Network – Silver and Gold (H405-A/14)	BSAPH	Public
H-405	Alcohol Abuse (H407-A/14)	BSAPH	Public
H-406	Discrimination in Healthcare (H408-A/14)	BFHP	Public
H-407	Sudden Infant Death Syndrome (H409-A/14)	BSAPH	Public
H-408	Pharmaceuticals – Support Efforts to Encourage the Proper Disposal of Unused and Expired (H410-A/14)	BSAPH	Public
H-409	Advertising - Inflammatory and Unethical by Attorneys (H411-A/14)	BSGA	Public
H-410	Comparative Effectiveness Research (H412-A/14)	BOCER	Public
H-411	Epidemic Terrorist Attack Victims, Government Responsibility of Health Care (H413-A/14)	BFHP	Public
H-412	Fluoridation (H414-A/14)	BSAPH	Public
H-413	Maternal and Child Healthcare Block Grants (H415-A/14)	BSA	Public
H-414	Employee Retirement Income Security Act of 1974 (H416-A/14)	BFHP	Public
H-415	Breastfeeding While On Methadone Maintenance (H417-A/14)	BSAPH	Public
H-416	Raw Milk – Health Risks (H418-A/14)	BSAPH	Public
H-417	Vaccines (H419-A/14)	BSAPH	Public
H-418	Domestic and Intimate Partner Violence – Development of Programs to Prevent (H424-A/14)	BSAPH	Public

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H-419	Health Care Fraud (H425-A/14)	BSA	Public
H-420	Automated External Defibrillator Availability (H426-A/14)	BSGA	Public
H-421	Minorities, Underrepresented – Increasing Numbers of Applicants, Graduates And Faculty At Colleges of Osteopathic Medicine (H429-A/14)	BOE	Public
H-422	Lead Exposure In Children – Prevention, Detection, and Management (H431-A/14)	BSAPH	Public
H-423	Hepatitis C Screening (H432-A/14)	BSA	Public
H-424	Regulation of E-Cigarettes and Nicotine Vaping (H435-A/14)	BSGA	Public
H-425	Firearm Safety (H406-A/14)	BSAPH	Public
H-426	Protecting Patients with Private Insurance from Balance Billing	BFHP	Public
H-427	Referred Sunset Res. No. H-403 - A/2018: H403-A/13 Airbags In Automobiles	BSAPH	Public
H-428	Referred Sunset Res. No. H-421 - A/2018: H427-A/13 Physician-Patient Relationship as Related to Proposed Gun Control Laws, Protection of the	BSAPH	Public
H-429	CMS Rules on Psychotropic Medications in Nursing Facilities	IOMA	Public

Res. No.	Resolution Title	Submitted By	Reference Committee
H-430	Opposition to Patient Discrimination of Osteopathic Physicians Because of Race, Color, Religion, Gender, Sexual Orientation, Gender Identity or National Origin	IOMA	Public
H-431	Recognition of Health Care as a Human Right	MOA	Public
H-432	Osteopathic Physicians and the Availability of Naloxone	OOA	Public
H-433	Physician Awareness of Firearm Safety in Older Persons	POMA	Public
H-434	Opposing Zero-Tolerance Immigration Policies and the Separation of Families at the Border	SOMA	Public
H-435	Recognizing Food Insecurity as a Public Health Issue	SOMA	Public
H-436	Community Pharmacies; Required Notification of Primary Care Providers Regarding Vaccination Administration	IOMS	Public
H-437	Firearm Violence	IOMA	Public

Res. No.	Resolution Title	Submitted By	Reference Committee

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

99th ANNUAL AOA HOUSE OF DELEGATES MEETING

2019 MEETING
RESOLUTION ROSTER
As of August 9, 2024

H-500	Amendment to the AOA Constitution & Bylaws – Bureau of Emerging Leaders and New Physician In Practice	BEL	C&B
H-501	Amendment to the AOA Constitution – Change to Term Limit for Members of the Board of Trustees	CAGOS	C&B
H-502	Executive Committee of the AOA Board Of Trustees, Composition of	BOT	C&B
H-503	AOA Board of Trustees – Public Member Position	BOT	C&B
H-504	AOA House Of Delegates Voting Rules	BOT	C&B
H-505	AOA Rules and Guidelines on Physicians' Professional Conduct (H506-A/14)	BOM	C&B
H-506			
H-507			C&B
H-508			C&B
H-509			C&B

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99th ANNUAL AOA HOUSE OF DELEGATES MEETING

2019 MEETING
RESOLUTION ROSTER
As of August 9, 2024

Res. No.	Resolution Title	Submitted By	Reference Committee
H-600			Ad Hoc
H-601			Ad Hoc
H-602			Ad Hoc
H-603			Ad Hoc
H-604			Ad Hoc
H-605			Ad Hoc
H-606			Ad Hoc
H-607			Ad Hoc
H-608			Ad Hoc
H-609			Ad Hoc
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H-616			Ad Hoc
H-617			Ad Hoc
H-618			Ad Hoc
H-619			Ad Hoc
H-620			Ad Hoc
H-621			Ad Hoc
H-622			Ad Hoc
H-623			Ad Hoc
H-624			Ad Hoc
H-625			Ad Hoc
H-626			Ad Hoc
H-627			Ad Hoc
H-628	Referred Res. No. H-636 - A/2018 Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the US	BSAPH	Ad Hoc
H-629	Clinical Data Registries and Qualified Clinical Data Registries	BSA	Ad Hoc
H-630	Communication Technology-Based and Remote Evaluation Services	BSA	Ad Hoc
H-631	Incident to Billing by Physician Assistants and Advance Practice Registered Nurses	BSA	Ad Hoc

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99th ANNUAL AOA HOUSE OF DELEGATES MEETING

2019 MEETING
RESOLUTION ROSTER
As of August 9, 2024

Res. No.	Resolution Title	Submitted By	Reference Committee
H-632	Patient Matching of Electronic Health Record Data	BSA	Ad Hoc
H-633	Post-Partum Depression	BSAPH	Ad Hoc
H-634	Cooperation of the Veterans Administration and Non-VA Clinicians	FOMA	Ad Hoc
H-635	Prior Authorization – Patient Authorization	IOMA	Ad Hoc
H-636	Obesity Treatment Reimbursement in Primary Care	MOA	Ad Hoc
H-637	Prior Authorization and Utilization Management Reform	MOA	Ad Hoc
H-638	Addressing the Gender Pay Gap in the Medical Profession	SOMA	Ad Hoc

SUBJECT: H200-A/14 HEALTH CARE SHORTAGE IN RURAL AMERICA

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Education recommend that the following policy be REAFFIRMED:

H200-A/14 HEALTH CARE SHORTAGE IN RURAL AMERICA
The American Osteopathic Association encourages the development of teaching centers in rural Federally Qualified Health Centers **AND OTHER ELIGIBLE ENTITIES**, so that residents can train and stay in these areas and practice osteopathic medicine. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H201-A/14 GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

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1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H201-A/14 GRADUATE MEDICAL EDUCATION – INCREASING**
4 **OPPORTUNITIES**
5 The American Osteopathic Association supports the efforts to increase the number of graduate
6 medical education training positions available to United States medical graduates. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H203-A/14 OSTEOPATHIC MEDICAL EDUCATION

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

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1 RESOLVED, that the Bureau of Education recommend that the following policy be
2 REAFFIRMED:

3 **H203-A/14 OSTEOPATHIC MEDICAL EDUCATION**
4 The American Osteopathic Association will establish a mechanism by which input can be
5 contributed from interested stakeholders if a plan is formulated to pilot or implement concepts
6 identified within the blue ribbon commission report. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H205-A/14 ASSURE GME RESIDENCY POSITIONS TO GRADUATES OF U.S. MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Educational Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H205-A/14 ASSURE GME RESIDENCY POSITIONS TO GRADUATES OF U.S.**
4 **MEDICAL SCHOOLS**
5 The American Osteopathic Association will work with COCA, AACOM, AMA, ACGME,
6 AAMC and LCME to advocate for Federal Legislation that will offer GME positions first to
7 DO or MD graduates of U.S. COCA OR LCME accredited medical schools. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H208-A/14 UNIFORMED SERVICES PHYSICIANS REQUIRING AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS – AOA SUPPORT OF ALL OSTEOPATHICALLY TRAINED

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Education recommend that the following policy be REAFFIRMED:

H208-A/14 UNIFORMED SERVICES PHYSICIANS REQUIRING AND ASSIGNED TO CIVILIAN RESIDENCY PROGRAMS – AOA SUPPORT OF ALL OSTEOPATHICALLY TRAINED

The American Osteopathic Association will continue to monitor, assist and support all osteopathic physicians who receive graduate medical education (GME) through the uniformed services process, removing barriers to osteopathic graduate medical education approval. 1998; revised 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H207-A14 GRADUATES OF LCME-ACCREDITED COLLEGES OF MEDICINE - ADMISSION TO OSTEOPATHIC RESIDENCY PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

RESOLVED, that the Bureau of Education recommend that the following policy be SUNSET:

H207-A14 GRADUATES OF LCME-ACCREDITED COLLEGES OF MEDICINE - ADMISSION TO OSTEOPATHIC RESIDENCY PROGRAMS

The American Osteopathic Association (AOA) allows each AOA Specialty College and AOA Specialty Board to consider the Liaison Committee on Medical Education (LCME) graduates participation in AOA residency training and become eligible to take that AOA residency's corresponding certifying AOA board with corresponding AOA membership. The AOA will assure that the revised residency standards allowing LCME graduates to participate in AOA residency training maintain osteopathic culture and osteopathic autonomy. The AOA will develop common program requirements between equivalent AOA and ACGME residency programs and establish limited pilot programs allowing matriculation of a limited number of LCME graduates into AOA residency programs. The AOA will develop basic Osteopathic Manipulative Treatment, OMM, and OPP requirements for LCME graduates to participate in AOA residency training, and that each AOA Specialty College, with input from the American Academy of Osteopathy (AAO), develop any further OMT, OMM, OPP requirements it deems necessary for the LCME graduates to participate in AOA residency training. 2014.

Explanatory Statement:
As of the 2020 match, no trainees will be entering AOA accredited GME programs.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H209-A14 CLINICAL ROTATIONS FOR INTERNATIONAL MEDICAL STUDENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Education

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H207-A14 ASSURE CLINICAL ROTATIONS FOR ~~INTERNATIONAL~~ US-EDUCATED MEDICAL STUDENTS

~~Policy of t~~The American Osteopathic Association supports adequate quality rotations for medical students as they pursue clinical education; and, in concert with other healthcare organizations, ~~the~~ federal, state and local governments, will OPPOSE ~~continue to monitor, correct and work to prevent any future~~ policies that provide an unfair advantage to ~~international~~ **INTERNATIONALLY-EDUCATED** medical students. 2009; reaffirmed 2014.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H210-A14 INHALATION OF VOLATILE SUBSTANCES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Education

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H210-A14 INHALATION OF VOLATILE SUBSTANCES**
4 The American Osteopathic Association endorses continuing medical education and medical
5 literature to enhance physician awareness of inhalation of volatile substances (huffing) and
6 endorses campaigns to enhance public awareness of this crisis. 2009; reaffirmed 2014.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H211-A14 INTEGRITY AND MISSION OF COMs UHSC GRANTING THE DO -- MAINTAINING THE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

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1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H211-A14 INTEGRITY AND MISSION OF COMs UHSC GRANTING THE DO**
4 **-- MAINTAINING THE**
5 The American Osteopathic Association upholds and supports maintaining the integrity and
6 mission of Colleges of Osteopathic Medicine and University Health Science Centers granting
7 the Doctor of Osteopathic Medicine degree. 2009; reaffirmed 2014

Reference Committee Explanatory Statement:
The Reference Committee heard testimony to amend this resolution to add an emphasis on increasing the number of primary care physicians, but determined this suggestion was too limiting to other specialties.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H212-A14 PSYCHIATRY CURRICULUM AND STAFFING

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

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1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H212-A14 PSYCHIATRY CURRICULUM AND STAFFING**
4 The American Osteopathic Association supports the use of members of the American College
5 of Osteopathic Neurology and Psychiatry and their commitment to serve as a resource for
6 developing core competencies and learning objectives for osteopathic psychiatry both in
7 undergraduate and graduate medical education. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H213-A14 TEENAGE ALCOHOL ABUSE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Education

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H213-A14 TEENAGE ALCOHOL ABUSE**
4 The American Osteopathic Association endorses continuing medical education for health care
5 professionals to aid them in educating lower and middle school students of the dangers of
6 alcohol and endorses outreach programs to elementary "lower" and middle schools to create
7 awareness of the dangers of alcohol. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H214-A14 MANDATORY CME COURSE REQUIREMENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Education

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H214-A14 MANDATORY CME COURSE REQUIREMENTS
The American Osteopathic Association opposes any federal attempts to impose any specific continuing medical education (CME) course requirements and will assist any ~~component~~ AFFILIATE societies in opposing additional ATTEMPTS BY STATES TO IMPOSE specific CME course requirements. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H217-A/14 COMMUNITY-BASED TEACHING HEALTH CENTERS RESIDENCY SUPPORT

SUBMITTED BY: Bureau of Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Education recommend that the following policy be REAFFIRMED:

H217-A/14 COMMUNITY-BASED TEACHING HEALTH CENTERS RESIDENCY SUPPORT

The American Osteopathic Association supports community-based programs as a model of training for osteopathic primary care residents throughout the United States. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H219-A14 PROFESSIONAL LIABILITY INSURANCE – TRAINEE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

RESOLVED, that the Bureau of Education recommend that the following policy be SUNSET:

H219-A14 PROFESSIONAL LIABILITY INSURANCE – TRAINEE
The AOA Department of Education and the appropriate councils within the AOA will work with the AMA and ACGME in exploring possible mechanisms to ensure that trainees are provided with sufficient professional liability insurance at all times and that potential mechanisms to consider will include (2014):

1) Required full disclosure of type and amount of PLI to AOA, OPTI, and trainees;
2) Prohibition of claims-made policies for trainees;
3) Development of a superfund or backup insurance to be used in the event of hospital closure or bankruptcy.

Explanatory Statement:
AOA postdoctoral training standards require that the training institution must ensure that trainees are provided with professional liability coverage for the duration of their training, and such coverage shall include protection against awards from claims reported or filed after completion of training and only applicable to actions occurring within the assigned scope of responsibilities for the approved program.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H308-A/14 INFLUENZA VACCINATION PROGRAMS FOR MEDICAL SCHOOLS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education

RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H308-A/14 INFLUENZA VACCINATION PROGRAMS FOR MEDICAL SCHOOLS

The American Osteopathic Association recommends and supports that all osteopathic medical schools have an ongoing influenza vaccination program for students. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H800-A/14 SINGLE GRADUATE MEDICAL EDUCATION ACCREDITATION SYSTEM

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Education

RESOLVED, that the AOA Board of Trustees recommend that the following policy be REAFFIRMED:

H800-A/14 SINGLE GRADUATE MEDICAL EDUCATION ACCREDITATION SYSTEM

The American Osteopathic Association (AOA) will evaluate and report to the membership and AOA House of Delegates annually, between 2015 and ~~**2021**~~ **2024**, concerning the following issues:

1) The ability of AOA-trained and certified physicians to serve as program directors in the single GME accreditation system;
2) The maintenance of smaller, rural and community based training programs;
3) The number of solely AOA certified physicians serving as program directors in each specialty;
4) The number of osteopathic identified GME programs and number of osteopathic identified GME positions gained and lost;
5) The number of osteopathic residents taking osteopathic board certification examinations;
6) The status of recognition of osteopathic board certification being deemed equivalent by the ACGME;
7) The importance of osteopathic board certification as a valid outcome benchmark of the quality of osteopathic residency programs, and be it further

Any proposed single graduate medical education (GME) accreditation system will provide for the preservation of the unique distinctiveness of osteopathic medicine, osteopathic graduate medical education, osteopathic licensing examinations, osteopathic board certification, osteopathic divisional societies, osteopathic specialty societies, osteopathic specialty colleges, the AOA, and the osteopathic profession. The AOA will remain vigilant in its oversight of the single accreditation process and utilize its ability to cease negotiations as delineated in the Memorandum Of Understanding (MOU) should osteopathic principles and educational opportunities be materially compromised. The AOA will seek to create an exception category to allow the institution/program, on a case by case basis, up to a one year extension without prejudice for an institution/program that has their budget previously planned so as not to put that institution/program at a competitive disadvantage. The AOA will advocate for an extension of the closure date for AOA accreditation beyond July 1, 2020, where appropriate for individual programs on a case by case basis. The AOA will enter into a single accreditation system that perpetuates unique osteopathic graduate medical education programs. 2014

Reference Committee Explanatory Statement:
The Committee heard testimony in support of extending the reporting period to promote continued monitoring of the process to ensure a smooth transition into the single GME accreditation system. Due to the AOA's 5-year sunset policy cycle, this resolution, if passed, would be up for review in 2024.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: STATEMENT OF SUPPORT FOR THE AMERICAN OSTEOPATHIC BOARD OF NEUROLOGY AND PSYCHIATRY

SUBMITTED BY: American College of Osteopathic Neurologists and Psychiatrists

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Board of Trustees (BOT) of the American Osteopathic Association (AOA) is the sole approving body conferring board certification to qualified physician candidates who have completed the requirements under the jurisdiction of their respective specialty certifying board[1]; and

WHEREAS, the American Osteopathic Board of Neurology and Psychiatry (AOBNP) is the designated specialty certifying board, empowered by the AOA Bureau of Osteopathic Specialists (BOS), overseeing the evaluation of qualified physician candidates who have completed the requirements of board certification of residency trained neurologists and psychiatrists[2] ; and

WHEREAS, the successful completion and designation of AOA board certification through the AOBNP, a subsidiary of the BOS is recognized in all 50 states and US territories and many countries around the world[1] ; and

WHEREAS, the members of AOBNP are active practicing physicians serving beyond their standard career and personal responsibilities to research and create relevant clinical and evidenced based testing formats for board candidates[3] ; and

WHEREAS, the AOBNP continue to evaluate and review updates and create innovative and verifiable testing modalities that meet the strict standards of board certification and requirements of potential board applicants[3, 4]; and

WHEREAS, the AOBNP works diligently with AOA and the BOS to maintain the highest standards to obtain and maintain board certification through innovative techniques and approaches that encourage continuous professional development, enhance knowledge of clinical guidelines, minimize risk in clinical practice, improve coordination of patient care and evolves with the needs and expectations of the changing demographics of the physician group[4, 5] ; and

WHEREAS, the membership of the American College of Osteopathic Neurologists and Psychiatrists voted to formally recognize through a resolution to be presented at the AOA House of Delegates, the selfless ongoing commitment by the AOBNP to support our profession through board certification; now, therefore be it[6,7]; now, therefore be it

RESOLVED, that the members of the American College of Osteopathic Neurologists and Psychiatrists (ACONP) declare their strong support and gratitude to the American Osteopathic Board of Neurology and Psychiatry (AOBNP) for their commitment

toward our profession and neurologists and psychiatrists eligible for board certification through this board; and, be it further

RESOLVED, that the members of the ACONP fully support the American Osteopathic Association (AOA) Board of Trustees, the AOA Bureau of Osteopathic Specialists and the AOBNP for the efforts in strengthening Osteopathic Certification for the future; and, be it further

RESOLVED, that the AOA acknowledges this statement in support of the AOBNP by the members of the ACONP.

References:

1. "About AOA Certification", certification.osteopathic.org
2. "FAQS", certification.osteopathic.org
3. "Welcome to the Osteopathic Board of Neurology and Psychiatry", certification.osteopathic.org
4. "Put the Power of AOA Board Certification Behind Your Practice", certification.osteopathic.org
5. "AOA Approves Creation of Two Pathways for AOA Board Certification", letter from AOA President William S. Mayo, D.O., February 28, 2019
6. Membership of American College of Osteopathic Neurologists and Psychiatrists
7. General membership meeting vote February 27, 2019.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: BOARD CERTIFICATION TEST RESULTS

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, osteopathic board certification and recertification exams are now conducted at testing centers; and

WHEREAS, results are submitted to the certifying board immediately after the test; and

WHEREAS, the American Osteopathic Association currently takes four months or longer to notify the physician of his or her test results; now, therefore be it

RESOLVED, that the American Osteopathic Association ~~encourage~~ **REQUIRE** its certifying boards to notify the physician AND PROGRAM DIRECTOR, IF APPLICABLE, within eight weeks of taking the test of their ~~score~~ **RESULTS**.

Explanatory Statement:
~~The ABONMM board certification and recertification results under the auspice of the AOA completed in October 2018 took 16 weeks or longer to notify physicians of their results.~~

Reference Committee Explanatory Statement:
To assist program directors meet ACGME requirements regarding resident board pass rates, the committee recommends amending the resolution to include the receipt of test results by program directors. In light of the desire to create a more timely and efficient process, it is recommended that the time for reporting results be decreased, to the extent possible. After discussion with AOA staff, it was determined that there may be exceptional or extenuating circumstances that may delay the intended timely release of results.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: CERTIFICATION COMPONENT DEVELOPMENT

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, family physicians comprise a large number of American Osteopathic Association (AOA) membership; and

WHEREAS, family physicians comprise more than one half of all AOA certified physicians; and

WHEREAS, decoupling from membership by the AOA has made certification the primary income source for the AOA; and

WHEREAS, family physician certification has consistently provided considerable positive income; and

WHEREAS, American Osteopathic Board of Family Physicians (AOBFP) certification enhances and promotes membership in American College of Osteopathic Family Physicians (ACOFP) and the AOA; and

WHEREAS, survival of ACOFP and survival of the AOA is likely to be heavily dependent on maintaining and enhancing valid osteopathic family physician certification; and

WHEREAS, without the income provided by family physicians, most of the other specialty certifying boards, as well as the AOA, would not be able to function; and

WHEREAS, a significant number of family physicians are expressing confusion, anger, and disbelief that their role is being taken for granted and their interests in osteopathic medicine are being shunned by the AOA and its current certifying board realignment process; and

WHEREAS, many AOBFP certified physicians and many future certified family physicians question the integrity of the proposed "simplified" certification which demonstrates little concern for osteopathic content; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) allows and encourages interaction between the American College of Osteopathic Family Physicians (ACOFP) and American Osteopathic Board of Family Physicians (AOBFP) to develop components for initial and ongoing osteopathic family medicine certification.; and, be it further

RESOLVED, that the resulting recommendations be submitted to the Bureau of Osteopathic Specialists for consideration and discussion, without outside influence from AOA staff and Board of Trustees.

Reference Committee Explanatory Statement:
The Committee recommends the resolution be referred to the ACOFP to clarify its intent. As written, the clear distinction between specialty college and specialty certifying board is blurred and sets up a potential conflict of interest.

ACTION TAKEN **REFERRED** *(to American College of Osteopathic Family Physicians)*

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT BOOT CAMP

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, Osteopathic Manipulative Treatment (OMT) is an essential modality of osteopathic family medicine; and

WHEREAS, the use of OMT can reduce the need for opioid medications; and

WHEREAS, the use of OMT in family medicine may reduce the need for other costly procedures; and

WHEREAS, the use of OMT can improve a patient's health outcome; and

WHEREAS, osteopathic family physicians are certified in OMT by the American Osteopathic Board of Family Physicians (AOBFP); and

WHEREAS, continuing hands-on education and review is necessary to maintain and improve skills in OMT; and

WHEREAS, the American College of Osteopathic Family Physicians (ACOFP) has developed, evaluated and implemented an Osteopathic Manipulative Medicine program (OMT Boot Camp) that is practical and valuable to the practicing osteopathic family physician; and

WHEREAS, the ACOFP believes the ACOFP OMT Boot Camp meets the requirements of the current Osteopathic Continuing Certification (OCC) Component 4; now, therefore be it

RESOLVED, that the American Osteopathic Association approve the American College of Osteopathic Family Physicians' OMT Boot Camp as partial fulfillment of the requirements of the American Board of Osteopathic Family Physicians Osteopathic Continuous Certification process, Component 4.

Reference Committee Explanatory Statement:
The BOS has jurisdiction over the components for OCC.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION SPECIALTY BOARD CERTIFICATION

SUBMITTED BY: American College of Osteopathic Family Physicians /American College of Osteopathic Internists / American College of Osteopathic Surgeons / American Osteopathic College of Dermatology / American Academy of Osteopathy / American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery / American College of Osteopathic Pediatricians

REFERRED TO: Committee on Educational Affairs

WHEREAS, osteopathic principles and practice are a critical component of osteopathic medical education; and

WHEREAS, osteopathic principles and practice are critical to the preservation of the distinctiveness of our profession; and

WHEREAS, osteopathic board certification must include osteopathic principles and practice in order to certify physicians who practice osteopathically; and

WHEREAS, the AOA Board of Trustees (BOT) adopted a resolution at its 2019 mid-year meeting intending to create two pathways, one with osteopathic principles and practice (specialty) and the traditional pathway including osteopathic principles and practice, as well as test items on OMM/OMT; and

WHEREAS, confusion exists regarding the intent of the BOT; now, therefore be it

RESOLVED, that the AOA:

1. Reaffirms its commitment to the inclusion of osteopathic principles and practice in every osteopathic board certification examination, regardless of specialty;
2. Continues the opportunity for osteopathic certifying boards to develop and administer OMM/OMT practical examinations which are specific and appropriate for their specialty;
3. Allows a requirement for specialty-specific content in CME for re-certification/continuing certification ~~**beginning with the 2022 CME cycle**~~; and
4. Continues to encourage the Accreditation Council for Graduate Medical Education to include an osteopathic educational component in Osteopathic Recognized residencies.

Reference Committee Explanatory Statement:

The Committee received extensive testimony in support of the concepts encompassed within the original resolution. In its deliberation, the Committee believed that this substitute resolution most appropriately reflected the principles of those concepts. The Committee believes the substitute resolution responds to the concerns of the osteopathic profession and provides intended direction to the AOA Board of Trustees, Bureau of Osteopathic Specialists and individual certifying boards. Due to

the diversity in specialties, the Committee believes that individual certifying boards are best equipped to set the policies for their diplomates regarding the amount and category of CME.

ACTION TAKEN **AMENDED SUBSTITUTE RESOLUTION APPROVED**

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION SPECIALTY BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Educational Affairs

WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to "advance the distinctive philosophy and practice of osteopathic medicine"; and

WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that "the BOS is the certifying body for the approved specialty boards of the AOA and is dedicated to establishing the high standards for certification of osteopathic physicians"; and

WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that "There are more than 100,000 DOs in the US, practicing their distinct philosophy in every medical specialty. We have additional training in Osteopathic Manipulative Treatment (OMT) and use this tool to help diagnose, treat and prevent illness and injury"; and

WHEREAS, www.doctorsthatdo.org also claims that "by combining the latest advances in medical technology with OMT, Doctors of Osteopathic Medicine offer their patients the most comprehensive care available in medicine today"; and

WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic Principles and Practice (OPP) and OMT via minimal standards established by ECOP, including over 200 hours of training in OMT, with practical exams, OSCE, and COMLEX exams; and

WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across the USA, show that 88% agree that osteopathic certification terminology should clearly state a holder is certified in OPP; and

WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for certification already approved that states "General certification represents a distinct and well-defined field of osteopathic medical practice"; now, therefore be it

RESOLVED, that the terminology for American Osteopathic Association issued board certifications should state that a certificate holder is "Board Certified in Osteopathic Principles and Practice of Pediatrics".

Explanatory Statement:
If a person is a graduate of an osteopathic medical school including passing OSCEs, and passed all 3 COMLEX, and took the osteopathic certification exam, then their certificate should say certified in osteopathic pediatrics and OMT.

FISCAL IMPACT:
The fiscal impact will be less on osteopathic medical students and also build greater interest in our exams from osteopathic medical students because they will get credit for their years and tests taken in medical school. Also, there will be no negative fiscal impact on the AOA with our resolution, because they won't have to bear the cost of an added practical exam development and administration, when NBOME/COMLEX/OSCE already test the students.

Reference Committee Explanatory Statement:
The Committee believes this resolution is too limited in its scope and is better addressed in H-224.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: H204-A/13 UNIFIED GRADUATE MEDICAL EDUCATION (GME) ACCREDITATION SYSTEM UNDER THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) – PROPOSED / H209-A/13 OSTEOPATHIC-FOCUSED TRAINING PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, at its 2018 meeting, the AOA House of Delegates REFERRED the policies noted in resolutions H201-A/18 and H205-A/18 to the Bureau of Osteopathic Education (BOE) to update the language in light of the single GME accreditation system; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Education recommends that the following polices be SUNSET:

H204 A/13 UNIFIED GRADUATE MEDICAL EDUCATION (GME) ACCREDITATION SYSTEM UNDER THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) – PROPOSED

The American Osteopathic Association will work toward the development of fellowships in osteopathic programs to create positions and/or graduate medical education (GME) slots in the event of unsuccessful negotiations with the Accreditation Council for Graduate Medical Education (ACGME); and any proposed unified GME accreditation system will protect and preserve the unique distinctiveness of osteopathic medicine, osteopathic graduate medical education, COMLEX-USA, osteopathic board certification, osteopathic divisional societies, osteopathic specialty affiliates, the AOA and the osteopathic profession.

and

H209 A/13 OSTEOPATHIC-FOCUSED TRAINING PROGRAMS

The American Osteopathic Association maintains that osteopathic-focused value and programs, which are defined as those programs using osteopathic principles and practice (OPP) and osteopathic manipulative medicine (OMM), always remain the foundation of osteopathic medical schools, COMLEX-USA, American Osteopathic Association (AOA) residency programs, osteopathic board certification, osteopathic licensure, osteopathic continuing medical education, and the osteopathic profession; and that all AOA residency programs, AOA program directors, Directors of Medical Education, AOA training institutions, and OPTI's shall maintain, measure, and enhance osteopathic-focused programs and shall continue to integrate OPP, OMM, and osteopathic culture into all core competencies of all osteopathic medical training programs. 2013

Explanatory Statement:
The BOE believes these policies have outlived their purpose due to the approval of the single GME accreditation system. Other AOA policies exist regarding the AOA's support of developing new graduate medical education programs and preserving and integrating osteopathic medicine into graduate medical education programs.

Reference Committee Explanatory Statement:
Other AOA policies that exist regarding the AOA's support of developing new GME programs and preserving and integrating osteopathic medicine into GME programs include H201-A/14, H800-A/14, H-300 A/16, H-329 A/16, H-212 A/17, and H-611 A/18.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: EDUCATION OF STUDENTS AND FACULTY ON OBTAINING PERMISSION BEFORE ALL STUDENT AND PATIENT ENCOUNTERS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, patient permission is the foundation for all medical practice, and gender discrimination is prohibited and addressed in the American Osteopathic Association's (AOA) Code of Ethics;[1] and

WHEREAS, permission is defined as "the act of permitting; formal consent: authorization"[2] which allows comfort and safety in treating patients;

WHEREAS, students of osteopathic medicine receive extensive training in osteopathic manipulative treatment (OMT),[3]

WHEREAS, OMT is a critical procedure to treating patients and is inherently defined by the AOA as a procedure,[4]

WHEREAS, when reflecting on curricula at various colleges of osteopathic medicine (COMs) interactions requiring permission would include those with studentS ~~patients~~ IN EDUCATIONAL ACTIVITIES, standardized patients, patients in practice, and others;

WHEREAS, we believe every graduate of a college of osteopathic medicine should demonstrate proficiency in obtaining permission; and

~~WHEREAS, obtaining permission is an Entrustable Professional Activity (EPA) as defined by the AAMC as part of several domains of competence including professionalism[5]; and~~

WHEREAS, time in the curricula is essential to student learning about and practicing the nuances of obtaining permission and its pitfalls; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourage all colleges of osteopathic medicine to prepare their educators and graduates to learn and demonstrate aptitude concerning the knowledge and practice of obtaining permission; and, be it further

RESOLVED, that the AOA promote and encourage both educators and students in the use of obtaining permission in all OMT AND/OR PHYSICAL CONTACT patient interactions – whether ~~it~~ THEY be studentS ~~patients~~ IN EDUCATIONAL ACTIVITIES, standardized patients, or others.

References

1. "Code of Ethics." American Osteopathic Association, Section 15 and 16, AOA, 24 July 2016, osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/. Accessed 11 Sept. 2018.
2. "permission." Merriam-Webster.com. 2018. https://www.merriam-webster.com (11 February 2019).
3. COCA. Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards. Element 6.4 and 6.6. 11 July 2017. < https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf >.
4. "American Osteopathic Association Policy Compendium." American Osteopathic Association, H647-A/15, p135-9. AOA, 8 August 2018, < https://osteopathic.org/wp-content/uploads/policy-compendium.pdf >. Accessed 03 October 2018.
5. ~~Association of American Medical Colleges. Core Entrustable Professional Activities for Entering Residency: Curriculum Developers' Guide. EPA 11, 2014. < https://members.aamc.org/eweb/upload/Core%20EPA%20Curriculum%20Dev%20Guide.pdf >.~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to "advance the distinctive philosophy and practice of osteopathic medicine"; and

WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that "the BOS is the certifying body for the approved specialty boards of the AOA and is dedicated to establishing the high standards for certification of osteopathic physicians"; and

WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that "There are more than 100,000 DOs in the US, practicing their distinct philosophy in every medical specialty. We have additional training in OMT and use this tool to help diagnose, treat and prevent illness and injury"; and

WHEREAS, www.doctorsthatdo.org also claims that "by combining the latest advances in medical technology with OMT, Doctors of Osteopathic Medicine offer their patients the most comprehensive care available in medicine today"; and

WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic Principles and Practice (OPP) and OMT via minimal standards established by ECOP, including over 200 hours of training in OMT, with practical exams, OSCE, and COMLEX exams"; and

WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across the USA, shows that 88% of respondents agree that osteopathic certification terminology should clearly state a holder is certified in osteopathic principles and practice; and

WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for certification already approved that states, "General certification represents a distinct and well defined field of osteopathic medical practice; now, therefore be it

RESOLVED, that the terminology for American Osteopathic Association issued board certifications should state that a certificate holder is "Board certified in the Principles and Practice of Osteopathic "Specialty".

Reference Committee Explanatory Statement:
Specific terminology on certificates is determined by the BOS and the individual certifying boards. The Committee requests the BOS report back to the 2020 House of Delegates on this issue.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC CERTIFICATION

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to "advance the distinctive philosophy and practice of osteopathic medicine"; and

WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that "the BOS is the certifying body for the approved specialty boards of the AOA and is dedicated to establishing the high standards for certification of osteopathic physicians"; and

WHEREAS, offering a board certification exam without osteopathic content is in direct conflict with the stated mission of the AOA and BOS; and

WHEREAS, according to www.osteopathic.org, "AOA board certification is an important quality marker for patients, employers, insurers and regulators"; and

WHEREAS, the AOA addresses the DO difference on www.doctorsthatdo.org, by stating that "There are more than 100,000 DOs in the US, practicing their distinct philosophy in every medical specialty. We have additional training in OMT and use this tool to help diagnose, treat and prevent illness and injury"; and

WHEREAS, www.doctorsthatdo.org also states that "by combining the latest advances in medical technology with OMT, Doctors of Osteopathic Medicine offer their patients the most comprehensive care available in medicine today"; and

WHEREAS, the July 2018 BOS handbook states that "the AOA, through the BOS, will provide a mechanism to evaluate the validity and reliability of all certification examinations conducted by AOA specialty certifying boards"; and

WHEREAS, the BOS has not established appropriate standards to osteopathically certify non-osteopathic physicians; and

WHEREAS, the AOA House of Delegates (HOD) already maintains approved terminology that AOA board certification is a marker of terminal academic achievement in osteopathic medicine; and

WHEREAS, the July 2018 bylaws of the BOS include provisions for the equal application of regulations and requirements or standards while conducting all or any part of an examination by any specialty certifying boards; and

WHEREAS, the survey results supplied by The Boston Consulting Group were limited to DO and MD students, residents and those newly out in practice; and

WHEREAS, the results of a survey of 408 people, 96% of whom were practicing DOs across the USA, were presented to the AOA Board of Trustees in February 2019 showing that 91.8% of respondents wanted to maintain osteopathic distinctiveness in osteopathic certification; and

WHEREAS, the results of a survey of 214 people, 97% of whom were practicing DOs across the USA, shows that 85% of respondents prefer equal eligibility requirements for applicants who are osteopathic and non-osteopathic; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) is qualified to certify a licensed physician in Osteopathic principles and practice; and

RESOLVED, that the Bureau of Osteopathic Specialties (BOS) should include samples of all practicing osteopathic physicians in a specialty when determining its psychometric parameters for osteopathic certification; and

RESOLVED, that the eligibility criteria for taking AOA board certification should be equivalent for osteopathic and non-osteopathic licensed physicians, and should include a minimum amount of learning in OPP and OMT, which would be sanctioned by the AOA, AAO, or OCA, at least equivalent to the minimum amount required by ECOP for osteopathic medical school graduation; and, be it further

RESOLVED, that the AOA should not offer an osteopathic certification option that eliminates osteopathic content.

Reference Committee Explanatory Statement:
The Committee believes the intent of this resolution is addressed in Substitute H-220.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC CONTENT AND CERTIFICATION STANDARDS

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the July 2018 Bureau of Osteopathic Specialties (BOS) handbook lists in Article 1. Protocol for establishing specialty certifying boards, section 1, D that, "Notification of the submission of a petition for establishing a new specialty certifying board and/or requesting an assignment or change of jurisdiction will be sent to each AOA specialty college and certifying board by the secretary of the BOS prior to consideration and recommendation"; and

WHEREAS, the American Osteopathic Association (AOA) Board of Trustees (BOT) voted to approve a resolution on February 26, 2019, which stated "to have the AOA endorse the creation of two pathways to AOA board certification" one without any osteopathic content; and

WHEREAS, the resolution voted on by the AOA BOT on February 26, 2019 that established 2 new osteopathic board exams, was not sent to each specialty college and certifying board prior to the BOT vote; and

WHEREAS, no specialty board or specialty board chair was involved in the survey completed by Boston Consulting Group which led to the proposed board certification changes; and

WHEREAS, Article VIII, Section 1, G and H state that "each specialty board will establish its individual requirements for years of AOA training for each primary and subspecialty certification… and each specialty certifying board and CCEC will establish its individual eligibility requirements for examination for certification. Practice within each field under each board will be defined in the policies and procedures of each specialty certifying board"; and

WHEREAS, the resolution approved on February 26, 2019, by the AOA BOT does not allow for specialty boards to establish individual eligibility criteria for certification; and

WHEREAS, Article XII General Procedures of AOA Specialty Certifying Boards Section 1 Bureau Reviews Prior to AOA Board of Trustees states that "All recommendations concerning specialty certifying boards must be presented to the Bureau before being presented to the AOA Board of Trustees for approval"; and

WHEREAS, the AOA is a member organization of osteopathic physicians; and

WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across the USA, shows that 96% of respondents feel that the decisions that shift the framework of the osteopathic profession should require a public comment period

before implementation and 95% of respondents feel that decisions the shift the framework of the osteopathic profession should require a vote by the AOA House of Delegates; and

WHEREAS, the AOA BOT and BOS did not follow the established and published bylaws, policies and procedures when it voted to change osteopathic board certification, including the elimination of osteopathic content from such certification; and

WHEREAS, the July 2018 BOS Handbook lists in Article 1. Protocol for establishing specialty certifying boards, section 1, E that, "The BOS may not waive any of the following protocols"; and

WHEREAS, practicing osteopathic physicians who are board certified by the AOA rely on that certification for hospital privileges, insurance contracts and credentialing; now, therefore be it

RESOLVED, that the resolution voted on by the American Osteopathic Association (AOA) Board of Trustees (BOT) on February 26, 2019, titled, "AOA Board Certification Pathway" is VOID; and, be it further

RESOLVED, that any future attempts to force specialty boards to remove osteopathic content from osteopathic certification exams be halted; and, be it further

RESOLVED, that any future attempts by the AOA to alter the standards of osteopathic teaching, practice, certification or evaluation be given a sufficient comment period to the AOA membership as a whole, and approved by the AOA House of Delegates via 2/3 majority; and, be it further

RESOLVED, that the AOA establish guidelines to set the general direction for minimum standards for osteopathic content in osteopathic certification, but that osteopathic specialty boards can maintain the ability to establish individual criteria, above and beyond that, for their specific specialty exam as they are charged with writing exams and evaluating candidates.

Reference Committee Explanatory Statement:
The Committee believes the intent of this resolution is addressed in Substitute H-220.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC SPECIALTY COLLEGES AND CERTIFICATION

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to "advance the distinctive philosophy and practice of osteopathic medicine"; and

WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that "the BOS is the certifying body for the approved specialty boards of the AOA and is dedicated to establishing the high standards for certification of osteopathic physicians"; and

WHEREAS, the July 2018 BOS handbook states that "the AOA, through the BOS, will provide a mechanism to evaluate the validity and reliability of all certification examinations conducted by AOA specialty certifying boards"; and

WHEREAS, specialty colleges are affiliated organizations with the AOA; and

WHEREAS, the AOA states on www.osteopathic.org, that "The AOA works with osteopathic specialty colleges to advance osteopathic medicine; and

WHEREAS, all Osteopathic certification will lead to Osteopathic Continuous Certification; and

WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across the USA, shows that 82% of respondents feel that osteopathic specialty colleges can be an option to administer practical board exams; now, therefore be it

RESOLVED, that under the guidance of osteopathic specialty boards, and overseen by the Bureau of Osteopathic Specialties, that all American Osteopathic Association affiliated osteopathic specialty colleges can administer practical exams in OMT for osteopathic certification, as well as provide necessary Osteopathic Continuous Certification in OMT for osteopathic continuous certification.

Reference Committee Explanatory Statement:
Exams must be developed and administered by the certifying boards, not the specialty colleges.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: PARENTAL LEAVE POLICIES FOR ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) ~~RESIDENCY~~ **PROGRAMS**

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) requires that graduate medical education institutions give written statements regarding parental leave policy availability, without requiring implementation or standardization of leave policies across programs[1]; and

WHEREAS, length and availability of parental leave policies in place for resident physicians are determined by respective specialty boards (e.g. American Board of Family Medicine, etc.)[1]; and

WHEREAS, there is discrepancy across specialties regarding establishment and encouragement to utilize parental leave policies[1,2,3,4]; and

WHEREAS, some specialty boards encourage minimum 8 weeks maternal leave, while female surgical residents report that the American Board of Surgery leave policies are a barrier to taking more than 6 weeks of leave[1,2,3,4]; and

WHEREAS, 90% of pediatric residency programs have established maternal leave policies, as compared to only 36.54% of plastic surgery residency programs[5,6,7]; and

WHEREAS, many residency programs do not have paternal leave policies[8]; and

WHEREAS, in a survey conducted by the Association of Women Surgeons of 347 female surgical residents with one or more pregnancies during residency, 72% reported that the six or less weeks of leave they could obtain was inadequate and 39% seriously considered leaving surgical residency due to the challenges faced regarding childbearing and leave[3]; and

WHEREAS, residents in some specialties often face discouragement when taking parental leave, and feel perceived stigma regarding pregnancy[1,2,3]; and

WHEREAS, the Family and Medical Leave Act, covering 60% of American workers including medical residents, states eligible employees are entitled to: "unpaid, job-protected leave for specified family and medical reasons," including up to twelve work weeks within a 12 month period for birth of a child and care for the newborn[9]; and

WHEREAS, a substantial decrease in infant mortality was found when women were given 12 weeks of maternity leave following the Family and Medical Leave Act[10]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) encourages the Accreditation Council for Graduate Medical Education (ACGME) to promote the standardization, within the common program requirements; availability; and accessibility of requesting adequate parental leave in adherence with the Family and Medical Leave Act; and, be it further

RESOLVED, that the AOA ~~to~~ encourageS the ACGME to advocate for transparency of parental leave policies ~~at the time of residency matching~~.

References

1. Greenfield NP. Maternity and medical leave during residency: Time to standardize?. Int J Womens Dermatol. 2015;1(1):55. Published 2015 Feb 20. doi:10.1016/j.ijwd.2014.12.009
2. Rangel, Erika L., et al. "Perspectives of Pregnancy and Motherhood among General Surgery Residents: A Qualitative Analysis." The American Journal of Surgery, vol. 216, no. 4, 2018, pp. 754–759., doi:10.1016/j.amjsurg.2018.07.036.
3. Rangel, Erika L., et al. "Pregnancy and Motherhood During Surgical Training." JAMA Surgery, vol. 153, no. 7, 2018, p. 644., doi:10.1001/jamasurg.2018.0153
4. American Academy of Pediatrics Policy Statement. "Parental Leave for Residents and Pediatric Training Programs." Pediatrics, vol. 131, no. 2, 2013, pp. 387–390., doi:10.1542/peds.2012-3542.
5. Sandler, Britt J., et al. "Pregnancy and Parenthood among Surgery Residents: Results of the First Nationwide Survey of General Surgery Residency Program Directors." Journal of the American College of Surgeons, vol. 222, no. 6, 2016, pp. 1090–1096., doi:10.1016/j.jamcollsurg.2015.12.004.
6. Garza, Rebecca M., et al. "Pregnancy and the Plastic Surgery Resident." Plastic and Reconstructive Surgery, vol. 139, no. 1, 2017, pp. 245–252., doi:10.1097/prs.0000000000002861.
7. Humphries, Laura S., et al. "Parental Leave Policies in Graduate Medical Education: A Systematic Review." The American Journal of Surgery, vol. 214, no. 4, 2017, pp. 634–639., doi:10.1016/j.amjsurg.2017.06.023.
8. Wasser, Miriam. "Many Top Medical Training Programs Lack Paid Family Leave Policies, Study Finds." WBUR, WBUR, 13 Dec. 2018, www.wbur.org/commonhealth/2018/12/12/medical-resident-paid-parental-leave.
9. Family and Medical Leave Act of 1993. Public Law 103-3, 107 Stat. 6. 1993.
10. Rossin, Maya. "The Effects of Maternity Leave on Children's Birth and Infant Health Outcomes in the United States." Journal of Health Economics, vol. 30, no. 2, 2011, pp. 221–239., doi:10.1016/j.jhealeco.2011.01.005.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: COMMENDATION OF AMA POLICY (AMA 955) ON EQUAL ACCEPTANCE OF COMLEX-USA FOR DO STUDENTS IN ALL US RESIDENCY PROGRAMS

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Educational Affairs

WHEREAS, the National Board of Osteopathic Medical Examiners (NBOME) COMLEX-USA licensure examination series is an evidenced-based assessment that reflects the distinctive osteopathic medical school curriculum, qualifications, competencies and practice patterns of osteopathic physicians; and

WHEREAS, successful passage of COMLEX-USA Level 1, Level 2, Level 2 Performance Evaluation are required by the AOA-Commission on Osteopathic College Accreditation and all United States colleges of osteopathic medicine for graduation with the DO degree; and

WHEREAS, many stakeholders including medical students and deans and the American Medical Association have cited the unintended consequences of the USMLE (United States Medical Licensing Examination) Step 1 impacting not only student well-being but also detracting from students' full engagement with their educational/curricular program un undergraduate medical education; and

WHEREAS, in this era of Single Graduate Medical Education (GME) accreditation and the resulting uncertainties and anxieties, many osteopathic medical students are concerned about being an effective, competitive candidate for their preferred residency specialty and program; and

WHEREAS, some residency Accreditation Council for Graduate Medical Education (ACGME) program directors require USMLE for all GME program applicants, including DOs, in order to evaluate which candidates to interview and rank in the National Residency Matching Program (NRMP); and

WHEREAS, in November 2018, the American Medical Association House of Delegates adopted a new policy calling for promotion of equal acceptance of COMLEX-USA and USMLE at all US residency programs; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) commend the American Medical Association (AMA) for its adoption of promoting equal acceptance of COMLEX-USA by all US Residency Programs; and, be it further

RESOLVED, that the AOA dedicate resources to support initiatives to reach ACGME residency and fellowship program leaders, including Program Directors and Program Coordinators, about the equivalent use of COMLEX-USA and USMLE in GME programs.

Reference Committee Explanatory Statement:
The Committee believes this resolution is better addressed in H-231.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: CLASSIFICATION OF OSTEOPATHIC MEDICAL GRADUATES AS UNITED STATES MEDICAL GRADUATES IN ELECTRONIC RESIDENCY APPLICATION SERVICE (ERAS)

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the single accreditation system between American Osteopathic Association (AOA) and the American Council of Graduate Medical Education (ACGME) for graduate medical education (GME) is heading to completion in 2020; and

WHEREAS, the final AOA match has concluded, and from this point forward both osteopathic and allopathic medical school graduates will be applying to the same set of GME programs; and

WHEREAS, osteopathic and allopathic medical students are both equally physicians under the law once medical licensure is obtained; and

WHEREAS, program directors for GME programs utilize filters built into the Electronic Residency Application Service (ERAS) to stratify applicants[1]; and

WHEREAS, the above-mentioned ERAS filters include filtering students by medical school type under the field: "Most Recent Medical School Type." For example, there are U.S. Public and U.S. Private school filters that apply only to M.D. students but there exists a separate third filter category for osteopathic medical schools. As such, osteopathic graduates are not considered as US medical graduates. There are also separate filters for foreign medical graduates and Canadian applicants[1]; and

WHEREAS, osteopathic medical students applying for residency programs in the new unified match may have their application filtered out, without being viewed by residency program directors, due students being placed in a separate "Osteopathic" category of filtered applicants, in a similar manner to how foreign medical and Canadian graduates are filtered out[1] ; and

WHEREAS, medical students applying for GME should be judged by programs based on factors that indicate medical school performance, including class ranking, grades, licensing exam scores, letters of recommendation, medical school performance evaluation (MSPE), extracurricular involvement, interview performance, and research conducted; and

WHEREAS, medical students spending money to apply to GME programs should have their application given fair consideration; and

29 WHEREAS, osteopathic medical graduates are US medical graduates and should not be
30 classified as a separate subtype of medical graduate comparable to a foreign medical
31 graduate; now, therefore be it

32 RESOLVED, that the American Osteopathic Association advocates to the American
33 Association of Medical Colleges to adjust Electronic Residency Application Service
34 filters based on medical school type such that Osteopathic applicants are included and
35 recognized within the US Public or Private Medical Graduates category.

36 References

37 1. How Filters Work. Retrieved February 18, 2018, from
38 https://www.aamc.org/download/446202/data/howfilterswork.pdf

Explanatory Statement:

Each year, osteopathic medical students' applications for GME training may be discarded without being looked at in the ACGME match at various programs and in various specialties. There currently exists methods to disregard all applications by applicants who are not U.S. M.D. graduates, including U.S. D.O. applicants, without examining the applicants file. These methods consist of filters that limit applications seen by program directors based on the type of medical school from which the applicant is graduating or has graduated. Now that the GME of the ACGME will be the only programs to which applicants may apply, and in keeping the good spirit of single accreditation, there should be no filters that eliminate U.S. M.D. or U.S. D.O. students' applications from consideration based on degree type. The narrowing down of applicants should instead be based on medical school performance. This is the most fair way to ensure that all U.S. medical school graduates have an equal opportunity for their application to be seen at each program to which they apply and submit an application fee.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: RECOGNITION OF COMLEX AND USMLE AS EQUAL LICENSING EXAMINATIONS AMONG RESIDENCY PROGRAMS

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, on February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of Understanding (MOU) outlining a single graduate medical education accreditation system in the United States[1]; and

WHEREAS, the intentional benefits of the single accreditation system for osteopathic medical students include preserving access to primary and subspecialty programs for osteopathic medical graduates, maintaining DO students' access to opportunities in the full spectrum of graduate medical education (GME), and promoting consistency across all GME programs in terms of training and evaluation of residents, ensuring the continuation and enhancement of world class GME[2]; and

WHEREAS, the ACGME acknowledges the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) and United States Medical Licensing Examination (USMLE) as equivalent licensing board examinations by stating that the ACGME does not specify which licensing board exam(s) (i.e., COMLEX-USA, USMLE) applicants must take to be eligible for appointment in ACGME-accredited residency programs[3]; and

WHEREAS, according to the 2018 National Resident Matching Program (NRMP) Program Director Survey, 64% of programs for all specialties utilized the USMLE with a target score in mind, with 34% utilized the USMLE as a pass; while only 34% of programs utilized the COMLEX-USA with a target score in mind and 27% of programs utilized the COMLEX-USA as a pass[4]; and

WHEREAS, in 2006 Slocum and Louder published a guide on converting COMLEX-USA to USMLE scores, but the information has since been outdated with further research arguing against the accuracy of such conversion – illustrating a need to communicate the value of the two licensing exams for program directors[5,6]; and

WHEREAS, Dr. Jon Gimpel, National Board of Osteopathic Medical Education (NBOME) President, commented on a potential conversion between the two exams stating, "because of the different natures of the examinations, it is not possible—or even desirable—to make a direct numerical comparison between the scores of the COMLEX-USA examination series and those of the USMLE"[7]; and

WHEREAS, as stated by AACOM, "The single GME accreditation system is not expected to reduce acceptance of the COMLEX-USA for residency admissions, but rather to

continue to grow acceptance with the goal of one day achieving universal acceptance. However, it is likely – at least for a while – that some ACGME programs will continue to prefer to receive a USMLE score. If a student has aspirations for such programs, then that student will have to make the decision about whether to take the USMLE in addition to the COMLEX-USA"[8]; and

WHEREAS, the American Medical Association (AMA) House of Delegates in November 2018 approved a resolution that advocates equality between the COMLEX-USA and USMLE exams; with the policy further promoting the education and use of COMLEX-USA by residency program directors for evaluation of medical students[9]; and

WHEREAS, in reference to the AMA 2018 House of Delegate Resolution (H-295.866), Dr. Boyd Buser, Past AOA President, commented, "This important recognition indicates that osteopathic medical graduates should not be compelled to take the USMLE series as a condition to apply for a residency program[10]"; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) promote ~~equality~~ PARITY between osteopathic and allopathic medical students, residents, and physicians among residency program directors; and, be it further

RESOLVED, that the AOA collaborate with the American Association of Colleges of Osteopathic Medicine, the National Board of Osteopathic Medical Education, the American Medical Association, the Accreditation Council for Graduate Medical Education, and all other appropriate parties to educate residency program directors on the interpretation of a Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) score with the understanding that the COMLEX-USA is the most appropriate standardized exam to evaluate the competency of an osteopathic medical student.

References

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: ADDICTION MEDICINE CAQ

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Osteopathic Association (AOA) approved the Addiction Medicine conjoint CAQ in 1995; and

WHEREAS, on April 12, 2016, the AOA passed a resolution that will provide DOs who are ABAM diplomats with a process to attain an AOA subspecialty certification in Addiction Medicine; and

WHEREAS, there are many DOs who will not benefit from the 2016 AOA resolution and still seek subspecialty certification in Addiction Medicine, including those who have completed an AOA approved Addiction Medicine fellowship program; and

WHEREAS, the Centers for Disease Control and Prevention anticipates that the number of death for all drug overdoses will be 74,000 in 2017. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. On average, 115 Americans die every day from an opioid overdose; and

WHEREAS, the Department of Health & Human Services, The White House Office of National Drug Control Policy, and the Department of Substance Abuse and Mental Health Services have acknowledged a severe shortage of Addiction Medicine specialists to treat the epidemic of opioid and alcohol addictions and the AOA has committed to assisting in training more physicians in substance use disorder (SUD). In October 2017 President Donald Trump formally declared the opioid crisis a public health emergency; and

WHEREAS, more hospitals and insurance companies are requiring certification for the treatment of addiction; those who are certified are also able to command more income and opportunities; and

WHEREAS, there is a lack of parity among DOs and MDs now that allopathically boarded physicians can become qualified to certify in addiction medicine as a subspecialty under the American Board of Medical Specialties (ABMS) Preventive Medicine Certifying Board, thereby making DOs who are not allopathically boarded ineligible; and

WHEREAS, as per policy, resolutions with a financial implication must be submitted to the AOA Finance Committee for review, consideration and recommendation prior to consideration by the AOA House of Delegates, therefore resolution H215 – A/2018 titled Addiction Medicine CAQ was referred to the AOA Finance Committee for a fiscal impact analysis; now, therefore be it

RESOLVED, that Osteopathic physicians who have completed an American Osteopathic Association (AOA) approved fellowships in Addiction Medicine be allowed to take the primary CAQ examination in Addiction Medicine; and, be it further

RESOLVED, that **A** clinical practice pathway ~~previously~~ **BE DEVELOPED AND** approved by the AOA **CONJOINT EXAMINATION COMMITTEE** in Addiction Medicine **AND** be ~~re~~opened for three (3) years **AFTER THE INITIAL EXAM ADMINISTRATION** for ~~all~~ **QUALIFIED** DOs who wish to become certified in the subspecialty of Addiction Medicine; and, be it further

RESOLVED, that the AOA Finance Committee submits a fiscal impact of H215 – A/2018 titled "Addiction Medicine CAQ" to be $151,000 while noting that the net financial impact will be $0 in year 1.

Reference Committee Explanatory Statement:
Due to the national opioid epidemic, it is the intent of the AOA that any DO with an active primary AOA board certification in any specialty would be able to seek certification through this pathway.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: ADDICTION MEDICINE CAQ

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Educational Affairs

WHEREAS, the American Osteopathic Association (AOA) approved the Addiction Medicine conjoint CAQ in 1995; and

WHEREAS, on April 12, 2016, the AOA passed a resolution that will provide DOs who are ABAM diplomats with a process to attain an AOA subspecialty certification in Addiction Medicine; and

WHEREAS, there are many DOs who will not benefit from the 2016 AOA resolution and still seek subspecialty certification in Addiction Medicine, including those who have completed an AOA approved Addiction Medicine fellowship program; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) anticipates that the number of death for all drug overdoses will be 74,000 in 2017. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. On average, 115 Americans die every day from an opioid overdose; and

WHEREAS, the Department of Health & Human Services, The White House Office of National Drug Control Policy, and the Department of Substance Abuse and Mental Health Services have acknowledged a severe shortage of Addiction Medicine specialists to treat the epidemic of opioid and alcohol addictions and the AOA has committed to assisting in training more physicians in substance use disorder (SUD). In October 2017 President Donald Trump formally declared the opioid crisis a public health emergency; and

WHEREAS, more hospitals and insurance companies are requiring certification for the treatment of addiction; those who are certified are also able to command more income and opportunities; and

WHEREAS, there is a lack of parity among DOs and MDs now that allopathically boarded physicians can become qualified to certify in addiction medicine as a subspecialty under the American Board of Medical Specialties (ABMS) Preventive Medicine Certifying Board, thereby making DOs who are not allopathically boarded ineligible; now, therefore be it

RESOLVED, that Osteopathic physicians who have completed an American Osteopathic Association (AOA) approved fellowships in Addiction Medicine be allowed to take the primary CAQ examination in Addiction Medicine; and, be it further

1 RESOLVED, that clinical practice pathway previously approved by the AOA in Addiction
2 Medicine be reopened for six (6) years for all DOs who wish to become certified in the
3 subspecialty of Addiction Medicine.

Explanatory Statement:
As per policy, resolutions with financial implication must be submitted to the AOA Finance Committee for review, consideration and recommendation prior to consideration by the AOA House of Delegates.

ACTION TAKEN **REFERRED** *(to AOA Finance Committee)*

DATE **July 21, 2018**

SUBJECT: H300-A/14 TRAINING -- EXTENDED RELEASE-LONG ACTING (ER/LA) OPIOID RISK EVALUATION AND MITIGATION STRATEGY (REMS)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H300-A/14 TRAINING -- EXTENDED RELEASE-LONG ACTING (ER/LA) OPIOID RISK EVALUATION AND MITIGATION STRATEGY (REMS)

The AOA encourages osteopathic physicians whose practice includes the prescribing of Extended Release-Long Acting (ER/LA) Opioids to complete ER/LA Opioid Risk Evaluation and Mitigation Strategy (REMS) training to ensure that ER/LA opioids are prescribed, when indicated, in a manner that enhances patient well-being and does not contribute to individual or public harm. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H301-A/14 MEDICAL WEBSITES AND SMARTPHONES / TABLET COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H301-A/14 MEDICAL WEBSITES AND SMARTPHONES / TABLET COMPUTER APPS TO DIAGNOSE ILLNESS – USE OF

The American Osteopathic Association (AOA) recognizes the values that health information websites and apps provide patients and encourages their use for patients to gain information about their health, and will encourage its members to recommend patients use evidence-based resources so that they may continue to actively engage in their own health care. The AOA should actively educate patients on the importance of seeing a physician when ill or injured and in need of a medical diagnosis, and that patients not allow recommendations from these medical websites or applications to be used as a basis for delaying, or as a substitute for, evaluation and treatment by a physician. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H305-A/14 FLU PANDEMIC – OSTEOPATHIC TREATMENT OF**
4 The American Osteopathic Association supports the active utilization of osteopathic
5 manipulative treatment, along with other recognized and approved medical interventions, in the
6 treatment of flu pandemics and other infectious outbreaks; and will conduct programs to
7 disseminate appropriately training in osteopathic manipulative treatment. 2009; reaffirmed as
8 amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING

The American Osteopathic Association is against **DIRECT-TO-CONSUMER MARKETING OF MEDICAL TESTS AND EXAMS THAT MAY BE** unnecessary**,** ~~exams HEALTH SCREENING EXAMS AND TESTING marketed directly to consumers~~ and encourages its members to educate their patients **ABOUT WHICH SERVICES ARE APPROPRIATE BASED ON** ~~and follow the~~ US Preventive Services Task Force **RECOMMENDATIONS AND OTHER NATIONALLY RECOGNIZED CLINICAL PRACTICE** Guidelines ~~WHEN APPROPRIATE~~. 2009; reaffirmed 2014

Reference Committee Explanatory Statement:

The Committee agrees with the Bureau of Socioeconomic Affairs' recommendation to expand the policy and base the need for tests and exams on United States Preventive Services Task Force (USPSTF) guidelines and other nationally recognized clinical practice guidelines as outlined below:

1) USPSTF recommendations are applicable to primary care. The USPSTF is a Congressionally mandated, independent panel of medical experts in primary care and prevention composed of primary care providers-internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and other behavior specialists who are charged with making "recommendations to primary care providers about clinical preventive services."

2) Medicare pays for preventive screening and tests assigned a grade "D" or "I" by the USPSTF. These grade assignments indicate a service is unnecessary. Someone unfamiliar with USPSTF grade assignments may misinterpret a low grade as a non-covered service when it may not be. Prostate screening is a prime example.

3) CMS, Medicare Administrative Contractors (MACs) and private payers base their coverage determinations on nationally recognized clinical practice guidelines (which usually are developed by specialty medical societies) more so than USPSTF guidelines.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H307-A/14 NEW BORN HIV TESTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H307-A/14 NEW BORN HIV TESTING
American Osteopathic Association policy recommends HIV testing immediately with expeditious reporting of results of newborns whose mothers' HIV status is unknown and where clinically indicated. 2003, reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H313-A/14 CDC – HIV PROPOSED RULE CHANGE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be SUNSET:

3 **H313-A/14 CDC – HIV PROPOSED RULE CHANGE**
4 The American Osteopathic Association voices its concern and opposition to the Centers for
5 Disease Control and Prevention (CDC) proposed rule-making change on42 CFR Part 34 to
6 remove human immunodeficiency virus (HIV) testing as a requirement for immigrants and
7 refugees; and, through its resources encourages members and the public to investigate and
8 comment on the proposed rule-making. 2009; referred 2014

Explanatory Statement:
This policy is no longer needed. On November 2, 2009, the Department of Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) published a final rule that removes HIV (Human Immunodeficiency Virus) infection from the list of communicable diseases of public health significance. As a result, HIV infection will not prevent non-U.S. citizens from entering the United States. Further, HIV testing will no longer be required for U.S. immigration medical screening. https://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H314-A/14 INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H314-A/14 INFLUENZA IMMUNIZATION FOR HEALTH CARE WORKERS AND EDUCATORS

The American Osteopathic Association strongly supports and recommends influenza vaccinations for all health care workers and educators according to current guidelines of the Centers for Disease Control and Prevention. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H316-A/14 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED:

H316-A/14 DUE PROCESS FOR ALLEGED IMPAIRED PHYSICIANS
It is the policy of the American Osteopathic Association that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the staff privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment, and, where appropriate, a careful clinical evaluation of the physician. 1999; reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H317-A/14 DRUG FORMULARIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H317-A/14 DRUG FORMULARIES
The American Osteopathic Association (AOA) supports drug formularies which allow for an expeditious appeal process with a further peer to peer review option. 1999; reaffirmed 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H318-A/14 HOME-BASED CARE FOR FRAIL ELDERLY

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H318-A/14 HOME-BASED CARE FOR FRAIL ELDERLY**
4 The American Osteopathic Association encourages all parties with economic and clinical
5 responsibility to develop programs and systems to assist the frail elderly patient population and
6 provide appropriate access to healthcare services. 1999; revised 2004; reaffirmed 2009;
7 reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H319A/14 HEALTH CARE COSTS IN LONG TERM SERVICES AND SUPPORT

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H319-A/14 HEALTH CARE ~~COSTS~~ EFFICIENCY IN LONG TERM SERVICES AND SUPPORT

The American Osteopathic Association reaffirms its commitment to the development and implementation of programs that improve the efficiency of long term services and support and ensure the delivery of quality care. 1984; revised 1989; reaffirmed 1994; revised 1999; reaffirmed 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H320-A/14 IMMUNIZATION REGISTRIES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H320-A/14 IMMUNIZATION REGISTRIES
The American Osteopathic Association encourages physicians to participate in the development of immunization registries in their communities and to use such registries in their practices.
1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:
A new resolution was developed - CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES - for presentation to the HOD to encompass other public and private clinical data registries in addition to immunization registries.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H321-A/14 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP ACTION

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED:

H321-A/14 NATIONAL PRACTITIONER DATA BANK – MEMBERSHIP ACTION

The American Osteopathic Association believes that adverse membership actions which do not involve professional competence or conduct such as nonpayment of dues, CME deficiencies and other association matters shall not be reported to the National Practitioner Data Bank (NPDB) unless otherwise required by law; and that final actions of expulsion of members from the American Osteopathic Association shall, when all appeal mechanisms have been exhausted by the osteopathic physicians, be reported to the National Practitioner Data Bank. 1999; reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H322-A/14 IMPORTATION OF MEDICATIONS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H322-A/14 IMPORTATION OF MEDICATIONS**
4 The American Osteopathic Association supports the importation of medications that may be
5 imported under the authority of the US Food and Drug Administration and encourages its
6 members to assist patients in utilizing the many programs that are available to provide patients
7 with free or reduced cost medications. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H323-A/14 ANY WILLING PROVIDER LEGISLATION

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H323-A/14 ANY WILLING PROVIDER LEGISLATION

The American Osteopathic Association encourages and supports the passage of legislation that will ensure the freedom of patients and physicians to enter into private contracts for health care services without regard to restrictions by any third party carrier; supports legislation that will allow any qualified physician (DO/MD) to negotiate with any third party carrier the terms for service to be provided; and supports legislation that will require any third party carrier to provide prompt and complete explanation to any requesting physician (DO/MD) whom it may deem unqualified. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H324-A/14 USE OF THE TERM "PHYSICIAN" DOCTOR" AND "PROVIDER"

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H324-A/14 USE OF THE TERM "PHYSICIAN" DOCTOR" AND "PROVIDER" - TRUTH IN ADVERTISING

The American Osteopathic Association (AOA) adopts as policy: (1) that ~~AOA members~~ DOS AND MDS, are encouraged to use the terms "physician" or "doctor" to describe themselves, leaving other terms such as "practitioner," "clinician," or "provider" to be used by non-physician clinicians or to categorize health care professionals as a whole; (2) supports the appropriate use of credentials and professional degrees in advertisements; (3) ~~providing a~~ SUPPORTS mechanismS for physicians to report advertisements related to medical care that are false or deceptive; (4) opposes non-physician clinicians' use of the title "physician" or "doctor" because such communication is likely to deceive the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine; (5) opposes legislation that would expand the use of the term "physician" OR "DOCTOR" to persons other than ~~US-trained~~ DOs~~,~~ and MDs; (6) supports ~~a~~ policIES~~y~~ that REQUIRE physicians and non-physician clinicians TO VERBALLY DISCLOSE THEIR DEGREES WHEN identifyING themselves to their patients, AND WEAR A NAMETAG WHICH CLEARLY DISPLAYS THEIR DEGREE DURING ALL PATIENT ENCOUNTERS~~noting their degree in both a verbal description as well as a visual identification by use of a nametag~~; (7) OPPOSE ~~will not support~~ legislation THAT, ~~which~~ would allow non-physician clinicians to be called "physicianS;" (8) supports ~~a~~ policIES~~y~~ THAT reservE~~ing~~ the title "physician" for ~~US-trained~~ DOs, and MDs who have established the integrity of their education, training, examination WHICH UNIQUELY PREPARE THEM ~~and regulations~~ for the unlimited practice of medicine; and (9) opposes the misuse of the title "doctor" by non-physician clinicians~~,~~ in all communications and clinical settings because such use deceives the public by implying THAT the non-physician clinician's education, training or credentialing is equivalent to a DO or MD. 2009; reaffirmed as amended 2014

Reference Committee Explanatory Statement:
Refer to Bureau of State Government Affairs (BSGA) for consideration and comment and report back to 2020 HOD.

ACTION TAKEN **REFERRED** *(to Bureau of State Government Affairs)*

DATE **July 27, 2019**

SUBJECT: H325-A/14 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H325-A/14 PHYSICALLY ACTIVE VIDEO GAMES – (EXERGAMING HEALTH) BENEFITS

The American Osteopathic Association recommends: (1) osteopathic physicians should be aware of the potential benefits of exergaming; (2) physicians should consider recommending exergaming as a component of a person's exercise program or when situational circumstances prohibit other types of exercise; and (3) additional research that demonstrates the benefits of exergaming. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H326-A/14 MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE PATIENTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H326-A/14 MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE**
4 **PATIENTS**
5 The American Osteopathic Association supports legislation ~~that will allow~~ **TO ELIMINATE**
6 **THE COVERAGE GAP (DONUT HOLE) IN** Medicare Part D ~~recipients, who are in~~
7 ~~the "donut hole", to utilize~~ **AND THE RESTRICTIONS THAT LIMIT PATIENTS**
8 **FROM UTILIZING** prescription discounts and vouchers. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H327-A/14 ELECTRONIC PRESCRIBING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H327-A/14 ELECTRONIC PRESCRIBING

The American Osteopathic Association (AOA) supports electronic prescribing (e-prescribing) for non-scheduled pharmaceuticals.

The AOA supports e-prescribing for all scheduled pharmaceuticals on a voluntary basis without CMS ~~reimbursement~~ monetary penalty **AND WITHOUT STATE SANCTIONED CIVIL OR CRIMINAL PENALTIES**.

The AOA encourages pharmacies to utilize e-prescribing systems that are in compliance with state and federal law.

The AOA supports the following principles in its advocacy efforts relating to the development of e-prescribing standards:

- SAFETY: Safety alerts should be prioritized and readily distinguishable from commercial messages; these messages should be allowed to be suppressed for efficiency.
- E-PRESCRIBING drugs should be listed with both generic and name brands.
- PRIVACY: Information on patients' medication should be current, comprehensive, accurate and maintained in compliance with HIPAA.
- TRANSPARENCY: Third part involvement must be transparent and disclosed TO THE PRESCRIBING PHYSICIAN AND PATIENT.
- DESIGN: Financial interests should not dictate the design of systems (i.e., all drugs should be available). Standards must require fail-safes in any system to prevent the introduction of ~~new~~ health care errors.
- INTEGRATION: Systems ~~should be proven~~ and should integrate with existing healthcare technology and existing workflow (i.e., download of patient data from EMR).
- SCALABILITY: Any standards should be broad-based and applicable to all healthcare delivery systems.
- TIMING: These standards should be in place at the earliest possible time to allow software vendors and practitioners adequate time to become compliant with said standards and perform all necessary testing prior to the implementation. 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H328-A/14 CARDIOVASCULAR DISEASE AND WOMEN

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H328-A/14 CARDIOVASCULAR DISEASE AND WOMEN
The American Osteopathic Association: (1) encourages its members to participate in continuing medical education programs on cardiovascular disease (CVD) in women; (2) urges osteopathic state and specialty associations to offer CME on CVD in women, as part of their educational offerings; (3) encourages its members to participate in national initiatives on women's health, especially cardiovascular health such as the National Heart, Lung, and Blood Institute's The Heart Truth (Red Dress) campaign; (4) ~~will continue to recognize National Women's Health Week and National Women's Check-Up Day; and~~ **(4) WILL CONTINUE TO RECOGNIZE NATIONAL WOMEN'S HEALTH WEEK AND NATIONAL WOMEN'S CHECK-UP DAY; AND** ~~(5) through its website, the AOA will link to organizations whose mission is to educate patients and physicians on CVD; and (6)~~ **(5)** encourages appropriately designed studies on contributors to CVD in women. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H329-A/14 HEALTHY WEIGHT FOR FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H329-A/14 HEALTHY WEIGHT FOR FAMILIES

The American Osteopathic Association encourages participation of its members in personal health promotion; strongly recommends osteopathic medical schools incorporate personal health promotion as a part of their graded curriculum; strongly recommends participation of its members in outreach efforts to engage with local school districts in order to develop and improve wellness policy interventions to reduce childhood obesity; strongly recommends the state and specialty associations to collaborate with local school districts and major local employers to enhance wellness policy development, implementation, data assessment and improvements; encourages its members to participate in national and local initiatives on obesity~~;~~ ~~and , through its website, the AOA will link to the most up-to-date evidence on treating obesity~~. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H330-A/14 ADMINISTRATIVE FEES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H330-A/14 ADMINISTRATIVE FEES
The American Osteopathic Association has determined that it is ethical for an osteopathic physician to charge patients fair and reasonable administrative fees as long as the patient is informed of these fees in advance, and the charging of administrative fees does not violate contractual or state law. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H331-A/14 END-OF-LIFE CARE – USE OF PLACEBOS IN

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED as AMENDED:

H331-A/14 END-OF-LIFE CARE – USE OF PLACEBOS IN

The AOA approves the attached position paper on Use of Placebos for Pain Management in End-of-Life Care and will be updated according to the current literature. 2004; 2009; reaffirmed as amended 2014

USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE

The placebo effect of medication can be a significant resultant action of any prescription. However, the substitution of a placebo in place of effective pain medication has been widely recognized as unethical, ineffective and potentially harmful. [~~1, 4, 5, 9, 10, 11, 15, 16, 23, 24~~ 1-9] A number of organizations have advised against the use of placebo substitution, including the American Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the American Medical Association), American Nursing Association, and the American Society of Pain Management Nurses.

This white paper describes the literature and rationale in support of the AOA's position on the controversial subject of the use of placebos for pain management in terminally ill patients.

I. Definition of Terms

A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution means the substitution of a physiologically inactive substance for a comparison with the physiologically active substance. Placebo effect is the positive psychosomatic response of an individual to a treatment; in contrast, the nocebo response is a negative psychosomatic response to a treatment.[~~2~~10] The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician's treatment plan and/or prescription for the symptom relief are more likely to obtain relief. [4 2]

Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a "nocebo response". A pleasant effect is called a "positive placebo response". It has been noted that, "a positive placebo response simply speaks

to the strength of an individual's central control processes (i.e., mind) to recruit their descending inhibitory system to block pain. The trained osteopathic physician knows that pain relief occurs both in the mind and in the body." [~~9~~ 4] The basis of the placebo effect in a therapeutic physician-patient relationship also involves good communication skills as well as listening to the patient. [~~3, 7, 9~~4, 11, 12]

To summarize, a placebo is a type of treatment, necessarily used in controlled clinical trials, that has no inherent physiological action yet is designed to mimic a therapy with a known active physiologic effect. Positive changes resulting from placebo administration would be due to expectations of success by the patient. Thus, the use of placebo effect is based on the patient's perception of the role of the placebo agent with symptom relief. The placebo response may be enhanced with a positive patient-physician relationship.

B. Addiction, substance abuse and dependence, tolerance, withdrawal and pseudo-addiction.

Some physicians inappropriately justify using placebo in pain management to avoid "addicting" the patient. Addiction, as defined by the American Academy of Pain Medicine,[13] "is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving." ~~Actually, it is rare for a person to develop an addiction to pain medications.~~ [~~15~~]

Substance abuse is defined as psychological and physical dependence on substances. Some physicians are concerned that prescribing narcotics may lead to substance abuse and therefore may attempt to use a placebo to assess whether the patient truly requires narcotics for pain relief. However, there is no scientific basis for using placebo in the assessment of the patient in pain who has or may have the potential for a substance abuse. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) [~~19~~14], lists definitive criteria for diagnosis of psychological and physical dependence on substances. This text categorizes "Substance-Related Disorders" but does not utilize the term addiction; further, nowhere in the DSM-V is placebo administration utilized with criteria for diagnosing various forms of substance abuse. Substance dependence is defined as a cluster of cognitive, behavioral and physiological symptoms. The essential feature of a substance dependent individual is continuous use of the substance despite significant substance-related problems, such as deleterious effects on occupation, relationships, health, and others.

Physicians may become uncomfortable with requests for increased dosages of pain medications, fearing that a patient is manifesting a substance-related disorder. A better understanding of the concepts of tolerance, physical dependence, physiological dependence withdrawal symptoms and pseudo-addiction, may help physicians understand and more effectively treat these patients.

Tolerance represents a markedly diminished effect that can occur with continued use of most medications; the degree depends upon the daily dose and length of use. The need for medication titration, either due to development of tolerance or to incomplete responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory changes in receptors and/or increased clearance resulting from induction of various

metabolic pathways. The problem of tolerance should therefore be anticipated as a possible outcome in prescription pain medications.

Withdrawal is defined by the DSM-V [14] as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such "drug seeking behavior" has been deemed as "proof" of "addiction." The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a substance-abusing patient according to the DSM- V.[14]

II. Legal Considerations in the Use of Placebos in Pain Management

While there are no specific laws governing the use of placebos in any circumstance, there is a considerable amount of legislation regarding a patient's right to pain management. There are several state statutes that address this issue, some of which are based on the Federation of State Medical Boards' Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.[15] This document clarifies that legislative statutes accepting these guidelines understand the ongoing increased scientific knowledge of pain management, and thus have no need to modify legislation as the science of pain management changes. This document does not mention placebo usage. [16]

The American Bar Association (ABA)[16] adopted a resolution concerning the promotion of pain management in all patients with chronic pain. This resolution states, "…that the American Bar Association urges federal, state and territorial governments to support fully the rights of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management and ongoing monitoring as part of basic medical care, even if such pain and symptom management may result in analgesic tolerance, physical dependence or as an unintended consequence shorten the individual's life." [16] Placebo substitution for active pain medicine without informed consent on the part of the patients clearly violates the nature and substance of the ABA's position. Additionally, in two Supreme Court decisions regarding the right to assisted suicide, the court promoted the right of individuals to appropriate palliative care and pain management. [16 17, 18]

While there is little case law concerning tort or administrative findings against physicians for inadequate pain management, this is likely to change in the near future. The main barrier to malpractice claims for inadequate pain management is use of the customary local standard to determine what constitutes ordinary care. The courts are steadily moving away from this standard to a national standard which uses clinical guidelines as the determinant of ordinary care. This is seen in the decision in the case of Nowatske v. Oserloh, where the court stated, "should customary medical practice fail to keep pace with development and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care…" [10 19]

Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality [1], the American Pain Society, [7] the Healthcare Facilities Accreditation Program [20] as well as the Joint Commission on Accreditation of Healthcare Organizations[21] are good examples of sources the courts are using to determine ordinary practice.-[1, 13, 17] These guidelines do not support the use of placebo in any fashion except in approved research studies when the appropriate patient informed consent has been obtained. Therefore, the physician thus cannot justify the use of placebo for pain management by attempting to diagnose "addiction" or with support from any of the above regulatory agencies. [105]

Furthermore, under California's elder abuse statute, [22] a physician was successfully sued by the deceased's family for inadequate pain management at the end of life. [2123]

III. Adverse Effects of Placebo Use

Pain is a universal experience and is subjective by nature. Despite the common colloquialism, "I feel your pain," no individual can truly experience another's pain. There are no laboratory tests or consistently reliable physical findings for assessment of pain. Patient self-report remains the gold standard for pain assessment. [1424] Use of a placebo in place of an effective pain medication for attempting to determine whether the patient at end-of life is really in pain is under no circumstances appropriate.

There is a concern if a physician deceives the patient and substitutes a placebo treatment in the place of a known effective treatment without informing the patient. Deception has no place within the therapeutic relationship and is counter-productive. A physician may counsel a patient that "this treatment may be effective in treating your condition," but evidence-based medicine cannot guarantee a treatment outcome.

In this era of informed consent, deception of the patient poses many problems, including erosion of the trust individuals and society as a whole have for physicians. There are methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a highly specialized procedure performed by a few skilled pain management physicians with appropriate informed consent.

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association's 2000 report, is an ongoing problem. [1725] While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. [8, 9, 164, 7, 26] It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a "suicidogen," whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death. [11 6] In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects [53] and potentially precipitate hyperalgesia [1827] or withdrawal in patients previously treated with pain medications.

IV. Summary

Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of known effective pain medication for determining whether the patient is really in pain is under no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose substance abuse, commonly referred to by some physicians as "addiction." There is no medical justification for the use of placebos to assess or treat pain at end of life.

The only appropriate use of a placebo is in approved clinical research with informed consent.

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Explanatory Statement:
Striking out statement on page 2 (lines 20-21) and corresponding reference. All remaining references have been checked and revised editorially.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H332-A/14 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

The American Osteopathic Association (AOA) will: (1) include ~~**optional**~~ questions relating to race, ethnicity, and socioeconomic status as part of the data collected from physicians in membership records; (2) encourage the American Association of Colleges of Osteopathic Medicine (AACOM), individual osteopathic medical colleges, osteopathic residency programs, state associations and specialty colleges to submit existing data on minority representation in the osteopathic profession to the AOA; (3) encourage all osteopathic organizations to work with and respond to future inquiries from the AOA on this and similar matters; (4) distribute all of the information gathered through this initiative only as non-identifiable or aggregate demographic data; and (5) encourage all specialty colleges to establish committees to address training, fellowship, cultural competency and service issues related to underrepresented minorities ~~**(including but not limited to Hispanic/Latino Ethnicity, Black/African American, Native American, Alaska Native and Hawaiian/Pacific Islander)**~~ and to work collaboratively with the AOA to **IMPLEMENT** programs ~~**implement**~~ with multi-cultural impact. 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H333-A/14 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

WHEREAS, the House of Delegates referred H-333-A/2014 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE to the Bureau of Osteopathic Clinical Education and Research (BOCER) to review and update as some of the information provided in support of the position statement was out of date and needed citations; and

WHEREAS, the BOCER reviewed referred resolution H-333 - A/2014 and developed an updated position statement; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED as AMENDED:

H333-A/14 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) OF THE CERVICAL SPINE

The American Osteopathic Association, in the hopes of advancing the science of osteopathic medicine adopts the following position (2004; reaffirmed 2009 [Editor's note: This policy has been referred to as some of the information is out of date and needs citations - 2014]).

(These recommendations are provided for osteopathic educators and physicians making decisions regarding the instruction of cervical spinal manipulation and the care of patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by a patient's physician. Like all reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the understanding that continued research is needed.)

AMERICAN OSTEOPATHIC ASSOCIATION OSTEOPATHIC MANIPULATIVE TREATMENT OF THE CERVICAL SPINE

~~Background and Statement of Issue~~

~~There has recently been an increasing concern about the safety of cervical spine manipulation. Specifically, this concern has centered on devastating negative outcomes such as stroke. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harm and make a recommendation about its use.~~

~~Benefit~~

~~Spinal manipulation has been reviewed in meta-analysis published as early as 1992, showing a clear benefit for low back pain. There is less available information in the literature about manipulation in regards to neck pain and headache, but the evidence does show benefit. There have been at least 12 randomized controlled trials of manipulative treatment of neck pain.~~

~~Some of the benefits shown include relief of acute neck pain, reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care. There is also short-term relief from tension-type headaches. Manipulation relieves cervicogenic headache and is comparable to commonly used first line prophylactic prescription medications for tension-type headache and migraine. Meta-analysis of 5 randomized controlled trials showed that there was a statistically significant reduction in neck pain using a visual analogue scale.~~

~~Harm~~

~~Since 1925, there have been approximately 275 cases of adverse events reported with cervical spine manipulation. It has been suggested by some that there is an under-reporting of adverse events. A conservative estimate of the number of cervical spine manipulations per year is approximately 33 million and may be as high as 193 million in the US and Canada. The estimated risk of adverse outcome following cervical spine manipulation ranges from 1 in 400,000 to 1 in 3.85 million manipulations. The estimated risk of major impairment following cervical spine manipulation is 6.39 per 10 million manipulations.~~

~~Most of the reported cases of adverse outcome have involved "Thrust" or "High Velocity/Low Amplitude" types of manipulative treatment. Many of the reported cases do not distinguish the type of manipulative treatment provided. However, the risk of a vertebrobasilar accident (VBA) occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation. This includes cases of ischemic stroke and vertebral artery dissection.~~

~~A concern has been raised by a recent report that VBA following cervical spine manipulation is unpredictable. This report is biased because all of the cases were involved in litigation.~~

~~The nature of litigation can lead to inaccurate reporting by patient or provider. However, it did conclude that VBA following cervical spine manipulation is "idiosyncratic and rare". Further review of this data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.~~

~~In direct contrast to this concern of unpredictability, another recent report states that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation. This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The authors concluded that the incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation. The current literature does not clearly distinguish the type of provider (i.e. MD, DO, DC or PT) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with VBA. This information may help to understand the mechanism of injury leading to VBA, as there are differences in education and practice among the various professions that utilize this type of treatment.~~

~~Comparison of Alternative Treatments~~

~~NSAIDs are the most commonly prescribed medications for neck pain. Approximately 13 million Americans use NSAIDs regularly. 81% of GI bleeds related to NSAID use occur without prior symptoms. Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications. The annual cost of GI tract complications in the US is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year. This makes GI toxicity from NSAIDs the 15th most common cause of death in the United States.~~

~~Epidural steroid injection is a popular treatment for neck pain. Common risks include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of procedures. Intrathecal injection occurs in ~ 0.6-10.9% of procedures. Intravascular injection is the most significant risk and occurs in ~ 2% of procedures and ~ 8% of procedures in pregnant patients. Cervical epidural abscess is rare, but has been reported in the literature.~~

~~Provocative Tests~~
~~Provocative tests such as the DeKline test have been studied in animals and humans. This test and others like it were found to be unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery.~~

~~Risk Factors~~
~~VBA accounts for 1.3 in 1000 cases of stroke, making this a rare event. Approximately 5% of patients with VBA die as a result, while 75% have a good functional recovery. The most common risk factors for VBA are migraine, hypertension, oral contraceptive use and smoking. Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for VBA.~~

~~A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.~~

~~Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for VBA. "Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises." In some cases manipulation may not be the primary insult causing the dissection, but an aggravating factor or coincidental event.~~

~~It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. 51% involved rotation, with the remaining 49% representing a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.~~

~~Conclusion~~
~~Osteopathic manipulative treatment of the cervical spine, including but not limited to High Velocity/Low Amplitude treatment, is effective for neck pain and is safe, especially in comparison to other common treatments. Because of the very small risk of adverse outcomes, trainees should be provided with sufficient information so they are advised of the potential risks. There is a need for research to distinguish the risk of VBA associated with manipulation done by provider type and to determine the nature of the relationship between different types of manipulative treatment and VBA.~~

~~Therefore, it is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including High Velocity/Low Amplitude, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients.~~

Background and Statement of Issue

Treating chronic pain continues to be an important health issue for osteopathic physicians. Chronic pain affects over 100 million Americans over the age of 18 and negatively impacts their quality of life.[1] In addition, it costs $600 billion a year in healthcare costs and loss of productivity.[1] Back and neck pain are two leading causes of chronic pain and they are amongst the leading causes of people living with disabilities in the United States (U.S.) as well as worldwide. More specifically, back and neck pain are ranked in the top 8 diseases and injuries in the U.S. regarding years lived with disability (YLDs)[2] and in the top 6 globally.[3] Cervical spine manipulation is one option for treating back and neck pain.

Concerns continue to arise regarding the safety of cervical spine manipulation. Specifically, concerns center on the potential development of serious adverse events such as stroke and cervical artery dissection after spinal manipulation. Since spinal manipulation is an option available to osteopathic physicians to incorporate into the care of their patients, it is important to examine these concerns and develop a position on the issue. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harms and make a recommendation about its use.

Benefit

Spinal manipulation has been reviewed in various systematic reviews and meta-analyses over the past three decades. The majority of the studies conducted on spinal manipulation focus on low back pain for which the evidence has shown spinal manipulation has clear benefits.[4-7] For neck pain, however, there are fewer studies and the findings vary, but there is some evidence that conclude spinal manipulation benefits patients presenting with neck pain.[8-13] This evidence indicates that the benefits of spinal manipulation include relief of acute neck pain, and reduction in neck pain as measured by validated instruments in sub-acute and chronic neck pain compared with muscle relaxants or usual medical care.[13-17] Bronfort et al.[15] specifically concluded that for patients with chronic neck pain, there is moderate evidence that (1) manipulation and mobilization are superior to general practitioner management in the short term, (2) high-technology exercise results in more pain improvement than manipulation in the long term for a mix of patients with acute and chronic pain, and (3) mobilization is superior to physical therapy and general medical care and similar to manipulation in both the short and long term.

Benefits of spinal manipulation for areas beyond the low back and neck include short-term relief from tension-type headaches.[14] Manipulation relieves cervicogenic headache and is comparable to commonly used first line prophylactic prescription medications for tension-type headache and migraine.

Harm

Overall

The literature presents varying conclusions on the harms of spinal manipulative treatment (SMT).[6,7] In a 2017 review of risks associated with spinal manipulation, 46% percent of the studies reviewed found spinal manipulation to be safe, 42% percent were neutral (did not find harm/benefit); and the remaining 12% percent concluded that spinal manipulation was unsafe because of the possibility of serious adverse events.[7] Nevertheless, the existence of any adverse effect should not be trivialized.

Studies have noted that there are two types of adverse effects as a result of SMT. The first type is considered to be mild adverse events that are short-term and non-serious such as dizziness, fatigue, and muscle soreness/ discomfort.[7,18] These side effects occur in 23-83% of patients.

The second type of adverse events is more serious and includes cervical artery dissection, stroke, spinal cord injuries, and other serious conditions outcomes related to vertebrobasilar accidents (VBAs). Currently, much of the literature discusses vertebrobasilar insufficiency or vertebralbasilar ischemia (VBI) which is a type of VBA and is often determined to be the link to the more serious adverse events. Nonetheless, serious adverse events are seen as a rarity, and it is estimated that they occur in the range of every 20,000 to 250,000,000 manipulation performed.[7,18-27]

Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low Amplitude (HVLA) types of manipulative treatment.[18,25] Unfortunately, many of the reported cases do not distinguish the type of manipulative treatment provided.

VBAs

VBAs account for 1.3 in 1000 cases of stroke, making them a rare event. Approximately 5% of patients with a VBA die as a result, while 75% have a good functional recovery.[28] The most common risk factors for VBAs are migraine, hypertension, oral contraceptive use and smoking.[29] Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for a VBA.[30]

The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.[14] A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.[31]

A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine manipulation was unpredictable.[14] The authors, however, concluded that a VBA following cervical spine manipulation was "idiosyncratic and rare". Further review of the data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.[32]

Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for a VBA.[14] "Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises." [24] In some cases manipulation may not be the primary culprit for causing the dissection, but an aggravating factor or coincidental event.[32]

It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. Fifty-one percent (51%) involved rotation, with the remaining 49% representing a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.[32]

Cervical Artery Dissection (CAD)

CAD occurs at a rate of 2.9 per 100,000 individuals every year in the general population, and a large majority (89%) of the individuals diagnosed with CAD have no symptoms or no significant disability that prohibits them from being productive within the following three months of the event.[33] Among those with symptoms, headaches and neck pain are the

predominant symptoms for CAD. This creates a dilemma for physicians because cervical spine manipulation is often sought to treat these medical issues. Thus, it is difficult to determine if manipulation causes CAD or if CAD existed at the time of treatment.

Limitations of Studies and Concerns with Pre-manipulation Screening

Due to the design of studies (case reports or retrospective surveys), infrequent reporting of adverse events, and the rare occurrence of many of the more serious complications, it is difficult to determine a causal relationship between SMT and the serious adverse effect.[7,33] Thus the lingering question of whether or not pre-existing pathologies may have existed prior to the patient receiving SMT remains.[18,26,34]

In Malone et al., the authors reported that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation.[26] This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation.[26,35]

Another noteworthy point to highlight is that the literature does not clearly distinguish the type of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with serious adverse effects. This information may help to understand the mechanism of injury leading to serious adverse effects, as there are differences in education and practice among the various professions that utilize this type of treatment. It is duly noted that the osteopathic approach strictly limits the "thrust", which is more commonly referred to as "impulse" in osteopathic practicums, to the physiologic barrier as opposed to the chiropractic approach may extend to the paraphysiologic space.

Additionally, pre-manipulation screening tools, that might be used to identify a patient's risk for VBA and cervical artery dissection have been widely criticized because they have been found to be unreliable and difficult to validate.[28,29,36-43] These studies have examined the DeKleyn's test and others like it and determined the tests are unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery. [36-43] For this reason, researchers and groups such as the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders recommend that all health care providers conduct a thorough patient history, physical examination and patient self-assessment to rule out certain pre-existing conditions.[13,44]

Alternative Treatments

Non-steroidal anti-inflammatory drugs (NSAIDs)

NSAIDS such as ibuprofen and aspirin are the most commonly prescribed medications for neck pain. More than 30 million people worldwide use NSAIDs regularly.[45] In fact, 5% of all medical visit outcomes in the U.S. include a prescription for NSAIDS.[46] NSAIDs offer temporary relief, but long-term use, gender, age, strength of dose as well as consumption of multiple medications simultaneously may be associated with serious risks affecting the gastrointestinal (GI), renal and cardiovascular systems.[47,48] Eighty-one percent (81%) of GI bleeds related to NSAID use occur without prior symptoms.[49] Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications.[30] The annual cost of GI tract complications in the U.S. is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year therein making GI toxicity from NSAIDs the 15th most common cause of death in the United States.[49-51]

Epidural steroid injections

Epidural steroid injections (ESIs) are a popular treatment for neck pain.[50] Complications to ESIs generally occur because of needle placement or drug administration. Common risks associated with needle placement include subdural injection, intrathecal injection and intravascular injection.[51] Subdural injection occurs in ~ 1% of procedures, intrathecal injection occurs in ~ 0.6-10.9% of procedures, and intravascular injection, the most significant risk, occurs in ~ 2% of procedures.[51] Other risks include cervical epidural abscess, dural puncture, spinal cord trauma, infection, hematoma, nerve damage, vascular injury and cerebral vascular or pulmonary embolus.[52,53] Complications that may arise from drug administration include osteoporosis, Cushing's syndrome, avascular necrosis of bone, and steroid myopathy. While complications due to needle placement or administration of steroids are rare, they have been reported in the literature. [52,53]

Conclusion

Osteopathic manipulative treatment of the cervical spine, including but not limited to HVLA treatment, is effective for low back and neck pain and is safe. Because of the rarity of serious adverse events, trainees and practicing physicians should be provided with sufficient information so they are advised of the potential risks and able to communicate the potential risks to their patients. Prior to recommending cervical spine manipulations, physicians should conduct a thorough patient exam and medical history review to try to identify any preexisting conditions that may indicate the patient is at risk for a serious adverse event. Additionally, it is recognized that there is a need for research to distinguish the risk of VBA and CAD associated with manipulation done by specific provider types as well as research to determine the nature of the relationship between the different types of manipulative treatment and VBA and CAD.

It is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including HVLA, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients. Physicians should use a combination of medical history reviews and physical exams, diagnostic studies, and best judgment to determine if a patient has any pre-existing conditions that place the patient at risk of suffering a serious adverse event.

Special Acknowledgements

In crafting the updated Position Statement, the Bureau of Osteopathic Clinical Education and Research (BOCER) would like to thank the Osteopathic Manipulation Medicine and Osteopathic Manipulative Treatment (OMM/OMT) Research Task Force for its input, and a special thank you to Hollis King, DO, PhD, who served as an outside contributor.

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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H334-A/14 RIGHT TO PRIVATELY CONTRACT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H334-A/14 RIGHT TO PRIVATELY CONTRACT

The American Osteopathic Association supports the fundamental right of physicians to privately contract with patients without penalties and regardless of payor, ~~within the framework of free market principles and seek~~SUPPORTSs changes in statutes and regulations ~~that will~~TO allow physicians individually and as defined groups ~~be allowed~~ to negotiate fair contracts with private sector and public sector health plans. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED as AMENDED:

H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP

The American Osteopathic Association reaffirms its commitment to promote **DIVERSITY** ~~the advancement and integration of qualified women and~~ underrepresented ~~minorities (including, but not limited to Hispanic/Latino Ethnicity, Black/African Americans, Native American/Alaska Natives, and Hawaiian/Pacific Islander)~~ into the osteopathic profession; endorses programs to encourage increased **DIVERSITY IN** enrollment ~~**of these groups**~~ at colleges of osteopathic medicine; and will work to identify and encourage **SUCH** qualified individuals ~~**from these groups**~~ for participation in those osteopathic affiliate and national activities which foster leadership opportunities. reaffirmed 1979; revised 1983, 1988, 1994; reaffirmed 1999, revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCES AND PROCEDURES

The American Osteopathic Association: (1) supports efforts to eliminate the abuse of performance enhancing substances, known as doping, for the purpose of enhancing athletic performance or physical appearance; (2) supports the efforts of the United States Anti-Doping Agency (USADA) and its program in accordance with the World Anti-Doping **AGENCY** (WADA) code and the WADA International Standards (IST) to protect clean athletes and ensure their rights to compete on a fair and level playing field, free from the pressures of performance enhancing drugs; and (3) encourages education of athletes, the public and physicians of the dangers of these substances. 1989, revised 1994, 1999, revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED:

H338-A/14 DIVERSITY IN LEADERSHIP POSITIONS
The American Osteopathic Association supports increased awareness of and encourages diversity in its leadership positions and encourages its divisional and specialty societies to do the same. 1999, revised 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H339-A/14 TOBACCO USE STATUS – REPORTING IN THE MEDICAL RECORD

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H339-A/14 TOBACCO USE STATUS – REPORTING IN THE MEDICAL RECORD

The American Osteopathic Association supports the ~~Agency for Healthcare Research and Quality's (AHRQ~~) U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) guideline on tobacco use cessation that specifically recommends ~~a method of~~ identifying tobacco use status on each patient visit to increase the likelihood of physician intervention with their patients who use tobacco. 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:
The policy is consistent with current USPSTF guidelines.

https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H344-A/14 MEDICAL COSTS INCURRED BY PATIENTS FOR SERVICES NOT COVERED BY THEIR INSURANCE

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H344-A/14 SURPRISE MEDICAL BILL ~~COSTS~~ INCURRED BY PATIENTS FOR SERVICES NOT COVERED BY THEIR INSURANCE

The American Osteopathic Association (AOA) will advocate for hospitals and other sites of medical services to inform patients in advance of scheduled procedures, who the service providers involved in their care will be and whether or not those providers are covered IN NETWORK AND COVERED by the patients' insurance. The AOA supports providing patients with an estimate of all the costs of their procedure as well as the identity of all ancillary providers that will be participating in their care in advance of the procedure if they are personally responsible for assuring payment for these services. The AOA strongly supports giving patients the opportunity to select ancillary providers who are ~~covered~~ IN NETWORK AND COVERED by their insurance so that they are not ~~exposed~~ UNKNOWINGLY RESPONSIBLE FOR MEDICAL EXPENSES AND ~~to~~ medical BILLS~~expenses for which they are not prepared~~. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H345-A/14 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT ACCESS AND USE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy
2 be REAFFIRMED:

3 **H345-A/14 ELECTRONIC MEDICAL RECORD (EMR) – STUDENT ACCESS**
4 **AND USE**
5 The American Osteopathic Association will work with the American Association of Colleges of
6 Osteopathic Medicine and the American Osteopathic Association of Medical Informatics to
7 promote the opportunity for medical students to document and practice order entry in EMRs at
8 facilities where osteopathic medical students are trained. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Professional Affairs

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH**
4 The American Osteopathic Association requests that the National Institutes of Health fund
5 independent research of the long term risk/benefits of testosterone therapy. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS – OSTEOPATHIC PHYSICIAN

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS – OSTEOPATHIC PHYSICIAN

The American Osteopathic Association ~~opposes the principle that any~~ SUPPORTS PARTICIPATION IN PATIENT satisfaction surveys **WITHOUT** ~~**WITH**~~ ~~have a significant~~ MINIMAL impact on ~~osteopathic~~ physician~~'s compensation~~PAYMENT. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: AVAILABILITY OF BIOSIMILAR PRODUCTS

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, the costs of biologics are a significant factor in rising drug prices, accounting for 38 percent of U.S. prescription drug spending, and 70 percent of drug spending growth between 2010 and 2015[1]; and

WHEREAS, entrance of biosimilars onto drug markets have significant potential to reduce drug prices and help contain spending growth, yet only 12 biosimilars have been FDA approved[2]; and

WHEREAS, the development and marketing of biosimilars should be encouraged, but additional consideration should be given to protecting patient; because biosimilars are developed with living organisms, they vary more significantly from their reference product than a chemical-based generic drug would; and

WHEREAS, physicians should maintain discretion over patient treatment plans and when therapies may be substituted in consideration of a patient's condition and circumstance; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports policies that strengthen the biosimilar market while preserving **THE** physician**-PATIENT RELATIONSHIP** ~~authority over patient care~~ and protecting patient safety; and, be it further

RESOLVED, THAT FDA APPROVED DRUGS SHOULD BE ACCESSIBLE TO PATIENTS, AND, BE IT FURTHER

RESOLVED, THAT THE DECISION ON WHICH BIOLOGIC OR BIOSIMILAR SHOULD BE USED REST WITH THE PATIENT AND THE PHYSICIAN; AND, BE IT FURTHER

RESOLVED, THAT THE AOA SUPPORTS PAYOR COVERAGE OF ALL FDA-APPROVED BIOLOGICS AND BIOSIMILARS TO ENHANCE PATIENT ACCESS AND CHOICE.~~RESOLVED, that the AOA will advocate for policies relating to the granting of "interchangeable" status to drugs that (1) requires manufacturers to study and demonstrate to the FDA that alternating between a reference product and proposed interchangeable biosimilar has no meaningful impact on patient safety or drug efficacy; (2) that physicians maintain autonomy to designate which biologic or biosimilar product is dispensed to patients; and (3) only permit drug substitutions upon approval of the physician ordering the drug.~~

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: MATERNAL MORTALITY

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

WHEREAS, the United States is the only industrialized nation with a rising maternal mortality rate[1]; and

WHEREAS, it is estimated that over 60% of the pregnancy related deaths are preventable[2]; and

WHEREAS, findings from state maternal mortality review committees reveal a growing number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period.[2]

WHEREAS, African American Women are 3-4 more times likely to die of pregnancy related complication; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports (1) the important work of maternal mortality review committees; (2) work with state and **RELEVANT** specialty medical societies to advocate for state and federal legislation **TO** establish~~ing~~ **AND MAINTAIN** Maternal Mortality Review Committees; and (3) work with state and **RELEVANT** specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

References

1. MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstet Gynecol. 2016;128(3):447-55.
2. Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs.

Explanatory Statement

Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal government collect data on maternal mortality. In some of states, where data is being collected and implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths. Our nation has a rising maternal mortality rate. Mental health conditions, including suicide and overdose, are the leading cause of maternal mortality in a growing number of states. Other causes include pre-eclampsia, obstetrical hemorrhage, cardiovascular disease and cardiomyopathy. Not all states or the federal

government collect data on maternal mortality. In some of states, where data is being collected and implementing best practices, they are showing a decrease in the maternal mortality rate. Maternal mortality review committees work to reduce preventable maternal deaths.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: EXTENDING MEDICAID **COVERAGE** TO 12 MONTHS POSTPARTUM

SUBMITTED BY: American College of Osteopathic Obstetricians and Gynecologists

REFERRED TO: Committee on Professional Affairs

WHEREAS, Medicaid is the largest single payer of maternity care in the United States, covering 42.6 percent of births and playing a critical role in ensuring healthy moms and babies[1]; and

WHEREAS, Medicaid is a women's health success story and is the pathway to jobs and financial stability for women and girls. Girls enrolled in Medicaid as children are more likely to attend college, and Medicaid coverage during pregnancy and a newborn's first year of life increases the likelihood that the child will experience upward mobility[2,3]; and

WHEREAS, Medicaid pregnancy coverage lapses at the end of the month after 60-days postpartum; and

WHEREAS, the postpartum period is simultaneously a time of vulnerability and maternal health risk, and a transition period with often unmet maternal health needs[4,5]; and

WHEREAS, findings from state maternal mortality review committees reveal a growing number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period[6]; and

WHEREAS, federal legislation has been introduced in 2019 to extend Medicaid coverage to 12-months postpartum; now, therefore be it

RESOLVED, that the American Osteopathic Association support ~~**and actively work toward enactment of**~~ state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum.

References

1. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.
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Economic Research Working Paper, 20835. Retrieved from http://www.nber.org/papers/w20835.

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Reference Committee Explanatory Statement

See references from H-335 – A/2019 which show that a majority of pregnancy-related preventable deaths occur during the postpartum period.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: NEW PHYSICIAN IN PRACTICE DEFINITION

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Professional Affairs

WHEREAS, a "new physician in practice" is not defined in the American Osteopathic Association's (AOA) Constitution and Bylaws; and

WHEREAS, there are conflicting descriptions of a "new physician in practice" referenced in the AOA Constitution, Article VIII, Section C.; and

WHEREAS, the need for osteopathic leadership among new physicians in practice is reflected by the growth of the profession and the increasing numbers of new physicians in practice, while also investing in leadership development for DOs who will one day lead the osteopathic medical profession; now, therefore be it

RESOLVED, that the American Osteopathic Association define a new physician in practice as a "physician is no more than 5 years past the completion of postdoctoral training with no more than 2 years gap in enrollment in an ACGME-approved postdoctoral training program."

Explanatory Statement

There is no absolute definition of a New Physician in Practice; however, there are two references to New Physician in Practice contained in the AOA Constitution. Article VIII, Section C. states, "…an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College Accreditation within the last 10 years…"

It should be noted that the resolution definition is intended to be inclusive of post graduate osteopathic physicians in fellowships.

Reference Committee Explanatory Statement

The Committee is concerned that this creates a definition that is inconsistent with how New Physician in Practice is defined for purposes of the New Physician in Practice position on the Board of Trustees.

ACTION TAKEN **REFERRED** *(to AOA Governance and Organizational Structure, Subcommittee on Constitution and Bylaws)*

DATE **July 27, 2019**

SUBJECT: HOSPITAL CONSOLIDATION – OPPOSITION TO

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, 87 rural hospitals closed from January 2010 through August 2018[1]; and

WHEREAS, on average 30 U.S. hospitals shutdown each year, with an increase expected this year[2]; and

WHEREAS, a larger share of the consumer health market gives merged providers more pricing power[3]; and

WHEREAS, increases in hospital market consolidation have been demonstrated as leading to an increase in the price for hospital care[4]; and

WHEREAS, providers that merged in concentrated markets experienced price increases of 20 percent or more since 2006[5]; and

WHEREAS, an analysis of 2005-2012 Medicare fee-for-service claims and enrollment data for the effect of cardiology market structure on utilization and health outcomes showed that an increase in consolidation leads to statistically and economically significant increases in negative health outcomes for patients[6]; and,

WHEREAS, that the American Osteopathic Association is concerned about the impact of hospital mergers and the consolidation of health systems on patients' access to quality and affordable care in rural and urban communities; now, therefore be it

RESOLVED, that the American Osteopathic Association opposes further consolidations of hospitals and health systems that are absent of sufficient ~~**legal safeguards in place**~~ **EVIDENCE OF AND COMMITMENT** to protect patients' access to quality and affordable care and physicians' ability to negotiate equitable relationships with hospitals and payors.

<u>References</u>

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PHARMACY BENEFIT MANAGERS – INCREASED REGULATION OF

SUBMITTED BY: Bureau of State Government Affairs / Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, multiple factors contribute to the rising cost of drugs in the United States; and

WHEREAS, consolidation in the pharmacy benefit manager (PBM) market has led to a power imbalance that favors PBMs and other corporate members in the drug supply chain, at the expense of individual consumers; and

WHEREAS, regulatory oversight of PBMs is currently limited at the federal level and in a majority of states;

WHEREAS, a lack of transparency and misaligned incentives have resulted in increased drug prices for consumers and large profits for PBMs; now, therefore be it

RESOLVED, that the resolution and following white paper be adopted as the policy of the American Osteopathic Association with respect to increased governmental regulation of pharmacy benefit managers.

PHARMACY BENEFIT MANAGERS – INCREASED REGULATION OF

BACKGROUND

The rising cost of drugs is a major concern in the U.S., where consumers pay two to six times more for prescription drugs than the rest of the world[1]. Between 2007 and 2017, drug spending in the U.S. increased by 40%, an increase largely attributable to existing drugs rather than new drugs entering the market[2]. Increased drug prices have resulted in patient noncompliance, with sometimes fatal consequences, as patients are either unable to afford their prescription medications or are forced to choose between buying them or other necessities like food and shelter.

There are a number of factors that distinguish the U.S. health care system and drug spending from other industrialized nations; for one, almost all countries except the U.S. have policies in place to lower drug prices, including price controls and cost-effectiveness thresholds[3]. By contrast, the U.S. government does not directly regulate drug prices, instead leaving it up to individual insurers to negotiate prices with drug makers. This fragmented and opaque system often results in different prices for different buyers, a power imbalance that favors corporate entities at the expense of consumers.

While numerous factors contribute to prescription drug pricing and affordability in the U.S., for purposes of this policy paper we will focus on the role of pharmacy benefit managers (PBMs)[4].

PHARMACY BENEFIT MANAGERS

PBMs are companies hired by insurers, employers, and government entities to manage prescription drug programs on behalf of health plan beneficiaries[5]. Originating several decades ago as processors of prescription drug claims for insurers, for which they earned a flat fee, PBMs initially lowered drug prices by forming large networks of health plan customers which enabled them to negotiate discounts with drug makers. Since then, consolidation among PBMs has concentrated an 85% market share in the hands of three major players (CVS Caremark, Express Scripts and OptumRX), and drug prices have risen as a result[6].

PBMs affect numerous aspects of the drug supply chain, and they are adept at leveraging their power with drug makers, employers and pharmacies to extract profits that they keep for themselves rather than passing them on to patients. As a result, patients pay cost shares that do not reflect the actual lower cost of the drug, which increases out-of-pocket costs and co-pays.

The following represents a summary of PBM revenue sources:

Rebates. PBMs decide which drugs will be covered on a prescription drug plan or plan formulary, and drug makers often pay "rebates" or other fees to PBMs to have their drugs included. Drug makers then pass these costs on to consumers in the form of higher drug prices.

PBMs also determine which pharmacies will be included in a prescription drug plan's network and how much they will be paid. Sometimes, PBMs entice plan sponsors to require beneficiaries to use a mail order pharmacy – usually one with financial ties to the PBM – for certain medications.

Prior Authorization. PBMs use prior-authorization requirements to steer patients to formulary drugs regardless of their efficacy, by requiring them to obtain prior authorization if they or their providers prefer to continue the original (non-formulary) drug. This can result in harm to patients who may miss doses or experience other negative effects from adjusting to a new drug, which may not be as effective as the one they were previously stable on.

Spread pricing. "Spread pricing" refers to the difference between what a PBM charges an insurer for a drug and what it reimburses the pharmacy for it. Neither the insurer nor the pharmacy knows what the PBM charges or reimburses the other for a particular drug, and PBMs take advantage of this lack of transparency to pocket the spread.

Gag clauses (partially mooted by the federal Patient Right to Know Drug Prices and the Know the Lowest Price Acts of 2018). Prior to the passage of the aforementioned Acts in October 2018, PBMs in most states could utilize "gag clauses" to prevent pharmacists from telling customers when their copayment amount would exceed the out-of-pocket cost of a drug. PBMs then kept the customer's overpayment, known as a "clawback," as profit. The Acts banned gag clauses, giving pharmacists the option – but *not* requiring them – to tell patients when a drug would cost less out-of-pocket.

Direct and Indirect Remuneration (DIR) Fees. DIR refers to the monies that a PBM may collect from a dispensing pharmacy to offset member costs[7]. The Centers for Medicare and Medicaid Services (CMS) originally created DIR as a way to track rebates and other price adjustments applied to Medicare Part D prescription drug plans that were not captured at the point of sale and that resulted in savings to a PBM, and ultimately to CMS (in theory).

Since its inception, DIR has transformed into a catchall term for any fees a pharmacy pays to a PBM, including fees to participate in the PBM's network or fees paid for failing to meet certain quality measures[8]. PBMs have also begun expanding the use of DIR from just Medicare Part D plans to commercial plans, and pocketing the savings. While some DIR fees are legitimate, many are assessed in an arbitrary and opaque manner that prevents pharmacies from fully understanding how much they will

be reimbursed for a prescription when entering into a PBM contract. In addition, many of the fees are charged retroactively which impacts the ability of independent pharmacies in particular to budget for, and ultimately implement, new patient services.

STATE ACTION

There is a growing desire among states to regulate PBMs, but approaches vary from state to state. Besides the gag clause ban, which Congress enacted nationally in 2018, state legislative proposals typically include one or more of the following elements: requirements that PBMs register with the state, requirements for certain mandatory disclosures by PBMs, and prohibitions on PBMs incentivizing the use of mail-order pharmacies[9].

As of December 2018, 23 states require PBMs to be licensed by a state agency. The agency promulgates rules for licensure, which may include state approval of compensation arrangements between PBMs and pharmacies to ensure that reimbursement rates are fair and reasonable, or requirements that PBMs disclose aggregate rebates to purchasers.

Thirteen states require substantial disclosures by PBMs, and sometimes by insurers as well, to promote transparency regarding rebates and the extent to which PBMs pass them on to insurers, and ultimately to patients, in the form of premium reductions or decreased cost-sharing requirements.

Three states currently have laws preventing PBMs from requiring or incentivizing patients to use mail-order pharmacies, which could drive some independent pharmacies out of business, thereby costing patients access to other services that their local pharmacies may provide. All major PBMs have their own mail-order pharmacies, which allow them to tightly control formularies and steer patients towards drugs for which they receive financial benefits, as well as to reap rewards from spread pricing. Large PBMs can also exclude other independent mail-order pharmacies from their networks and negotiate prices that allow them to undercut competitors, which raises antitrust questions.

PBMs were originally created to save consumers money, and increased regulation by states could theoretically drive up operating costs and reduce savings for consumers; however, extensive consolidation among PBMs has since tilted the balance of power away from consumers and obscured prices as well as the ability of outsiders to determine PBMs' real effect on the costs of the drug supply chain. States have little power to prevent future PBM mergers, thus increased regulation and transparency requirements may be their only effective tools.

RECOMMENDATIONS

The AOA adopts the following statements as its official position on PBMs:

State and federal governments should work to ensure that PBMs function as originally intended; that is, to save patients money. In order to accomplish this goal, a multi-pronged approach that incorporates various elements below in order to target PBMs' various revenue sources and address misaligned incentives should be considered.

PBMs should be required to publicly disclose any rebates or other "financial benefits" that they receive from other members of the drug supply chain and pass through a certain percentage to the plan sponsor. They should also be prevented from utilizing prior authorization requirements to steer patients to formulary drugs or mail-order pharmacies to which they have financial ties.

In order to improve the viability of independent pharmacies and preserve competition, PBMs should be prohibited from charging pharmacies retroactive DIR fees.

Capping patient copayments at the pharmacy reimbursement rate or the cost without insurance would help address PBM clawbacks.

THE AOA SUPPORTS HEALTH POLICY WHICH PROMOTES MAKING LIFE SAVING MEDICATIONS (I.E. EPINEPHRINE FOR ANAPHYLAXIS, NALOXONE FOR DRUG OVERDOSE, AND INSULIN/GLUCAGON FOR DIABETES) FREE FOR UNINSURED PATIENTS AND A FULLY COVERED BENEFIT FOR INSURED PATIENTS.

The U.S. Department of Justice should enforce antitrust protections to prevent additional PBM market consolidation, which is likely to lead to further drug formulary restrictions and reductions in the number of – and PBM reimbursement for – independent pharmacies.

Lastly, governmental action to improve PBM transparency is key. The Federal Trade Commission (FTC) has the unique power to shed light on the effect of PBMs on the drug supply chain through its Section 6(b) authority and accompanying subpoena power. Section 6(b) allows the FTC to "conduct wide-ranging economic studies that do not have a specific law enforcement purpose," and it could exercise this authority to obtain PBM rebate and fee information and to analyze PBMs' effects on drug pricing[10].

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3. https://thehill.com/opinion/healthcare/369727-us-drug-prices-higher-than-in-the-rest-of-the-world-heres-why
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10. https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, firearm-related deaths in the United States have increased to a twenty year high[1]; and

WHEREAS, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides, and accidents in the United States, the highest rate among industrialized countries[2,3]; and

WHEREAS, firearms are the third-leading cause of death due to injury after poisoning and motor vehicle accidents[4,5]; and

WHEREAS, 109 firearm deaths occur each day due to firearm-related homicides, suicides, and unintentional deaths[6]; and

WHEREAS, gun violence in the United States had a total societal cost of $229 billion in 2015[7]; and

Whereas, in 2017, of the 25 million individuals who submitted to a background check to purchase or transfer possession of a firearm, 103,985 were by prohibited purchasers and were blocked from making a purchase[8]; an estimated 6.6 million firearms are sold annually with no background checks[9]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will support federal legislation requiring comprehensive criminal background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) will support efforts to require firearms safety training as a condition to purchase any class of firearms in any venue; and, be it further

RESOLVED, that H421-A/15 is superseded by this resolution.

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Explanatory Statement

The intent of this policy is to supplement the following existing policies:
H630-A/18 Comprehensive Gun Violence Reform
H318-A/16 Firearms--Commission of a Crime While Using a Firearm
H340-A/16 Physician Gag Rules--Opposition To
H450-A/15 Firearm Violence
H406-A/14 Firearm Safety

Reference Committee Explanatory Statement

The Committee supports firearm safety training, and recommends that this be rewritten to focus on public health policy, in accordance with the AOA's Mission Statement.

ACTION TAKEN **REFERRED** *(to Bureau on Federal Health Programs)*

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-315 - A/2018: H316-A/13 HUMAN CLONING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

WHEREAS, sunset resolution H-315 - A/2018, titled "HUMAN CLONING", was referred to the Bureau on Scientific Affairs and Public Health for updated information; now, therefore be it

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends H-316 - A/2013 be SUNSET and the following white paper be adopted:

HUMAN CLONING

BACKGROUND

Somatic cell nuclear transfer (SCNT) or, to use the more common vernacular, cloning is the process of creating genetic duplication of a cell or an organism naturally or artificially.[1,2,3] The National Institute of Health (NIH) describes "cloning" as a process "that can be used to produce genetically identical copies of a biological entity".[4] More specifically, the National Human Genome Research Institute (NHGRI) of NIH, identifies three categories of artificial cloning: gene, reproductive and therapeutic. The latter two types of cloning are often lumped together as "human cloning," which is controversial and the focus of much debate.

TYPES OF CLONING

Gene Cloning

Gene cloning (also known as DNA cloning or molecular cloning) is the process wherein genes or segments of DNA are copied. DNA cloning is beneficial to medicine because the technology allows doctors to treat patients by replacing flawed genes associated with inherited diseases with healthy ones. Gene cloning is primarily seen in genetically engineered food and in animals to help them grow stronger. This type of cloning does not have the possibility of creating an adult living creature.

Reproductive Cloning

Reproductive cloning is the process of using SCNT to obtain eggs that could develop into an adult living creature. The mature somatic cell is transferred into another egg cell and allowed to develop into an embryo in a test-tube and then implanted into the womb of a living creature. The hope is that the outcome will be a birth with the same genetic makeup as the living creature from which the mature somatic cell was taken.

Reproductive cloning experimentation has been occurring for many decades but has primarily focused on animals as opposed to human beings. In 1979, mice were cloned by splitting mouse embryos. In 1996, the lamb, Dolly was successfully cloned. In 1998, several calves were cloned. Another notable cloning of a mammal was in 2003, when an endangered ox, Banteg, was cloned. While there have been a few successfully cloned mammals, there have been no verified successful attempts to clone a human embryo/being.

Therapeutic (Research) Cloning

Therapeutic cloning is the process of creating a cloned embryo in an effort to produce embryonic stem cells to help understand the epidemiology of diseases and to develop new treatments.[4,5] Therapeutic cloning involves some of the same techniques used in reproductive cloning. However, the stem cells are harvested from the embryo during the test tube phase, therein destroying the embryo.

ARGUMENTS FOR OR AGAINST CLONING

In the United States and worldwide, cloning remains a moral and ethical point of consternation. There are arguments both for and against the use of cloning, but there appears to be a consensus amongst many that cloning an actual human being is not acceptable.[5,6] Therapeutic cloning is often the center of most debates for many regarding balancing patient care, morals and ethics.

Arguments against therapeutic and reproductive cloning[6]:

- Reproductive and therapeutic cloning leads to the destruction of human embryos which many see as viable human life.
- Reproductive cloning usurps the divine plan or interferes with the natural order.
- Cloning violates human dignity and treats human beings as commodities or items to be manufactured.
- Cloning causes risks to human health; the majority of implanted embryos die in gestation or result in births with significant abnormalities. In addition, the need for human embryos may cause women in poverty to compromise health due to incentives to sell embryos.

Arguments for therapeutic and reproductive cloning[6]:

- Reproductive and therapeutic cloning presents a unique ability to research and identify treatments to address human diseases by providing insight to researchers on developmental and pathogenic events not discoverable otherwise.
- Cloning may lead to alleviation of human suffering and cures for costly and debilitating diseases by providing genetically matched tissue for transplantation.
- Cloning promotes scientific inquiry.

LEGISLATION IN THE U.S. ON CLONING

Currently, the federal government does not explicitly prohibit cloning. However, the government does prohibit the use of federal funds for cloning, regardless of the purpose (therapeutic or reproductive cloning). [6,7] The NIH primarily conducts gene cloning. NIH relies on federal funding which is prohibited from being used in therapeutic or reproductive cloning activities, and accordingly, NIH researchers have not cloned any mammals nor have any of the institutions or centers supported human cloning activities.

The Food and Drug Administration (FDA) has weighed in on human reproductive cloning. In a 1998 letter about human cloning, the FDA claimed jurisdiction over clinical research using cloning technology for reproductive purposes. The FDA equated using cloning technology to the same process as developing new drugs.[8] In a second letter dated March 28, 2001, regarding Cloning Technology, the agency reiterated its jurisdiction over clinical research using such technology. The FDA explicitly stated that the process is subject to the Health Service Act and the Federal Food, Drug and Cosmetic Act. also indicated that all approval responsibilities for any human clinical use of any therapies derived from cloning research fell within its purview.[9]

In an effort to address the void left by the federal government, several state legislatures have provided guidance on human cloning.[7]

- **Eight (8) states** prohibit human cloning for any purpose – no reproductive or therapeutic cloning (cloned human embryos for embryonic stem cell research as well as to implant in a uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota and Virginia
- **Six (6) states** prohibit state funding of human cloning for any purpose – Arizona, Arkansas[10], Indiana, Louisiana, Maine and Nebraska
- **Ten (10) states** have "clone and kill" laws which allow therapeutic cloning research, but prohibit cloning of embryos to be implanted for childbirth (reproductive cloning) – California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, Montana, New Jersey and Rhode Island
- **Five (5) states** allow state funding for embryonic stem cell research (therapeutic cloning or in vitro fertilization) – California, Illinois, Missouri, Maryland and New York
- **Two (2) states** have legislation that precludes health professionals from being compelled to participate in human cloning (healthcare rights of conscience laws) – Idaho and Louisiana

Twenty-six (26) states and the District of Columbia do not have any legislation addressing therapeutic (biomedical research) and/or reproductive (to produce children) cloning.

These data were pulled from sources dated between 2015 through 2019. To the best of BSAPH's knowledge, these policies remain in effect as of May 1, 2019.

KEY ORGANIZATIONS SUPPORTING THERAPEUTIC/RESEARCH CLONING

Many key organizations have made position statements regarding the benefits it views in therapeutic cloning and accordingly expressed their support. In addition, these organizations have declined to support cloning for reproductive purposes. These organizations include:

American Association for the Advancement of Science (AAAS) – The AAAS has a statement on Human Cloning that states it endorses a legally enforceable ban on efforts to implant a human cloned embryo for the purpose of reproduction.[11] AAAS recognizes that the health risks associated with reproductive cloning make such cloning unconscionable. The AAAS, however, does encourage continued dialogue as new technology advances emerge.

Also, AAAS supports stem cell research (genetic and therapeutic cloning) which has potential health benefits. The AAAS calls for strict monitoring of the process and developments and appropriate oversight through regulation. [11]

American Association of Medical Colleges (AAMC) – On its website under the Advocacy section, the AAMC expressly supports ongoing research into SCNT and endorses legislation that would allow therapeutic/research cloning.[12] Additionally, the AAMC recommends a ban on all forms of reproductive cloning.

American Bar Association (ABA) - The ABA addressed this issue in 2002 and 2004. ABA supports law and policy prohibiting reproductive cloning. [13,14]

American Medical Association (AMA) - The AMA does not endorse reproductive cloning. However, if in the future reproductive cloning is permitted, the AMA acknowledges that physicians must be educated and understand somatic cell donors must provide informed consent. Additionally, any child produced through reproductive cloning is recognized as a human-being. Code of Medical Ethics Opinion 4.2.6.[15]

The AMA says physicians can determine whether they will participate in stem cell research or use its products. The AMA implores clinician researchers to be able to articulate the risks and benefits of embryonic stem cell use for research purposes. In addition, AMA encourages physicians to allow their

commitment to the welfare of patients to guide them in their professional standards. Code of Medical Ethics Opinion 7.3.[16]

National Academies of Medicine, Sciences and Engineering (National Academies) - The National Academies, based on recommendations generated by 2002 joint panel, recommends a legally enforceable ban on the practice of human reproductive cloning, but does support using SCNT to produce stem cells for developing new medical therapies for life-threatening diseases and advancing knowledge.[17]

AOA AND HUMAN CLONING

The osteopathic community and the AOA have discussed this issue at length since 1998. Recognizing the moral and ethical dilemmas of human cloning, AOA has continued to monitor the issue and provide updates to its constituents in order to facilitate a discussion.

After reviewing the existing literature on cloning, the American Osteopathic Association (AOA) adopts the following policies:

1. The AOA does not endorse the practice of human cloning for purposes of reproduction (efforts to implant a human cloned embryo for the purpose of reproduction).
2. The AOA recognizes the benefits and harms of human cloning for therapeutic (research) purposes with respect to embryos, donors and patients suffering from debilitating and life-threatening diseases and conditions. Physicians shall have the autonomy to determine whether or not they will participate in therapeutic cloning. They should carefully weigh all ethical and moral aspects of the process and determine what is best for the well-being of patients, society as a whole, and the advancement of medical knowledge and practice.
3. The AOA shall review its policy in light of any new evidence that will be generated by research entities as well as monitor state and federal legislation in the field and update the policy as necessary.

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12. Association of American Medical Colleges. Somatic Cell Nuclear Transfer (Therapeutic Cloning). Retrieved May 1, 2019 from https://www.aamc.org/advocacy/research/283222/stemcellresearch.html.
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15. American Medical Association. Cloning for Reproduction. Code of Medical Ethics Opinion 4.2.6. Retrieved May 1, 2019 from https://www.ama-assn.org/delivering-care/ethics/cloning-reproduction.
16. American Medical Association. Research with Stem Cells. Code of Medical Ethics Opinion 7.3.8. Retrieved May 1, 2019 from https://www.ama-assn.org/delivering-care/ethics/research-stem-cells.
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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: MISALIGNED INCENTIVES IN MEDICARE PLANS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, third party payers and Pharmacy Benefit Managers (PBMs) incentivize patients to be cost conscious by encouraging the use of lower cost medications and services through deductibles, copayments, and the "donut hole"; and

WHEREAS, third party payers and PBMs incentivize physicians through the use of claims analysis, such as HEDIS measures; and

WHEREAS, HEDIS measures require claims to be made through the payer or PBM directly from the pharmacy; and

WHEREAS, purchasing medications for a "cash price" may be less expensive, but will not result in the collection of claims data impacting physician quality measures; and

WHEREAS, these incentives create conflicting priorities, and subsequently potential ethical pitfalls, for a patient to obtain medications outside of the PBM, and for the physician to be penalized for this; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~is opposed~~ **SUPPORT** ~~to incentives that do not~~ **EFFORTS TO** align patient's behaviors with cost-effective, reportable high quality care; and, be it further

RESOLVED, that the AOA will work to identify these misaligned incentives**, AND ADVOCATE FOR CHANGES TO THE MEDICARE PROGRAM THAT SUPPORT PHYSICIANS IN DELIVERING HIGH-VALUE CARE AND DISCOURAGE PLANS FROM PREVENTING PATIENTS FROM SEEKING LOWER COST-EFFECTIVE TREATMENT OPTIONS;**; and, be it further

RESOLVED, that the AOA will seek to ~~influence~~ **EDUCATE** third party payers and Pharmacy Benefit Managers to align patient and physician incentives, and, be it further

RESOLVED, that the AOA will advocate **AGAINST** ~~for the prohibition of~~ misaligned **PAYMENT AND QUALITY** incentives in Federal Healthcare programs **THAT DO NOT PROMOTE IMPROVED HEALTH OUTCOMES.**~~through legislation and other regulations designed to prevent competing incentives.~~**; AND, BE IT FURTHER**

RESOLVED, THAT THE AOA WORKS TO EDUCATE THE NCQA REGARDING THE NEED TO MODIFY HEDIS RULES.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: WHITE PAPERS - UPDATING

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the American Osteopathic Association (AOA) has developed many detailed, in-depth policy statements also known as "white papers"; and

WHEREAS, these "white papers" often contain citations of relevant statistics, studies, and other data; and

WHEREAS, the AOA attempts to use the most current data to compile these "white papers"; and

WHEREAS, the AOA reviews all of its policies on a rolling five year basis; and

WHEREAS, the AOA desires to have policy statements which are up-to-date and relevant to the current environment; now, therefore be it

RESOLVED, that when policies which are or include a "white paper" as a part of the policy are reviewed as part of the regular policy review process, the reviewing entity shall review and update all statistics, studies, and other data to ensure that these references are the most up-to-date statistics, studies, and data that are available; and, be it further

RESOLVED, that the reviewing entity shall affirm in an explanatory statement that all statistics, studies, and other data have been reviewed and are the most current available.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: DEVELOPMENT OF A NATIONAL IMMUNIZATION INFORMATION REGISTRY

SUBMITTED BY: Illinois Osteopathic Medical Society

REFERRED TO: Committee on Professional Affairs

WHEREAS, immunizations currently prevent 2-3 million deaths each year worldwide; and

WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates worldwide; and

WHEREAS, vaccines not only provide individual protection for those persons who are vaccinated, they can also provide community protection by reducing the spread of disease within a population; and

WHEREAS, physicians, patient care providers, and pharmacists have a responsibility/duty to promote immunizations to all eligible people for vaccines; and

WHEREAS, vaccinations can be administered in many settings including physician offices, community health fairs and local pharmacies providing more convenient and accessible option for people to receive needed immunizations; and

WHEREAS, patients often change vaccination providers during the course of an individual's vaccination series; and

WHEREAS, patient's do not always communicate receipt of vaccines to their healthcare providers; and

WHEREAS, it is often necessary for providers to be able to access immunization records in emergency situations; now, therefore be it

RESOLVED, that any healthcare provider delivering vaccination services must document administration of all immunizations in a national immunization information registry; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) advocate for development of a national immunization information registry.

Explanatory Statement

Requiring documentation of all vaccinations administered by any healthcare provider in a mandatory National Immunization Information Registry would provide healthcare providers with vital information about their patient's vaccination status, allowing for improved vaccination rates and appropriate vaccine completion, thereby reducing the number of deaths and other complications from vaccine preventable diseases, and reduction in the number of duplicate vaccinations received by patients.

References

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Orenstein, W. a. (2017, April 10). Simply put: Vaccination saves lives. *Proceedings of the National Academy of Sciences of the United States of America*, pp. 114 - 116.

Vaccines & Immunizations: What Would Happen If We Stopped Vaccinations? (2018, June 29). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/vac-gen/whatifstop.htm

Reference Committee Explanatory Statement

The Committee believes that this Resolution is duplicative of H629-A/19 CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: CONSULTANT REPORTS ACCESSIBILITY/ AVAILABILITY-AMERICAN OSTEOPATHIC ASSOCIATION

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the mission of the American Osteopathic Association (AOA) is to advance the distinctive philosophy and practice of osteopathic medicine[1]; and

WHEREAS, as the legislative body of the AOA, the House of Delegates shall exercise the delegated powers of the divisional societies in the affairs of the AOA, and shall perform such other functions as set forth in the Bylaws[2]; and

WHEREAS, delegates are duly elected by AOA Divisional Societies[3]; and

WHEREAS, it is widely accepted that sound decisions are best made on factual data, information, and knowledge[4]; and

WHEREAS, AOA consultant reports base recommendations on distillation of facts so better decisions can be made[5]; and

WHEREAS, delegate responsibilities include serving on reference committees, participating in caucuses, testifying at reference committee hearings, and ultimately voting on reference committee recommendations[6]; and

WHEREAS, the accuracy, reliability, veracity, and validity of consultant recommendations can only be assured through transparency of the entire unredacted report[7]; now, therefore be it

RESOLVED, that in order for the members of the American Osteopathic Association (AOA) House of Delegates to perform their duties as mandated in the Association Bylaws, all AOA consultant reports shall be made available in their entirety, without alterations, deletions, or redactions, to any AOA member, Divisional Society Executive Director, and/or Health Policy Fellow.

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5. https://hbr.org/1982/09/consulting-is-more-than-giving-advice
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Reference Committee Explanatory Statement

The Committee is concerned that this resolution is too broad and requests that it be clarified and that it acknowledge legal limitations which restrict information disclosure and dissemination.

ACTION TAKEN **REFERRED** *(to Kentucky Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: WHISTLEBLOWER POLICY – AMERICAN OSTEOPATHIC ASSOCIATION

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Sarbanes-Oxley Act of 2002[1], which applies to publicly-traded companies and requires them to adhere to standards in governance that increase the role board member play in overseeing financial transactions and auditing procedures; and

WHEREAS, responsible nonprofits have been using the Sarbanes-Oxley as a standard for their own financial practices, as these practices can only improve a nonprofit's internal controls and provide needed transparency; and

WHEREAS, other provisions of Sarbanes-Oxley and the IRS 990 Form[2] regulate, insider transactions and conflicts of interest, disclosure or transparency to the public, whistleblower protection and document destruction; and

WHEREAS, in an era of greater scrutiny of nonprofit organizations, Sarbanes-Oxley provides an excellent blueprint for nonprofits to reach a level of governance that can only help their reputations and ensure the trust of their members, donors and supporters; and

WHEREAS, the AOA has many members and friends of the profession e.g. state & specialty executive directors, PhD faculty at osteopathic institutions, etc., and many of those are called on to voluntarily serve on bureaus, councils and committees or intermittently advise the organization on relevant subject matter, without whose work the AOA would not be able to fulfill its mission to advance the practice of osteopathic medicine; and

WHEREAS, the current AOA Whistleblower Policy does not clearly include these members and/or volunteers as it is currently outlined, and it is prudent to have one organizational policy; and

WHEREAS, those members and/or volunteers may be reluctant to report any concerns that arise regarding the governance of the organization secondary to potential retaliatory measures by the organization, leadership or staff; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy:

Whistleblower Policy

The AOA encourages its employees and members and/or volunteers to disclose and report concerns regarding perceived violations of federal and state laws and regulations and perceived financial irregularities.

Such reports may be made by any employee or member and/or volunteer openly, confidentially or anonymously, and they may be made in person, by telephone or in writing, including email.

Employees can report such concerns without fear of reprisal to any of the following individuals: department directors, the chief operations officer, the associate executive directors, the chief financial officer, the general counsel, the executive director or the AOA president. Employees can also report such concerns to the AOA Audit Committee.

Members and/or volunteers may report any concerns, charges or complaints to the AOA Committee on Ethics, including violations of the AOA Constitution & Bylaws, as per Article VII, Section 1(h).

Employees or members and/or volunteers who prefer to raise their concerns confidentially may do so by sending the appropriate executive or committee as outlined above a sealed envelope through US mail or interoffice mail and marking the envelope "Personal & Confidential" or by sending an email with the words "Personal & Confidential "in the subject line.

AOA employees or members and/or volunteers may also report their concerns about perceived violations of federal and state laws and regulations and perceived financial irregularities to appropriate governmental agencies without fear of adverse action.

The AOA complies with all applicable requirements of federal and state statutes and regulations concerning employee or member and/or volunteer "whistleblower" activity, including, without limitation, the Illinois Whistleblower Act [740 ILCS174/5, *et seq*].[3]

Among its provisions, the Illinois Whistleblower Act prohibits an employer from discharging or otherwise retaliating against an employee for any of the following actions:

- disclosing to a law enforcement agency or other government agency information that the employer reasonably believes discloses a violation of any state or federal law, rule or regulation
- refusing to participate in any activity that would result in the violation of any state or federal law, rule or regulation.

The Illinois Whistleblower Act also prohibits an employer from making, adopting or enforcing any rule, regulation or policy that prevents its employees from disclosing information to a government or law enforcement agency when employees have reasonable cause to believe that the information concerns a violation of a state or federal law, rule or regulation.

Likewise, the AOA extends these same protections for whistleblowing activity to its members and/ or volunteers. The AOA prohibits retaliation, or threat of retaliation, by or on behalf of the AOA, against members and/ or volunteers for making good faith complaints, reports or inquiries under this policy or for participating in a review or investigation under this policy. This protection extends to those whose allegations are made in good faith, but prove to be mistaken. The AOA reserves the right to discipline persons who make bad faith, knowingly false, or vexatious complaints, reports or inquiries.

References

1. https://pcaobus.org/About/History/Documents/PDFs/Sarbanes_Oxley_Act_of_2002.pdf
2. https://www.irs.gov/pub/irs-pdf/i990.pdf
3. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2495&ChapterID=57

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION – ORGANIZATIONAL HEALTH, VIABILITY & TRANSPARENCY

SUBMITTED BY: Kentucky Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the American Osteopathic Association (AOA) maintains a Healthy and Viable Affiliate Organizations Program to monitor and assess the status of its affiliated organizations; and

WHEREAS, AOA state and specialty affiliates are required to report the number of classes of membership annually, as well as detailed financial statements, tax returns, board contacts, and annual reports; and

WHEREAS, AOA membership numbers cannot be assumed to remain stable given a number of factors including decoupling of AOA board certification and membership, the myriad of professional organizations physicians are required to join, decreased employer reimbursement of professional dues; and

WHEREAS, transparent, healthy, and viable organizations require bidirectional communication and accountability between a parent organization and its affiliates; now, therefore be it

RESOLVED, that the American Osteopathic Association, in order to be transparent and to assure a healthy and viable organization, will annually report to the affiliate organizations the following:

1. The numbers in each Class of Membership
2. Detailed financial statements, including tax returns and audits
3. A complete list of Board of Trustees' contact information
4. Clear annual reports accounting for how funds were spent and progress made, including a description of how the expenditure directly helped physicians in practice or contributed to the advancement of the profession

Reference Committee Explanatory Statement

The resolution calls for the AOA to provide detailed confidential business information and reports to affiliated organizations that owe no fiduciary responsibilities to the AOA, creating a risk of public release of confidential information. Moreover, the proposed disclosures are unnecessary and excessive. The AOA already makes contact information available for its Trustees (FirstInitialLastNameDO@osteopathic.org), makes tax and financial information available to members on request, its 990 tax returns are available on-line, and it provides detailed budget and expenditure information to existing appropriate oversight bodies (Finance Committee oversight of audit process, Joint Board-House Budget Review Committee).

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: EXPANSION OF MEDICAID IN ALL STATES

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Patient Protection and Affordable Care Act (PPACA) allows states to expand Medicaid coverage to persons whose income is below 138% of the federal poverty level ($16,753 for an individual or $34,638 for a family of four in 2019), with the federal government paying 93% of the expansion cost for new enrollees in 2019 and 90% in 2020 and beyond; and

WHEREAS, the PPACA has resulted in a reduction in the healthcare uninsured rate in the United States from 16% in 2010 to 8.8% in Q1 2018[1]; and

WHEREAS, states that have enacted Medicaid expansion have experienced a reduction in uninsured patients to 8.7% and states that did not expand Medicaid still have 18.4% uninsured; and

WHEREAS, the Michigan Osteopathic Association supported the Medicaid Expansion with targeted lobbying efforts in the State of Michigan; and

WHEREAS, Michigan's Medicaid expansion enrollment exceeded 600,000 individuals by March 2015, and serves as an effective model for states that have not as yet enacted Medicaid expansion[2]; and

WHEREAS, as of January 2019, 14 states (Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Wyoming) have failed to enact legislation to expand Medicaid eligibility; and

WHEREAS, research shows that Medicaid expansion has helped to reduce disparities in coverage by income and age, has had positive economic outcomes in expansion states, and infant mortality rates have declined in Medicaid expansion states and risen in states that have not enacted Medicaid expansion[3]; and

WHEREAS, studies provide evidence that Medicaid expansion reduces mortality from drug overdoses and increases access to treatment[4]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) incorporate Medicaid expansion as a top priority to improve patient access to care and to improve health outcomes; and be it further

RESOLVED, that the AOA support Medicaid expansion in the 14 states that have not as yet enacted relevant legislation to expand Medicaid eligibility to uninsured individuals who meet the definitions to qualify based on the 138% of federal poverty level as provided in the Patient Protection and Affordable Care Act.

References
1. https://www.healthaffairs.org/d0/10.1377/hblog20180913.896261/full/
2. http://www.detroitnews.com/story/news/politics/2015/03/31/snyder-medicaid-expansion-reaches-residents/70731872/
3. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/
4. https://ldi.upenn.edu/healthpolicysense/medicaid-expansion-and-opioid-epidemic

Reference Committee Explanatory Statement
The Committee believes that existing policy H338-A/18 UNINSURED – ACCESS TO HEALTH CARE is more comprehensive and covers the concerns of this resolution. Further, this resolution may be overly prescriptive, veer outside of health care policy, and does not appropriately take into account the financial constraints of states, as well as other state-based health care programs that may be in place.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: SUPPORT FOR OMT PRIVILEGES

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, the osteopathic profession has undergone unprecedented growth in the last 20
2 years, with DOs expected to represent 25% of all graduates in 2020; and

3 WHEREAS, with increased brand awareness of osteopathic medicine the use of osteopathic
4 manipulative treatment (OMT) is expected to increase; and

5 WHEREAS, the use of OMT has been shown to decrease use of oral pain medication (Prinsen
6 JAOA 2014) including opiates, and thus can play a role in addressing the current opioid
7 crisis; and

8 WHEREAS, many osteopathic physicians encounter difficulties when trying to obtain privileges
9 for the use of OMT within medical systems and hospitals; and

10 WHEREAS, the American Osteopathic Association does not have a standardized hospital
11 privileging document for OMT; now, therefore be it

12 RESOLVED, that the American Osteopathic Association (AOA) support and advocate for all
13 physicians who desire to practice osteopathic manipulative treatment (OMT) within
14 medical systems and hospitals; and, be it further

15 RESOLVED, that the AOA create guidelines that can be distributed upon request to hospitals,
16 medical systems, and other interested entities that standardize credentialing and
17 privileging processes, including proctoring and approval of privileges to practice OMT.

Explanatory Statement

Reference:

Prinsen JK, Hensel KL, Snow RJ. OMT associated with reduced analgesic prescribing and fewer missed work days in patients with low back pain: an observational study. J Am Osteopath Assoc. 2014;114(2): 90-98

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: ANTI-INTIMIDATION STANDARDS AMONG PHYSICIANS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the rate of suicide among physicians is greater than that of the general population and more than half of surveyed medical students (58%) and residents (50.7%) screen positive for depression[1,2]; and

WHEREAS, according to a 2015-2016 survey of U.S. residents and fellows, 48% of the respondents indicated they experienced bullying behavior from other healthcare professionals including attending physicians (29%) and nurses (27%) contributing negatively to the training environment and impacting physician wellness[3]; and

WHEREAS, the most common bullying behaviors described in the healthcare setting include belittling, undermining work, work sabotage, unjustified criticism, and excessive monitoring of one's work, followed by sarcasm, destructive innuendo, critical comparisons among colleagues, and attempts to humiliate[3,4]; and

WHEREAS, there is an increased awareness of the impact intimidation plays on job satisfaction, toxic/difficult work environment, and the hierarchical culture pervasive in medical education and graduate medical education; now, therefore be it

RESOLVED, that the American Osteopathic Association support the implementation of anti-intimidation standards within healthcare training programs and workplaces.

References

1. Dyrbye L. et al. Burnout among U.S. medical student, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014 Mar; 89(3):443-451.
2. http://afsp.org/wp-content/uploads/2016/11/ten-facts-about-physician-suicide.pdf. Accessed April 1, 2018
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5. 4. https://www2.bostonglobe.com/ideas/2019/03/15/america-becoming-doctor-can-prove-fatal/u3x4xfPC9VR2zSCnKArgYM/story.html. Accessed April 25, 2019

Explanatory Statement

In an effort to improve physician wellness, one actionable item is to create a culture of safety and caring rather than intimidation in the traditional, toxic hierarchical teaching structure within medical education. The goal is to reduce the incidence of depression, substance abuse, and suicide among physicians and physicians in training.

Reference Committee Explanatory Statement
The Committee believes that H505-A/19 AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT covers the concerns of this resolution.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: ADVOCATING FOR WOMEN'S RIGHT TO REPRODUCTIVE HEALTHCARE ACCESS AND SUPPORT OF ROE V. WADE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Supreme Court ruled in favor Jane Roe and the pursuit of safe, legal abortion rights for women in the United States in 1973 in response to the unconstitutionality of states' imposition of laws and statutes that interfere with an individual's right to autonomy and privacy regarding the creation of a family[1]; and

WHEREAS, in 1967, 17% of pregnancy-induced maternal demise was due to illegal abortion complications performed without medical personnel and resources[2]; and

WHEREAS, according the CDC Abortion Surveillance Systems, "652,639 legal induced abortions were reported," which indicate 652,639 women chose abortion as their choice of medical care in 2014, elucidating the enormity of need of such resources and patient autonomy[3]; and

WHEREAS, according the CDC Abortion Surveillance Systems,[4] (.0006%) women died in 2013 as a result of complications post legal abortion[3], further elucidating the benefit of women's rights to choose as opposed to the aforementioned loss of life while abortion was made illegal nationwide; and

WHEREAS, women of low socioeconomic status and minorities will suffer the brunt of the repercussions of overturning Roe v. Wade due to the loss of funding protections for Title X subsidiaries, like Planned Parenthood, that provide affordable reproductive healthcare that includes annual mammograms, preventative gynecological healthcare and screenings, access to birth control, sexual education, and safe abortion procedures, leading to increased incidences of malignancies, unplanned and unwanted pregnancies, and unsafe abortion practices[4]; and

WHEREAS, "abortion in the United States is an extremely safe procedure. Restrictions imposed in some states are not based on medical evidence and will do nothing to improve women's health and safety. In fact, these requirements put women at risk by standing in the way of safe reproductive care."[8]; and

WHEREAS, "research shows that carrying an unwanted pregnancy to term is more dangerous to a woman's health than abortion."[8]; and

WHEREAS, "induced abortion is among the safest outpatient procedures performed in the United States."[9]; and

WHEREAS, "the risk of mortality from childbirth in the United States is estimated to be 14 times higher than the risk from induced abortion, and the risk of all maternal

morbidities, defined as "conditions either unique to pregnancy or potentially exacerbated by pregnancy that occurred in at least 5% of all pregnancies" is significantly higher among women who give birth than among those who have abortions."[9]; and

WHEREAS, "the evidence suggests that unintended pregnancy is one of the most critical challenges facing the public health system and imposes significant financial and social costs on society. Long-term studies confirm that reducing unintended pregnancy incidences would increase labor force participation rates, improve academic achievement, have better economic efficiency, increase the level of health and reduce in crime rates among vulnerable groups."[10]; and

WHEREAS, the American College of Obstetrics and Gynecology (ACOG) holds and supports the committee opinion for clinical guidelines on women's reproductive health and rights that "safe, legal abortion is a necessary component of women's health care… Legislative restrictions fundamentally interfere with the patient-provider relationship and decrease access to abortion for all women, and particularly for low-income women and those living long distances from health care providers."[4]; and

WHEREAS, ACOG, which currently represents 58,000 OG/GYNs in the U.S. and abroad[8], and the American Congress of Obstetricians and Gynecology published a position statement in 2016 emphasizing that "...Prohibitions on essential care that are based on religious or other non-scientific grounds can jeopardize women's health and safety."[5]; and

WHEREAS, physicians are trained to serve with the patient's best interest in mind, regardless of personal moral or ethical convictions as long as the legal standard of care is practiced; and

WHEREAS, the decision to safely terminate pregnancy should be solely at the discretion of the patient and their healthcare team; and

WHEREAS, opposition to abortion lies on moral premise, judgement, and conviction and on the idea that states should be held financially and socially accountable for the welfare of women who become unexpectedly pregnant according to ACOG[6]; now, therefore be it

RESOLVED, that the American Osteopathic Association stand by the American College of Obstetrics and Gynecology in their recommendation of increased provisions for safe and legal abortion and reproductive healthcare resources and opposition of the reversal of Roe v. Wade by drafting an official statement reflecting this position.

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Explanatory Statement

The reversal of Roe v. Wade will undoubtedly increase the rate of illegal abortions performed in the United States, vastly increasing infertility and mortality risks due to patients' lack of knowledge on how and when to best perform these procedures via chemical methods. Abortions will occur regardless of its legality. At the forefront of our oath and practice is the patient's right to safety, autonomy and dignity. Therefore, depriving women of the right to safe, legal access to reproductive health, family planning, and abortion services is not only unconstitutional but directly infringes on their right to autonomy over their bodies and lives.

Moreover, women of low socioeconomic background are at highest risk due to the inevitable reduction of funding allocated to Title X programs liked Planned Parenthood. As a result, we stand in strong opposition to the reversal of Roe v. Wade, the subsequent legal repercussions for female patients who seek autonomy, and the danger to life that is illegal abortion.

Reference Committee Explanatory Statement

The Committee recognizes that this is a divisive topic, and wishes to respect individual physician and patient beliefs. The Committee supports comprehensive reproductive health care, as well as policies that support care for patient populations while protecting the individual physician-patient relationship as reflected in H358-A/19 INTERFERENCE LAWS; however, it feels that the content of this resolution veers overly into politics.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: ADVOCATING FOR MORE DO REPRESENTATION WITHIN MEDICAL TV SHOWS AND MOVIES

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are currently 114,425 practicing osteopathic physicians (DOs) in the United States and DOs are projected to represent more than 20% of all practicing physicians by 2020[1]; and

WHEREAS, 57% of DO physicians work in a primary care specialty and 40% work in specialties such as emergency medicine, OB/GYN, anesthesiology, general surgery, and psychiatry[1]; and

WHEREAS, there have been few, if any, DO physicians represented in any of the major medical dramas (e.g., Grey's Anatomy, Chicago Med, The Good Doctor, ER, etc.) or other forms of entertainment media; and

WHEREAS, public perception of physicians is influenced by how positively or negatively by they are portrayed on television[2]; and

WHEREAS, viewers of certain medical dramas perceive what they view on TV as credible[3] and undoubtedly incorporate their perception into expectations as a patient; and

WHEREAS, it is the goal of the American Osteopathic Association to "advance the distinctive philosophy and practice of osteopathic medicine"[4]; now, therefore be it

RESOLVED, that the American Osteopathic Association supports, advocates, and lobbies for increased representation and accurate portrayal of osteopathic physicians as characters in media, including, but not limited to: television shows and movies.

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Explanatory Statement

Increasing the number of osteopathic physicians on TV and in movies has the potential to help educate the public about our profession and furthermore demonstrate the unlimited license to practice medicine that DOs hold in all 50 states. Lobbying for this exposure will be an efficient and cost-effective way to promote the DO brand. In addition, research showing that the public view of the profession is influenced by TV medical dramas suggests that viewing osteopathic physicians on television will result in viewers (the public) having an increased level of trust and familiarity with our profession..

Reference Committee Explanatory Statement

Due to organizational resource limitations, existing branding campaign, and high-profile osteopathic physicians on social media BOT feels that this resolution is appropriately addressed through existing channels. Further, the Committee believes that "advocating" and "lobbying for" this resolution falls outside the approved scope and resources of AOA departments.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: DECRIMINALIZATION OF SELF-INDUCED ABORTION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, self-induced abortion is a deliberate termination of pregnancy performed by the woman herself or with the help of non-medical assistance[1]; and

WHEREAS, nearly half of the pregnancies in the United States are unintended[2]; and

WHEREAS, unintended pregnancies in the United States are most common among women and girls of low income, especially those who are below the federal poverty level[2]; and

WHEREAS, more than 700,000 Google searches were performed looking into self-induced abortions in 2015[3]; and

WHEREAS, unintended pregnancy may be the driving factor behind internet searches related to self-induced abortion[4]; and

WHEREAS, a study with 1,235 respondents found that 73% of those individuals searching for self-induced abortion indicated that they were pregnant and did not want to be, and 11% of those respondents reported that they had ever attempted to self-induce an abortion[4]; and

WHEREAS, a variety of factors may serve as barriers to the utilization of abortion care including, but not limited to, financial constraints, state or clinic restrictions, and travel-related logistical issues[5]; and

WHEREAS, the World Health Organization (WHO) states that "nearly every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe and legal induced abortion, and timely care for complications[6];" and

WHEREAS, the American Medical Association (AMA) policy H-5.980 opposes the criminalization of self-induced abortion, as does the American College of Obstetricians and Gynecologists (ACOG) in the position statement on the matter[7,8]; and

WHEREAS, the Massachusetts Medical Society states support of advocating against any legislative efforts that criminalize self-induced abortion[9]; and

WHEREAS, the WHO defines an "unsafe abortion" as a "procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both," which encompasses self-induced abortion[10]; and

WHEREAS, part of the WHO's reproductive health strategy published in 2004 outlines that most maternal deaths arise from complications during childbirth, the postpartum period, or after unsafe abortions[11]; and

WHEREAS, as a 2014 study estimates that 2% of abortion patients had attempted a self-induced abortion at some point[8]; and

WHEREAS, there are estimates that show in certain states as many as 100,000 women may have attempted to self-induce an abortion[12]; and

WHEREAS, abortions managed by appropriately licensed and skilled practitioners carry risk, like any medical procedure, such as infection hemorrhage, or damage to the uterus and other organs[13]; and

WHEREAS, the criminalization of self-induced abortions may directly impact patient care by leading to increased suspicion of patients presenting to healthcare providers for miscarriages, potentially reducing the likelihood of patients seeking needed treatment[14]; and

WHEREAS, self-induced abortions without appropriate medical supervision would be subject to the same, if not greater, risk; and

WHEREAS, a report from the SIA legal team shows that Arizona, Delaware, Idaho, Nevada, New York, Oklahoma and South Carolina have laws on record with language that directly criminalizes self-induced abortion[15]; and

WHEREAS, prosecutorial overreach may be used to press criminal charges against patients who have participated in self-induced abortion; and

WHEREAS, patients who have attempted to self-induce an abortion may be less prone to access the healthcare system regarding complications due to fear of legal retribution; now, therefore be it

RESOLVED, that the American Osteopathic Association stand in support of the decriminalization of self-induced abortions along with legislative efforts to support that goal, and oppose legislation that criminalizes self-induced abortion on the basis that these criminalization efforts may increase our patient's medical risk and threaten their well-being.

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Reference Committee Explanatory Statement

The Committee supports harm reduction strategies that encourage patients to seek needed health care without fear of legal repercussions, as in the case of a minor who may avoid seeking treatment for illness resulting from underage drinking in addition to the intent of this resolution; however, the Committee believes that the resolution should be referred back to SOMA for clarification and refinement.

ACTION TAKEN **REFERRED** *(to Student Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: DE-STIGMATIZATION OF MENTAL ILLNESS IN PHYSICIANS

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, a 2013 study published in General Hospital Psychiatry found that of about 203 physicians that succeeded in committing suicide, toxicology results showed a low rate of pharmaceutical treatment and analysis of victim cases showed that many were mentally ill or experienced problems related to job stress[1,2]; and

WHEREAS, a 2016 survey of 2106 female physicians found that nearly 50% felt that they met criteria for a mental illness but refused treatment[3]; and

WHEREAS, "fear of reporting the diagnosis to a medical licensing board" and "belief that a diagnosis was embarrassing or shameful" are two reasons that were given by surveyed female physicians behind not receiving treatment for their mental illness[3]; and

WHEREAS, for female physicians with a formal diagnosis in this survey, only 6% disclosed their diagnosis on medical licensing applications[3]; and

WHEREAS, a 2017 study evaluated how many states have initial and renewal licensure applications are considered "consistent" (the application did not have any questions about mental health conditions or only asked about current impairment from a mental health condition) and found that from 51 applications (the 50 states plus the district of Columbia), only one-third of states have applications that are considered to be "consistent"[4]; and

WHEREAS, 2,325 of 5,829 physicians surveyed (40%) in a 2016 study, cited "concerns about repercussions to their medical licensure" as their reason for being reluctant to be formally treated for a mental health condition[4]; and

WHEREAS, the above study found that physicians were more likely to be reluctant to seek care for a mental health condition if they worked in a state with applications that were not considered "consistent" ($P = 0.002$) leading to the conclusion that questions about a prior mental illness or mental health conditions present a barrier to those physicians that may need to seek help[4]; and

WHEREAS, according to the American Foundation for Suicide Prevention (AFSP), compared to the general male population and general female population, the suicide rate for male physicians is 1.41 times greater and the suicide rate for female physicians is 2.27 times greater, respectively[7]; and

WHEREAS, according to the AFSP, "Among physicians, risk for suicide increases when mental health conditions go unaddressed,"[7]; and

WHEREAS, the American Medical Association (AMA) has approved a policy on June 13th, 2018, that encourages state licensing boards to remove or change questions on their applications that reference prior mental health conditions in favor of questions that specify current physical or mental conditions using the verbiage recommended by the Federation of State Medical Boards (This verbiage reads, "Are you currently suffering from any condition for which you are not appropriately being treated that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?")[5]; and

WHEREAS, the AMA cites concerns for growing rates of physician and medical student depression, burnout, and suicide as being the trigger for adopting this new policy in an attempt to encourage physicians to seek medical care when they need it without fear of stigmatization or hindrance to their ability to obtain their medical license[5]; and

WHEREAS, the Florida Board of Medicine, in December 2018, in response to the new policy adopted by the AMA and increasing rates of suicide among physicians, has given preliminary approval to remove questions about prior mental health conditions/treatment and substance abuse in favor of questions that specify if applicants "currently have any condition that impairs them from safely practicing and whether they currently are using drugs or intoxicating chemicals,"[6]; and

WHEREAS, the purpose of licensure questions asking about "any" history of mental illness is to identify physicians that may present a risk to themselves or their patients. However, the data presented in this resolution has shown that most physicians are not reporting their conditions honestly with the current licensure questions and are avoiding seeking treatment for their conditions due to fear that a diagnosis would prevent them from maintaining or obtaining their licensure. This perpetuates stigmatization of mental illness and puts these suffering physicians at increased risk for committing suicide; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate in support of the removal of questions on physician state licensing applications that ask about prior history of mental illness in alignment with our colleagues at the American Medical Association; and, be it further

RESOLVED, that the AOA advocate in support of questions on physician state licensing applications that use the verbiage concerning current untreated or undertreated conditions such as those that have been approved by the Federation of State Medical Boards.

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Explanatory Statement

Questions on the physician state licensing applications that ask about prior mental illnesses serve as a barrier to those that may need treatment due to fear of their answers affecting their licensure. An above whereas statement shows that very few physicians answer these questions honestly. The AFSP has stated that unaddressed mental illness increases rates of suicide among physicians and the barrier presented by the current state licensure questions prevents physicians from seeking care so as to avoid a diagnosis. As an organization with a holistic view of the human body as a complete unit (body, mind, and spirit), the AOA and SOMA should be active in supporting the health and wellness of their physicians, residents, and medical students.

Reference Committee Explanatory Statement

The Committee recommends the approval of H-362 SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIAN – SUPPORT FOR in lieu of this resolution, as it encompasses the Resolveds of this resolution as well as other considerations.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OPPOSING TARGETED REGULATION OF ABORTION PROVIDERS (TRAP LAWS)

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Targeted Regulation of Abortion Providers (TRAP laws) are defined as legislation and policy that apply ambulatory surgical center standards to family planning clinic; require specific physical outlays to such clinics; require facilities or clinicians to have attending rights at local hospitals; and/or require clinicians to be board-certified in specific specialties in order to provide medication based and/or surgical-based abortions[1, 3 5]; and

WHEREAS, TRAP laws single out medical practices of providers who provide abortions and impose on them requirements that are different and more burdensome than those imposed on other medical practices[2] which necessitates significant patient and provider adaptation[6]; and

WHEREAS, there is no statistically significant evidence that performing an abortion at an ambulatory surgical center reduces the risk of morbidities and adverse effects when compared to a standard family planning clinic[4]; and

WHEREAS, providers of abortion reported heightened levels of stress, increased costs, and lowered productivity when complying to TRAP laws without any change in outcome[6]; and

WHEREAS, TRAP laws specifically governing abortion are more prevalent and impose more stringent requirements than laws governing office-based surgeries, procedures, sedation, or anesthesia[3,5]; and

WHEREAS, countries with less restrictive abortion laws have lower rates of abortions when compared to countries with more restrictive laws[8]; and

WHEREAS, it is reported that TRAP laws directly interfere with the patient-physician relationship[3,6] which is in violation of AOA policy H307-A/13 INTERFERENCE LAWS7; and

WHEREAS, it is the recommendation of the American College of Obstetricians and Gynecologists to end legislation, including TRAP laws, that impedes access to abortion services and interferes with the patient-provider relationship[3]; now, therefore be it

RESOLVED, that the American Osteopathic Association oppose the Targeted Regulation of Abortion Providers (TRAP laws) that impede and discriminate against a physician's ability to provide appropriate care to patients seeking family planning services, including abortion.

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Explanatory Statement

In light of recent bills passed in Iowa that would ban abortions on detectable heartbeat of the fetus, it is prudent that SOMA and the AOA take an official stance on laws that would prevent abortion providers from providing care to patients seeking abortions. Many TRAP laws are essentially backdoor abortion bans, especially in rural and underserved communities where there are insufficient resources to comply with these targeted regulations.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: PHYSICIAN PSYCHOLOGICAL TRAUMA AND MENTAL HEALTH

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, violence against health care workers is a demoralizing and frustrating part of providing medical care for which there is little help available to the victims and is nearly an epidemic.[1] Physical injury is only a small part of the overall trauma health care workers face when caring for those who are not able to care for themselves; and

WHEREAS, physicians and medical personnel often face life and death situations for which they are trained but are none-the-less psychologically traumatized and there is little if any organizational assistance available.[2] Recent data suggests physician burnout costs $4.6 billion dollars yearly.[3] and the World Health Organization recently re-classified burnout as an "Occupational Phenomenon;"[4] and

WHEREAS, if physicians were to seek psychological assistance for mental or emotional traumas sustained within the scope of their professional duties, there are no assurances that they will not be penalized by employers, insurers, or licensing and regulatory boards for seeking such care. Studies have found that about 35% of physicians do not seek regular health care for themselves. In one study, almost 50% of female physicians did not seek treatment despite feeling that they met criteria for a mental disorder;[5] and

WHEREAS, if a law enforcement officer were to experience the same type of trauma (example: a death of a person within the scope of the person's duties) they would be expected and in most cases required to receive psychological assessment, treatment, and have paid administrative leave to properly deal with the repercussions of the event. This treatment would not adversely affect their professional standing. If a physician, resident, or student were to experience the trauma of having a person die within the scope of their professional duties they would be normally expected to resume their work and would not receive psychological assessment, treatment, or paid time off to deal with the repercussions of the event. A recent study finds that the long work hours of an intern's first year of medical residency are associated with accelerated cellular aging due to prolonged stress exposure[6]; and

WHEREAS, if a physician were to seek professional psychological care they may be penalized as evidenced by increased insurance premiums, denial of disability and life insurance policies, and intrusive questions about past health care that does not likely affect professional performance and may negatively impact hospital staff appointments, licensure, board certification or credentialing; now, therefore, be it;

RESOLVED, that the American Osteopathic Association (AOA) continue to work to ensure that physicians are not publicly or professionally stigmatized for seeking care and treatment for injuries or psychological trauma resulting from their professional duties; and, be it further

RESOLVED, that the AOA continue ongoing promotion of physician mental health care as a necessary part of normal physician professional development requiring appropriate care to avoid suicide, depression, and burnout; and, be it further

RESOLVED, that the AOA work with payors and other invested parties to remove any and all financial penalties and stigmas associated with mental health care received ensuring the continued wellness of our physician workforce.

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Explanatory Statement:

We are in a crisis for physicians in America. Burnout is an often discussed and "hot topic" epidemic. The work of the AOA & MOA has been significant on this front, but as a value to our members we believe the need for public consideration of this as a late submission to the AOA House for consideration in 2019. It is important to show our members that we care about their needs when these timely topics are discussed. Thanks for your thoughtful consideration.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: NUTRITION AND LEADING BY EXAMPLE

SUBMITTED BY: Osteopathic Physicians and Surgeons of Oregon

REFERRED TO: Committee on Professional Affairs

WHEREAS, at the 2018 American Osteopathic Association (AOA) House of Delegates, resolution H-365 was approved resolving that the AOA consider meal nutritional content when planning events; and

WHEREAS, the preponderance of evidence shows negative health outcomes associated with the consumption of sugar sweetened beverages and processed meats and;

WHEREAS, the World Health Organization, International Agency for Research on Cancer has classified processed meat as carcinogenic to humans (Group 1); and

WHEREAS, nudges, defined as a subtle environment cues designed to make healthy food choices the easy choice have been shown to increase consumption of healthy foods; and

WHEREAS, the AOA has the opportunity to lead by example - recognizing the impact that nutrition has on human health when providing meals; and

RESOLVED, that sugar sweetened beverages and processed meats be excluded from all American Osteopathic Association (AOA) sponsored events where a meal is served; and, be it further

RESOLVED, that the AOA encourage osteopathic medical schools, residency programs, and hospitals to offer plant-based meals and eliminate sugar sweetened beverages and processed meats when meals are served.

Reference Committee Explanatory Statement
As per AOA policy will be referred to Finance Committee for fiscal analysis.

ACTION TAKEN **REFERRED** *(to AOA Finance Committee)*

DATE **July 27, 2019**

SUBJECT: REFERRED RESOLUTION H305 - A/2018 - INTERFERENCE LAWS

SUBMITTED BY: Bureau of Federal Health Programs / Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, resolution H305-A/2018 titled H307-A/2013 INTERFERENCE LAWS was referred to the Bureau on Federal Health Programs and Bureau of State Government Affairs for adding updated n information to the policy; now therefore be it

RESOLVED, that the Bureau of Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H307-A/13 INTERFERENCE LAWS

The American Osteopathic Association approved the following policy paper and recommendations to assist in responding to state and federal proposals and agencies that attempt to adopt interference laws (2013).

~~Several~~ A NUMBER OF states have pursued legislation that dictates how physicians treat and counsel patients during a medical exam. These laws interfere with the patient-physician relationship, and undermine physician judgment AND REPRESENT a departure from evidence-based medicine. As a result, these laws are collectively referred to as "interference laws."

~~There are four different classifications of interference laws.~~ INTERFERENCE LAWS FALL INTO ONE OF FOUR DIFFERENT CLASSIFICATIONS.[1] The first prevents physicians from asking their patients about risk factors that may affect their health or the health of their families (PHYSICIAN "GAG LAWS"). ~~An~~ ONE example OF A GAG LAW ~~of this law~~ is a 2011 Florida law which ~~limited~~ BARRED physicians from asking questions about a patient's gun ownership.[2] The law WAS ENJOINED IN 2012 ON FIRST AMENDMENTS GROUNDS, A DECISION WHICH WAS UPHELD BY A FEDERAL APPEALS COURT IN 2017.[3] ~~a~~ALTHOUGH 14 OTHER STATES HAVE CONSIDERED SIMILAR LAWS, NONE HAVE PASSED.[4] ~~s no longer in effect as it was permanently enjoined in June 2012. This issue resurfaced in January 2013 when President Obama signed 23 executive orders regarding gun control. The President's 16th executive order clarified that the Affordable Care Act "does not prohibit doctors from asking patients about guns in their homes."[2]~~

The second type of interference law requires physicians to discuss specific treatments that may not be APPROPRIATE OR medically necessary.[5] ~~Examples~~ ONE EXAMPLE of this ~~include~~ IS NEW YORK'S PALLIATIVE CARE INFORMATION ACT OF 2011, WHICH REQUIRES HEALTH CARE PROVIDERS TO OFFER TO DISCUSS END-OF-LIFE OPTIONS ~~laws which require physicians to offer patients information about end-of-life care. These efforts have also been pursued at the federal level, where in 2011 the Obama Administration attempted to promulgate regulations under the Affordable Care Act that would pay physicians for counseling Medicare patients on end-of-life options. Some argue that requiring physicians to discuss this subject with all patients is inappropriate, because physicians are~~ AND PALLIATIVE CARE SERVICES WITH TERMINALLY ILL PATIENTS, WITHOUT DISCRETION AS TO HOW AND WHEN TO RAISE THE ISSUES.[6]

SOME ARGUE THAT REQUIRING PHYSICIANS TO DISCUSS THIS SUBJECT WITH ALL PATIENTS IS INAPPROPRIATE, BECAUSE PHYSICIANS ARE not able to use their judgment to determine ~~which~~ IF OR WHEN patients should receive such sensitive information. ~~Further examples are laws which require physicians to inform women about their breast density when obtaining a mammogram, and laws which require physicians to inform patients that a negative test result for Lyme disease may not be accurate.~~

The third type of interference law requires physicians to provide tests or treatments which are not supported by evidence, including ones that are invasive or required without the patient's consent.[7] Examples of this are laws which require physicians who perform abortions to first perform a fetal ultrasound. It is argued that a fetal ultrasound is medically unnecessary and ~~not supported by evidence-based medicine~~ THERE IS NO LEGITIMATE MEDICAL PURPOSE FOR REQUIRING ONE IN THIS CIRCUMSTANCE.

~~The fourth and final type of interference law places restrictions on the content of information that physicians can disclose to patients.[5] Examples of this include laws which limit a physician from~~ THE FOURTH AND FINAL TYPE OF INTERFERENCE LAW PLACES RESTRICTIONS ON THE CONTENT OF INFORMATION THAT PHYSICIANS CAN DISCLOSE TO PATIENTS.[8] EXAMPLES OF THIS INCLUDE LAWS WHICH LIMIT A PHYSICIAN FROM providing information about the dangers of chemicals used in the hydraulic fracturing process, also known as "fracking."

Impact on the Osteopathic Medical Profession and THE Patient-Physician Relationship

Interference laws threaten the osteopathic medical profession, in particular due to the intrusion INTO THE ~~of~~ patient-physician relationship, which is an essential component of the osteopathic care model's emphasis on preventive medicine and treatment of the whole patient.[9] The patient-physician relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open communication between the physician and patient.[10]

Another critical element of osteopathic medical practice in general and the patient-physician relationship in particular is the concept of physician and patient autonomy and "patient-centered" care. The Institute of Medicine (IOM) defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[11] Patient-centered care is an essential element in the practice of evidence-based medicine. **THE** American Osteopathic Association (AOA) ~~policy~~ supports the use of evidence-based medicine and the implementation of ~~"all~~ **APPROPRIATE** methods ~~appropriate~~ to optimize natural healing and to address the primary cause of disease.~~"[12]~~

The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication. "Osteopathic physicians **(DOs)** consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. ~~Osteopathic Physicians (~~DOs~~)~~ are trained to look at the whole person, and osteopathic physicians integrate the patient into the health care delivery process as a partner."[13] Interference laws which prevent DOs from discussing certain health-related subjects such as the safe storage of firearms or the health ~~concerns of fracking undermines this partnership and violates the osteopathic principle of preventive medicine. If a DO is not allowed to adequately counsel a patient on the dangers of a loaded and the safe storage of firearms, they are unable to provide information which may prevent a firearm-related death in the patient's household~~ IMPLICATIONS OF FRACKING UNDERMINE THIS PARTNERSHIP AND VIOLATE THE OSTEOPATHIC PRINCIPLE OF PREVENTIVE MEDICINE. DOs HELP PREVENT PEDIATRIC DEATHS BY COUNSELING CAREGIVERS ON THE IMPORTANCE

OF SEATBELT AND HELMET USE, BUT WITHOUT THE ABILITY TO ADEQUATELY COUNSEL A PATIENT ON THE IMPORTANCE OF SAFE FIREARM STORAGE THEY MAY BE UNABLE TO HELP PREVENT SIMILAR DEATHS FROM IMPROPERLY STORED FIREARMS. "[T]he purpose of [a firearms] inquiry is so that the practitioner can determine what subject matters require further follow-up in the practice of preventive medicine."[14] THE AOA ~~policy~~ rejects any censorship of professional communication, supports enactment of legislation protecting the patient-physician relationship and opposes any attempt to interfere with the patient-physician relationship.[15]

Additionally, interference laws that require DOs to discuss treatments which are not medically necessary or are not supported by evidence-based guidelines violates the osteopathic principle of treating the whole patient and can undermine patient trust. IN KANSAS, FOR EXAMPLE, PHYSICIANS ARE REQUIRED TO PROVIDE MISLEADING INFORMATION TO PATIENTS REGARDING AN UNPROVEN LINK BETWEEN BREAST CANCER AND ABORTION.[16] ~~If a DO is always required to provide information on a certain treatment, they are unable to treat the whole patient in an objective manner, thereby preventing the DO from exercising their judgment as a physician.~~ TWENTY-THREE STATES CURRENTLY REQUIRE HEALTH CARE PROVIDERS TO REFER PATIENTS TO STATE-CREATED "INFORMED CONSENT" MATERIALS, AND ACCORDING TO A 2016 AUDIT BY RUTGERS UNIVERSITY, 31 PERCENT OF THE INFORMATION INCLUDED IN THESE MATERIALS WAS FOUND TO BE MEDICALLY INACCURATE.[17] BLANKET REQUIREMENTS THAT DOs PROVIDE INFORMATION ON A PARTICULAR TREATMENT, OR MEDICALLY INACCURATE INFORMATION, TO ALL PATIENTS PREVENTS THEM FROM EXERCISING THEIR INDEPENDENT MEDICAL JUDGMENT AND TREATING THE WHOLE PATIENT IN AN OBJECTIVE, EVIDENCE-BASED MANNER. Similarly, interference laws which require DOs to perform certain procedures or treatments violate the osteopathic principle of providing individualized patient-centered care. If a DO is required to perform a certain procedure or treatment for every patient, there is no individualized assessment as to what is in a particular patient's best interests and there is no discussion with the patient because the patient has no choice. Instead of individualized care, this is a "one size fits all" approach. Ultimately, DOs are prevented from rendering individualized, evidence-based care, and patients are prevented from being involved in patient-centered care.

Legal Challenges

Two types of interference laws have been challenged in court. Florida's controversial Firearm Owner's Privacy Act, which restricted physicians from asking patients about firearm ownership, was ~~permanently~~ enjoined in June 2012 when a Florida district court found that it violated physicians' First Amendment rights, A DECISION WHICH WAS UPHELD BY A FEDERAL APPEALS COURT IN 2017. In granting the injunction, the judge stated the law "chills practitioners' speech in a way that impairs the provision of medical care and may ultimately harm the patient."[18] The court also held that physician questioning did not violate patients' Second Amendment rights stating, "[t]he law does not affect nor interfere with a patient's right to continue to own, possess, or use firearms.

Protecting the right to keep and bear arms is irrelevant to this law."[19] IN ADDITION, A SIMILAR 2012 LAW WHICH PREVENTED PHYSICIANS IN PENNSYLVANIA FROM DISCUSSING HOW FRACKING CHEMICALS MAY BE AFFECTING THEIR PATIENTS' HEALTH WAS STRUCK DOWN BY THE STATE SUPREME COURT IN 2016.[20]

Mandatory ultrasound laws have also been challenged on First Amendment grounds. North Carolina's mandatory ultrasound law was struck down as a violation of physician and patient First Amendment rights. The court held that "[t]he Act goes well beyond requiring disclosure of those items traditionally a

part of the informed consent process. In this case, the state compels the provider to physically speak and show the state's non-medical message to patients unwilling to hear or see [that message]."[21]

Conversely, A NEARLY IDENTICAL KENTUCKY LAW WAS UPHELD BY A FEDERAL APPEALS COURT, ~~the Fifth Circuit Court of Appeals upheld a similar mandatory ultrasound law in Texas,~~ WHICH FOUND~~finding~~ that the law WAS REASONABLY RELATED TO THE "INFORMED CONSENT" PROCESS AND did not violate THE First Amendment rights of physicians and patients.[22] Significantly, the ~~recent decision BY~~CIRCUIT SPLIT ~~-~~BETWEEN THE COURTS ~~the Fifth Circuit Court of Appeals sets up a possible circuit split with the Fourth Circuit Court of Appeals and~~ SETS UP a probable hearing by the United States Supreme Court on the issue of mandatory ultrasound laws.

Mandatory ultrasound laws have also been challenged in court on Fourteenth Amendment Substantive Due Process grounds. A mandatory ultrasound law in Oklahoma was ruled to be unconstitutional as a violation of patients' Fourteenth Amendment due process rights, because it placed an "undue burden" on a woman's right to seek an abortion.[23]

Efforts of Medical Associations

Several medical associations have developed policies or taken action in opposition to interference laws. In 2015, ~~2011,~~ the American Medical Association (AMA) ~~adopted~~ REAFFIRMED a 2011 resolution which opposes any intrusion into patient-physician relationships and supports physician judgment. In ~~October 2012~~MAY 2018, the American Academy of Family Physicians (AAFP), THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE AMERICAN COLLEGE OF PHYSICIANS ISSUED A SET OF JOINT PRINCIPLES BASED UPON THEIR ORGANIZATIONS' POLICIES WHICH OPPOSE GOVERNMENTAL INTERFERENCE WITH PHYSICIANS' OBLIGATIONS TO PROVIDE COMPREHENSIVE, EVIDENCE-BASED INFORMATION TO PATIENTS.[25] ~~passed a resolution supporting the patient-physician relationship and opposing all legislative attempts to interfere with this relationship.[18] Additionally, in July 2012, the American College of Physicians (ACP) adopted a resolution which set forth seven principles for federal and state governments to follow when attempting to interfere with the patient-physician relationship.[19] Further, in October 2012 the heads of five medical associations (ACP, AAFP, ACOG, AAP, ACS) came together to publish an article in the New England Journal of Medicine.[20] The article promotes physician autonomy, empowering patients to make informed decisions about their care, and preventing legislators from interfering with the patient-physician relationship.[21] In January 2013, the Council of Medical Specialty Societies (CMSS) adopted this article as policy.~~

T~~In August 2012, t~~he American Bar Association (ABA) also ~~adopted a resolution~~HAS POLICY specifically opposing laws which prevent physicians from asking patients about firearm ownership. The ABA ~~resolution~~ POLICY states that these laws clearly violate the First Amendment rights of physicians and patients, and physician questioning does not in any way violate Second Amendment rights of patients.[26]

Finally, several state medical associations have adopted resolutions on the issue of interference laws. Many of these policies are very basic and simply state the association's opposition to any interference with the patient-physician relationship. Additionally, these policies often promote the use of evidence-based medicine, seek to preserve physician judgment and support litigation which blocks the enforcement of interference laws.

Conclusion

The AOA supports the protection of the patient-physician relationship as especially paramount to the osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole patient and the use of preventive medicine. The patient-physician relationship is a ~~critical~~ FUNDAMENTAL aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication AND TRUST. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner THAT IS BASED UPON EVIDENCE they believe is best for their patients.

The AOA affirms that legislation which interferes with the patient-physician relationship impairs the autonomy of osteopathic physicians and prevents osteopathic physicians from using their ~~best~~ INDEPENDENT MEDICAL judgment based on years of rigorous education and training.

The AOA asserts that physicians must be able to communicate freely with patients without fear of government intrusion in order to assure safe, comprehensive and effective medical treatment.

The AOA considers ~~that~~ legislation ~~which~~ THAT undermines physician judgment TO BE~~is~~ a barrier to evidence-based medicine. The AOA supports the use of evidence-based medicine to ensure high quality patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating a "one size fits all approach," thereby preventing an individualized assessment of what is in a particular patient's best interests.

The AOA affirms that legislation which interferes with the patient-physician relationship undermines patient-centered care. Patient-centered care actively involves the patient in making decisions regarding their own medical care. Statutorily required medical practices prevent patients from being involved in making medical decisions, because the patient has no choice.

The AOA ~~affirms~~ BELIEVES THAT the ethical principle of informed consent is undermined when patients are statutorily required to undergo certain treatments or procedures, because the patient has no choice.

The AOA opposes all legislation at the state and federal level ~~which~~ THAT requires physicians to discuss or perform certain treatments or procedures not supported by evidence-based guidelines, because such legislation undermines physician judgment.

The AOA opposes all legislation at the state and federal level which prevents physicians from discussing certain health-related risk factors with their patients, because such legislation violates the First Amendment rights of physicians and patients AND IS IN CONFLICT WITH EVIDENCE-BASED MEDICAL BEST PRACTICES.

The AOA believes that physicians should be free to counsel patients on end-of-life care on a case-by-case basis rather than AS A RESULT OF an across-the-board mandate.

The AOA supports ~~court~~ LEGAL challenges ~~of~~ TO interference laws that violate First Amendment and Fourteenth Amendment rights of physicians and patients under THE State and Federal Constitutions.

The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as needed.

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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: REFERRED RESOLUTION H306-A/18 - STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Bureau of State Government Affairs

WHEREAS, resolution H306-A/2018 titled H308-A/2018 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES was referred to the Bureau of State Government Affairs for updating; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED **AS AMENDED**:

H308-A/13 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES

The following policy paper and the recommendations provided within are approved to assist the American Osteopathic Association in responding to policy proposals aimed at funding graduate medical education (GME) at the state-level; the AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within this paper. (2013).

AOA POLICY PAPER: STATE GRADUATE MEDICAL EDUCATION FUNDING

BACKGROUND

Physician training requires students to attend four years of medical school, usually paying those costs out-of-pocket or through loans. Following successful completion of medical school, their training continues as medical residents. Medical residents see and treat patients under the supervision of more experienced physicians. This training usually takes place in hospitals though residents often rotate to ambulatory sites such as clinics and physician offices. On average, this residency training takes four years to complete, although high**LY** specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues.[1] However, the **FEDERAL GOVERNMENT IS** current**LY** **THE** ~~single~~ largest **SINGLE** funder of GME**,** ~~is the Department of Health and Human Services (HHS)~~ **PROVIDING APPROXIMATELY $15.9 BILLION IN FUNDING** through the Centers for Medicare and Medicaid Services (CMS) **IN 2018**.[2] **NEARLY TWO-THIRDS OF THIS FUNDING COMES FROM MEDICARE, WITH THE MAJORITY OF THE REMAINDER FUNDED THROUGH MEDICAID.**[3] ~~The federal government contributes approximately $~~**15**~~9.5 billion in Medicare funds and approximately $2 billion in Medicaid dollars to help pay for GME~~. Additional funding is provided by the Department of Defense, the Department of Veterans Affairs and the U.S. Public Health Service.[4] In providing Medicare funding, Congress has acknowledged that training physicians is a public good. Despite that acknowledgement, there have been periodic calls to remove GME from Medicare and Medicaid and secure other sources of funding. So far, Congress has neither acted on these recommendations nor

have other entities stepped up to assume a greater share of the financial responsibility (relative to Medicare or Medicaid) for physician training.

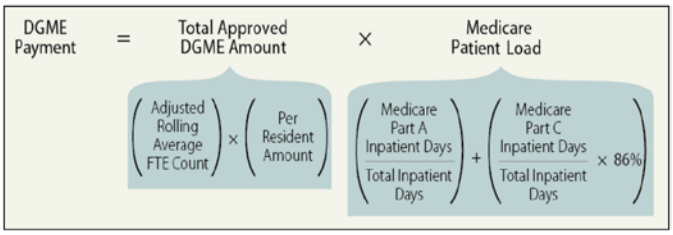
~~With calls to reduce federal spending~~, **WITH CAPS ON THE FEDERAL BUDGET, GME FUNDING HAS BEEN AND WILL CONTINUE TO BE RELATIVELY FLAT. ADDITIONALLY,** ~~is potentially faced with a significant reduction in funding. The Obama~~ **THE TRUMP** Administration ~~and several members of Congress have~~ **HAS** ~~spoken out in favor of~~ **SUPPORTED BOTH CONSOLIDATION AND** reduc~~ing~~**TION** OF GME funding as part of a comprehensive approach to reducing overall federal spending.[5] Additionally, **IN DECEMBER 2018, THE CONGRESSIONAL BUDGET OFFICE ISSUED RECOMMENDATIONS TO CONSOLIDATE AND REDUCE FEDERAL PAYMENTS FOR GME AT TEACHING HOSPITALS** ~~several bills have been introduced at the federal level that attempt to address GME funding shortages~~.[6] Conversely, medical schools, hospitals and medical associations see a need to increase funding and residency slots to help train physicians and fill projected workforce shortages and are working at both the state and federal levels to achieve increased funding for GME.

There are two mechanisms ~~in~~ **THROUGH** which Medicare and Medicaid distribute GME funding: direct medical education (DME) and indirect medical education (IME) payments. DME payments are based on resident salaries, supervision and other educational costs. IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest ~~hurdles in~~ **OBSTACLES TO** federal GME funding is the Balanced Budget Act of 1997 ~~(BBA)~~, which limited the number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME payment. The law also reduced the IME multiplier over a four-year period, however, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ~~(BIPA)~~ delayed the IME reduction. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments **WHICH TOOK** ~~taking~~ effect on April 1, 2013.[7]

MEDICARE

The formula for determining Medicare payments to hospitals for direct costs of approved GME programs is established in section 1886(h) of the Social Security Act ~~(the Act)~~.[9] A DME payment is determined by multiplying a hospital-specific, base-period per resident amount by the weighted number of full-time equivalent residents working in all areas of the hospital and the hospital's Medicare share of total inpatient days.[10] The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to count residents training in non-hospital settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time residents spend in that setting.[11]

Figure 1. Medicare DGME Payment Formula



Source: CRS analysis of Title XVIII of the Social Security Act (SSA) and relevant regulations.
Note: The adjusted rolling average FTE count is subject to the GME cap.

As previously mentioned, IME payments are based on additional operating costs of a GME program. The factors for IME payment generally include sicker/more complex patients, maintaining stand-by capacity for certain specialized services (e.g. burn units), residents ordering more tests and trainees being less efficient in providing care. IME payments provide for the legitimate increase in costs training hospitals incur.[12] IME payments are calculated by adding the individual intern/resident-to-bed ratio into

a formula already established in the Medicare statute. The current IME adjustment is calculated using a multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately 5.5% in Medicare payments for every 10-resident increase per 100 beds.

MEDICAID

Despite **FEDERAL LAW NOT REQUIRING STATE MEDICAID PROGRAMS TO SUPPORT GME,** ~~being under no obligation to do so~~, Medicaid is the second largest **FUNDER OF** ~~contributor to~~ GME programs. ~~Several~~ **A MAJORITY OF** states have implemented mechanisms within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME funding is structured similarly to Medicare, providing direct and indirect payments. The most recent data available estimates that Medicaid paid **APPROXIMATELY** $**4.3**~~3.87~~ billion to GME programs in 201**5**~~2~~, up from $3.**87**~~78~~.in 20**12**~~09~~.[13, 14] ~~From~~ **DESPITE THE FACT** that **MUCH OF THAT FUNDING,** ~~at least half~~came from matching federal payments**, THREE STATES REPORTED THAT THEY EXPLICITLY REDUCED THEIR MEDICAID SPENDING ON GME, AND ANOTHER SEVEN REPORTED AT LEAST A TEN PERCENT REDUCTION IN MEDICAID GME PAYMENTS BETWEEN 2012 AND 2015**.[15] ~~However, several states have reduced their funding for GME programs through their Medicaid programs.~~

In 2005, 47 states provided $3.18 billion through Medicaid to support GME.[16] By 201**5**~~2~~, only 42 states and the District of Columbia (DC) supported GME through their Medicaid program.[17] Arizona, Massachusetts, Montana, Rhode Island, Vermont and Wyoming have since ended GME funding, citing budget shortfalls**, AND** ~~**ALABAMA,**~~ **MICHIGAN AND TENNESEE REPORTED THAT THEY RECENTLY CONSIDERED ENDING FUNDING AS WELL**.[18, 19] ~~Additionally, some states like, Iowa, Michigan, Oregon and Pennsylvania, have discussed ending Medicaid support for GME.[19] Others, like Florida and Washington, have decreased Medicaid funding for GME in the last few years.[20]~~

Medicaid Fee-for-Service

Forty states and the District of Columbia make DME and/or IME payments under the Medicaid fee-for-service program. A fee-for-service program is a payment model where services are unbundled and paid for separately.[20] ~~Twelve~~ **FOURTEEN** states and DC fund DME and/or IME programs using a calculation method similar to Medicare's GME funding formula**, SOMETIMES IN ADDITION TO OTHER METHODS**~~. The remaining states calculate payments by "some other method,"~~ which usually include~~s a~~ variation**S** of a per-resident or lump-sum amount. The per-resident or lump-sum amount**S** **ARE** ~~is~~ based on the "hospital's share of total Medicaid revenues, costs or patient volumes." **TWENTY-NINE STATES REPORTED CALCULATING PAYMENTS SOLELY BY "SOME OTHER METHOD" IN 2015.** [21]

Medicaid Managed Care

Capitated managed care is a state's use of risk-based capitation payments within their Medicaid program. This typically includes contracting with one or multiple managed care organizations (MCOs) to administer the Medicaid program for a defined population of Medicaid patients.[22] Thirty-**NINE**~~six~~ states and DC use capitated Medicaid managed care programs. ~~Currently, 23 states and DC included DME and/or IME payments under their Medicaid managed care programs.[23]~~

~~Fourteen~~**SIXTEEN** states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments.[23] This **REPRESENTS**~~is~~ a**N INCREASE** ~~decline~~ in the number of states who have made direct payments under managed care **SINCE 2012**.[24] States who make direct Medicaid payments indicate **THAT** they wish to help train future physicians who will service Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state

health policy goals. ~~Five of these states pay for both DME and IME costs and three states do not distinguish between the two costs.~~[24]

~~Nine~~**TWELVE** states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations. ~~Five~~**HALF** of these states – **IOWA,** Kansas, Kentucky, Michigan, ~~Oregon~~**MINNESOTA** and ~~Washington~~**MISSISSIPPI** – require MCOs to distribute the negotiated payments to teaching hospitals. The other ~~four~~**SIX** assume MCOs will distribute the payments.[25]

ALIGNING GME FUNDING WITH HEALTH POLICY PRIORITIES

States continue to look to align GME funding with other health policy goals. This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians. **A 2016 STUDY REVEALED THAT THIRTY-TWO STATES LINKED MEDICAID GME PAYMENTS TO A STATE POLICY GOAL OF INCREASING THE SIZE OF THE PHYSICIAN WORKFORCE, COMPARED TO 22 STATES IN 2012.** [26]

~~*Kansas and*~~ *Florida* ***AND KANSAS***

In an effort to promote accountability in the use of GME funds, ~~Kansas and~~ Florida **AND KANSAS** link Medicaid GME payments to stated state policy goals. ~~Kansas~~**IN FLORIDA, THIS** applie**S**~~d~~ to both fee-for-service **(FFS)** and managed care Medicaid programs, while ~~Florida~~**KANSAS** ~~GME payments~~ focus**ES SOLELY** on ~~fee-for-service~~ **FFS** payments.[27] Like most states, ~~Kansas and~~ Florida **AND KANSAS** have focused on encouraging training in primary care specialties **AND INCREASING ACCESS TO CARE IN** rural and medically underserved areas.

Kansas also uses GME payments to promote an increased supply of physicians serving the Medicaid population, and **FUNDS TEACHING HOSPITALS AS WELL AS TEACHING SITES IN NON-HOSPITAL SETTINGS.** ~~increase the geographic distribution and fund teaching hospitals that have experienced GME funding cuts through the Medicare program~~. **IN FLORIDA, GME PAYMENTS HAVE BEEN EXTENDED TO INDIVIDUAL TEACHING PHYSICIANS UNDER FFS.** ~~In addition to Medicare and Medicaid GME funding, Florida also~~ **THE STATE ALSO** uses alternative sources to fund residency programs **IN ADDITION TO MEDICAID AND MEDICARE, INCLUDING THE STATEWIDE MEDICAID RESIDENCY PROGRAM AND THE GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM.** ~~serving Veterans Administration medical, loan repayment for residents and physicians serving underserved or designated shortage areas after training, and offers state appropriations for additional funding to encourage new training opportunities and cost/resource sharing between groups.~~[28] **THE FORMER WAS CREATED IN 2013 WITH $80 MILLION IN RECURRING STATE AND MATCHING FEDERAL FUNDS TO SUPPORT PAYMENTS TO HOSPITALS WITH ACCREDITED RESIDENCY PROGRAMS, WHILE THE LATTER WAS CREATED IN 2015 WITH $100 MILLION ALLOCATED TO EDUCATING AND TRAINING PHYSICIANS IN SPECIALTIES WHICH ARE IN A STATEWIDE DEFICIT. IN 2018, THE FLORIDA LEGISLATURE APPROPRIATED $242.3 MILLION TO THESE PROGRAMS.** [29]

~~Florida's Community Hospital Education Act also provides funding intended for primary care specialties. This program appropriates state funds into the Medicaid program, with hospitals being paid directly from this fund to help support primary care specialty interns and residents.~~[28]

Texas

In **2014,**~~2007,~~the Texas legislature **ALLOCATED $12 MILLION TO SEVERAL INITIATIVES WHICH TOGETHER CREATED 100 NEW RESIDENCY POSITIONS ACROSS NINE**

NEW PRIMARY CARE AND TWO NON-PRIMARY CARE PROGRAMS.[30] IN 2015, THE LEGISLATURE CONSOLIDATED THESE INITIATIVES INTO A SINGLE GME EXPANSION PROGRAM, TO WHICH IT APPROPRIATED $49.5 BIENNIALLY. THIS RESULTED IN AN INCREASE IN PER-RESIDENT FUNDING FROM $65,000 TO $75,000 PER YEAR AND THE CREATION OF 130 NEW RESIDENCY POSITIONS IN 2016-2017.[31] ~~authorized an additional $62.8 million in state funding for GME positions and for faculty costs. However, the additional funding was not enough to pay for the growth necessary to keep up with the physician shortage.[29] Texas saw a 50% cut in its GME funding in 2012-2013. Per capita formula funding cut $25 million from its budget, now spending $4,400 per resident from $6,600. The Texas Higher Education Coordinating Board (THECB) family medicine residency funding saw a significant $15.6 million cut, from $21.2 million to $5.6 million. THECB Primary Care Residency Program ($5 million) and THECB GME Program ($600,000) were both cut altogether. Finally, the Physician Loan Repayment Program was cut by $17.7 million, from $23.3 million to $5.6 million.~~

SINCE 2009, THE Texas **HEALTH AND HUMAN SERVICES COMMISSION (HHSC) HAS** also provide**D**~~s~~ supplemental funding **TO FIVE STATE-OWNED TEACHING HOSPITALS** for approved medical residency training programs.[32] ~~In the Texas Administrative Code, the Texas Health and Human Services Commission~~ **THE HHSC** reimburses ~~approved state-owned or state-operated teaching hospitals, the~~ **EACH** hospital **DIRECTLY USING A CALCULATION THAT IS BASED UPON THE HOSPITAL'S SELF-REPORTED MEDICAID INPATIENT DAYS AND RESIDENT FULL-TIME EQUIVALENTS. HHSC ALSO SEPARATELY PROVIDES IME PAYMENTS TO TEACHING HOSPITALS TO OFFSET THEIR HIGHER PATIENT CARE COSTS RELATIVE TO NON-TEACHING HOSPITALS, INCLUDING COSTS RELATED TO SUPERVISING AND MAINTAINING RESIDENT RECORDS.[33]** ~~'s inpatient direct GME cost for hospital cost reports. The costs are calculated using a similar method as set out in Title XVIII of the Social Security Act.[30]~~

THESE INCREASES FOLLOW YEARS OF CUTS TO GME FUNDING, INCLUDING A 50% CUT IN 2012-2013, WHICH LED TO THE ELIMINATION OF THE TEXAS HIGHER EDUCATION COORDINATING BOARD (THECB) PRIMARY CARE RESIDENCY PROGRAM AND THE THECB GME PROGRAM IN 2019.

Utah

In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state's physician shortage and coordinate GME funding that would be better aligned with the state's workforce needs.[31] UMEC is a quasi-governmental body whose responsibilities include assessing the physician workforce demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician shortages in rural locations and managing the GME funds from CMS.

To better address the state's GME funding needs, Utah applied for, and was granted, a CMS waiver that placed GME funding into a funding pool, rather than directing money to hospitals.[32] By pooling all of the state's GME funding, UMEC was able to distribute the funds directly to hospitals and programs based on specific workforce needs and objectives.[34] **THE WAIVER RESULTED IN A 29% INCREASE** ~~The waiver has had noticeable results: the number of residents in Utah increased 29%~~ between 1997 and 2007, from 442 residents in 25 programs to 568 residents in 30 programs.[35] ~~Training hospitals and programs are now accountable to UMEC for how the GME funds are spent. UMEC also worked with training programs to encourage residents to practice in Utah. Workforce coordination efforts also identified new rural training opportunities in areas like family medicine, general surgery, internal medicine, pediatrics and psychiatry.[36] The~~ **, BUT** ~~waiver~~ ultimately ended on June 30, 2010.[36] **ACCORDING TO UMEC'S MOST RECENT (2016) REPORT, THE STATE HAS**

AVERAGED 202 RESIDENTS PER YEAR BETWEEN 2006 – 2016, REPRESENTING AN APPARENT DECLINE FROM LEVELS UNDER THE WAIVER.[37]

ADDITIONAL GME FUNDING MODELS

There are several other GME funding models that have the potential to provide revenue for GME programs. These models differ based on who would receive payment, how funds would be allocated among recipients, what mechanisms would be needed to assure accountability and whether payment would be linked to the achievement of specific performance measures. These models are not mutually exclusive and could be combined to enhance stability and accommodate GME policy objectives. In some cases, a combination of several models would be necessary to pay for different kinds of costs to address specific educational or workforce objectives.

All-Payor System

~~The~~**SEVERAL STATES HAVE EXPERIMENTED WITH VARIATIONS ON AN** all-payor system, **WHICH COMBINES FUNDING FROM ALL PUBLIC AND PRIVATE SOURCES TO PAY FOR STATE GME PROGRAMS,** ~~has proven to work in several states~~ **BUT ONLY MARYLAND'S IS CURRENTLY OPERATIONAL.** ~~The AOA's Physician Education Advancing Community Health (PEACH) program is an example of a payor funded program whereby Health Maintenance Organizations would help fund GME.~~ **ALTHOUGH PRIVATE PAYORS RARELY FINANCE GME DIRECTLY, THE HIGHER RATES THAT THEY PAY TO TEACHING INSTITUTIONS HELP TO SUBSIDIZE GME PROGRAMS.**~~The extents to which private insurers help fund portions of residency training and costs are nearly incalculable~~[7] ~~The nonprofit RAND Corporation did a survey-based study in 2006 and found that private payers, like insurance companies, indirectly fund about 43% of the costs associated with training physicians. However, hospitals tend not to negotiate for physician training costs when they contract with private insurers.~~[39]

Maryland **IMPLEMENTED THEIR** ~~currently has an~~ all-payor system **IN 1977.**[38] **PRIOR TO 2014, THE STATE USED A PROSPECTIVE, DIAGNOSIS-BASED PAYMENT MODEL, WHICH KEPT THE RATE OF INCREASED SPENDING PER ADMISSION BELOW THE NATIONAL RATE, ALTHOUGH IT WAS LESS SUCCESSFUL AT CONTAINING OVERALL HOSPITAL SPENDING DUE TO INCREASED ADMISSION RATES.**[39] **SINCE 2014, MARYLAND HAS USED A PAYMENT MODEL THAT REQUIRES EACH HOSPITAL TO MONITOR BOTH THE NUMBER AND COST OF ADMISSIONS.** ~~where the~~**PAYMENT RATES ARE ESTABLISHED BY THE QUASI-GOVERNMENTAL** Health Services Cost Review Commission, **AND ALL PAYORS MUST PAY A GIVEN HOSPITAL THE SAME RATE FOR THE SAME SERVICE, BUT EACH HOSPITAL NEGOTIATES ITS OWN RATES**~~sets hospital rates for all payers~~.[40] Maryland has built costs associated with GME funding ~~into its rate-setting system~~**, AS WELL AS SURCHARGES TO SUPPORT AN "UNCOMPENSATED CARE POOL" AND A PUBLIC PLAN FOR RESIDENTS WITH CHRONIC HEALTH CONDITIONS, INTO ITS RATE-SETTING SYSTEM**.[41] ~~The rates for graduate medical education are reviewed on an annual basis based on financial and resident count reports.~~[41] Maryland also has a Medicare waiver **THAT ALLOWS IT TO SET MEDICARE PAYMENT RATES. HISTORICALLY,** ~~in which the federal government pays more in Maryland than anywhere else. In return,~~ Maryland ha**D**~~s~~ to keep its Medicare costs below national growth **FOR HOSPITAL PAYMENTS PER ADMISSION IN ORDER TO MAINTAIN ITS WAIVER, BUT THE TEST UNDER THE CURRENT WAIVER FOCUSES ON THE PER CAPITA GROWTH IN HOSPITAL SPENDING**.[42] ~~Maryland is currently in jeopardy of losing its waiver due to federal sequester concerns.~~

New York **PREVIOUSLY OPERATED AN** ~~'s~~ all-payor system **THAT** ~~was created through the "Professional Education Pool" which collects and distributes money for GME.[43] New York requires all payors to contribute to the fund, including Blue Cross and Blue Shield, commercial insurers, health maintenance organizations (non-Medicaid and non-Medicare), businesses, self-insured funds and third party administrators. There are two ways for payors to make payments: first, by voluntarily contributing an amount based on per covered life of the individual or family; or if no direct contribution is made, a surcharge on each payment of inpatient costs plus a 24% differential~~ **LEVIED A "COVERED LIVES ASSESSMENT" TAX ON PRIVATE HEALTH INSURERS BASED UPON MEMBER FEES BY REGION AND TYPE OF INSURANCE.** ~~The Professional Education Pool monies are collected in a trust fund and distributed to teaching hospitals on a monthly basis in accordance with their adjusted share of the region's total GME spending.[43]~~ **THE MONEIES COLLECTED WENT INTO TWO POOLS, ONE THAT SUBSIDIZED CARE FOR INDIVIDUALS WHO WERE UNABLE TO PAY AND ANOTHER THAT FUNDED GME. IN THE LATE 2000S, HOWEVER, THE GME FUNDING POOL WAS REALLOCATED TOWARD UNCOMPENSATED CARE IN TEACHING HOSPITALS, AND OTHER "HIGH PRIORITY" ITEMS.[44]**

Health Care Provider Model

Medicare pays for GME through a health care provider model. This approach links payments for clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital's patient care costs, this model is particularly appropriate for IME payment.

Several variants of this model have been proposed to encourage more training in nonhospital settings. These variants include a direct pay approach whereby payment would follow the resident training in a nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the entities or a fixed allocation developed in accordance with national cost data; or payment to the entity that bears substantially of the costs of the nonhospital rotations. The first two variants would create substantial administrative burdens. Although less burdensome and disruptive, the third option appears less likely to achieve its stated goal. A voucher or "set-aside" system also could be established whereby a specified share of payment for direct training costs would be earmarked for nonhospital settings.

The principle advantage of the provider model is that regulatory, cost reporting, auditing and compliance mechanisms already are in place and well established. To this extent, these mechanisms have created persistent problems, which is also a disadvantage. This model also fails to provide financial support for training that occurs outside of patient care settings (e.g., much of the training in preventative medicine).

Education Model

Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing education and/or health care services (e.g., a health department, public health agency, organized health care delivery system or hospital system.) Because this model treats direct GME costs as costs of education not patient care, adherents suggest that greater weight will be placed on educational needs as training decisions are made. In return for payment, the program sponsor (or its designees) would assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME costs and payments would be established through written agreements between the sponsor and clinical training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME payment.

The principle advantage of this approach is its focus on education. Unfortunately, it also would require a major shift in program accountability and funding, particularly when training occurs in community teaching hospitals rather than academic medical centers, where medical schools and hospitals are linked through common ownership or other longstanding corporate or strategic ties. This approach could also discourage hospitals from maintaining or starting GME programs.

As a variant to this model, vouchers could be given directly to residents so that they could purchase their own GME. Unlike the vouchers mentioned in conjunction with the provider model, these vouchers would permit residents to control funding for their graduate training, allowing monies to flow to all training sites. In theory, this approach would enhance competition among GME programs. It is not clear, however, how much effect it would have because programs already compete for residents and rotation sites.

Besides the disadvantages mentioned above, this approach would require a new regulatory mechanism for determining which residents qualify for funding and how many positions would be funded. It also fails to address national physician workforce needs or to assure that adequate resources are available in needed specialties and geographic areas. Implementing this approach could result in substantial year-to-year fluctuations in program size, undermining the stability of existing programs and making faculty and resource allocations difficult. Residents could also be hard pressed to hold their programs accountable once training decisions are made.

Planning Model

Under this approach, funding would be channeled through planning or coordinating bodies such as GME consortia, state GME, physician workforce commissions or task forces. The primary function of these bodies would be to assess the health care needs of their communities and to allocate funds based on local workforce considerations.

Because this approach ties training and funding decisions to local health care needs, it could provide the states, payers and consumers a stronger role in allocating funds to meet workforce objectives. According to the Council on Graduate Medical Education, however, existing evidence tends to suggest that reliance on consortia to assume such a role may be premature. Adopting this model would also require development of a new regulatory mechanism to assure accountability. Payment to state entities or consortia provides little incentive to nonteaching hospitals to initiate new GME programs.

Performance Model

This model links payment to the achievement of specific performance measures or objectives. Funding could also be used to support specific projects or demonstrations on infrastructure development or particular workforce goals.

While this approach encourages innovation and quality enhancement, it is more suitable as a supplemental funding mechanism than as a primary source of GME payment. This model is also dependent on well-defined quality measures and workforce priorities. Neither may be sufficiently well developed to support all GME funding decisions at this time. This approach could also result in substantial year-to-year fluctuation in payments if all funding decisions are based on meeting specific performance measures.

CONCLUSION

With federal and state budgets look to cut spending, GME programs are particularly vulnerable. AOA policy, "affirms its support for maintaining and enhancing the quality of teaching programs."[44] As states address shortfalls in federal GME funding, the AOA encourages all viable models to be examined. While all-payor systems have proven effective in some states, each state is different and may require its own unique GME funding system. Additionally, as states and the federal government implement health

insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to fund GME. This will help address concerns related to workforce shortages as the covered population grows.

The AOA supports states creation of alternative GME funding mechanisms and the alignment of this funding with their states health care priorities. Most important, within these priorities are training those specialties with the largest workforce shortages and providing care to those residents in the greatest needs (those in rural and underserved areas).

The AOA believes that state GME funding must account for osteopathic programs that incorporate the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

The AOA believes that state GME funding should focus on programs that address comprehensive health care systems that deliver care through a variety of settings. This includes training residents in hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs should also provide training in advancing technologies within the delivery of care.

The AOA believes that state GME funding should emphasize the importance of both basic and clinical research in an effort to advance the practice of medicine and the care patients receive.

The AOA supports the physician-led, team-based model of care. The AOA believes that state GME funding should promote this model of care by promoting interprofessional education, so that physicians can not only learn to lead the health care team, but also better understand the skills and abilities each member brings to that team.

Finally, this policy is intended to compl~~i~~**E**ment AOA Policy, ~~H252-A/04 RESIDENCY TRAINING SLOTS. The PEACH program~~ **H329-A/2016 GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES** ~~represents one advocacy tool developed to assist states in developing alternative GME financing~~, and the AOA should continue to ~~create additional resources that~~ support the osteopathic community in **ITS** efforts to ~~**provide adequate**~~ **TO INCREASE** GME funding.

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED RESOLUTION H346-A/13 - OFFICE BASED SURGERY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Bureau of State Government Affairs

WHEREAS, resolution H-342-A/2018 titled H-346-A/2013 OFFICE BASED SURGERY was referred to the Bureau of State Government Affairs for updating with current data; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED **AS AMENDED**:

H346-A/13 OFFICE BASED SURGERY

The American Osteopathic Association approves the following Policy Statement on Office-Based Surgery (2008; reaffirmed as amended 2013):

OFFICE-BASED SURGERY

Background

A number of surgical procedures that were once only performed in hospitals or ambulatory surgery ~~facilities~~ **CENTERS (ASCS)** can now be performed in a physician's office. Of the 80 million outpatient surgeries performed in the US in 2009, **THE MOST RECENT YEAR FOR WHICH COMPREHENSIVE DATA IS AVAILABLE,** it is estimated that over 12 million were performed in physicians' offices.[1] Proponents of office-based surgery assert that many procedures can be performed safely and effectively in a physician's office due to advances in technology, anesthesia, and laparoscopic techniques. In addition, many argue that office-based surgery is easier to schedule and more comfortable for patients than surgery performed in a hospital. Perhaps most significant, however, is the reported cost savings for office-based surgery compared to surgery performed in a hospital. One study reported that the **AVERAGE** cost of an **UNICOMPARTMENTAL KNEE ARTHROPLASTY** ~~inguinal hernia repair~~ done in an office setting **WAS AN AVERAGE OF $20,500 LESS THAN THE AVERAGE CHARGE OF $46,845** ~~was $895 compared to $2,237~~ for the same procedure in the hospital.[2]

Despite these benefits, the practice of office-based surgery has been controversial due to the lack of established rules and regulations. At the beginning of the 21st century, the fact that most states did not regulate office-based surgery led some observers to compare it to the "Wild West."[3] **AS OF**~~By~~ 201**4**~~0~~, 2**9**~~5~~ states had enacted rules, regulations or guidelines that specifically applied to office-based surgery.[4] These regulations help to ensure that office-based surgery is conducted with appropriate equipment, adequately trained personnel and established patient safety standards. However, because this practice remains unregulated in many states, the concern that surgery performed in a physician's office may not be as safe as surgery performed in a hospital or licensed **ASC** persists.

While the media has reported a number of stories of tragic outcomes following office-based surgery, the actual ~~number~~ **RATE** of morbidity and mortality following ~~office-based surgery~~ **THESE PROCEDURES** is hard to determine because ~~reporting~~ adverse event~~s is only~~

~~required in twenty states.~~[5] **REPORTING IS REQUIRED IN LESS THAN HALF OF ALL STATES.**[5] ~~A number of reports that have been published documented adverse events.~~

ACCORDING TO A 2017 FLORIDA REPORT THAT COMPARED RISK-ADJUSTED HOSPITALIZATION RATES FOLLOWING SURGICAL PROCEDURES ACROSS PHYSICIAN OFFICES, FREESTANDING ASCS, AND HOSPITAL OUTPATIENT DEPARTMENTS IN FLORIDA, RATES WERE GENERALLY HIGHER FOR OFFICE-BASED PROCEDURES, ESPECIALLY MORE COMPLEX PROCEDURES.[6]

~~A 2004 survey by the American Association of Ambulatory Surgery Centers reported that only 12 out of every 10,000 office-surgical center patients required emergency transfer to hospitals in 2003. In another survey of 1,200 plastic surgeons, 95 deaths were reported in nearly 500,000 liposuction procedures.[6] Since 1986, at least 41 deaths and over 1,200 injuries have occurred during cosmetic surgery in Florida. Closed malpractice claims in Florida have also identified 830 deaths and approximately 4,000 injuries associated with office-based surgical care occurring between 1990 and 1999.[7] Finally, since Florida's Board of Medicine imposed mandatory reporting requirements on physicians performing office-based surgery, 20 adverse incidents and five deaths were reported in a five-month period.~~ Although office-based surgery may be appropriate for many surgical patients, proper attention must be given to patient safety **IN ORDER** to ~~avoid~~ **MINIMIZE** adverse events.

Need for Office-Based Surgery Rule Development

States have taken different approaches to the regulation of office-based surgery. A ~~variety~~ **NUMBER** of state medical boards have adopted guidelines or rules for physicians to follow ~~regarding~~ **WHEN PERFORMING** office-based procedures. ~~The North Carolina Medical Board approved a position statement on office-based procedures on Jan. 23, 2003 after surveying the physicians in the state on this necessity.~~ **A POSITION STATEMENT ISSUED BY THE NORTH CAROLINA MEDICAL BOARD ON THIS ISSUE CONTAINS RECCOMENDATIONS ON** ~~Guidelines address~~ physician credentialing, emergencies, performance improvement, medical records, equipment and supplies, and personnel. Any failure to comply puts a physician at risk of disciplinary action by the board.[7]

IN MANY STATES, OFFICE-BASED SURGERY CENTERS ARE EXEMPT FROM LICENSURE REQUIREMENTS THAT APPLY TO HOSPITALS AND ASCS BECAUSE THE PROCEDURES THAT THEY PERFORM ARE CONSIDERED TO BE RELATIVELY LOW-RISK. SOME STATES REQUIRE CENTERS TO REGISTER WITH A STATE AGENCY SUCH AS THE DEPARTMENT OF HEALTH, WHILE OTHERS DO NOT REQUIRE ANY GENERAL OVERSIGHT, AND SURGICAL PRACTITIONERS ARE REGULATED BY STATE MEDICAL LICENSING BOARDS IN THE NORMAL COURSE OF THEIR PHYSICIAN OVERSIGHT DUTIES.[8] ~~On Feb. 25, 2005, the Washington Medical Quality Assurance Commission adopted voluntary guidelines that encourage office-based surgical facilities to be accredited. The Oklahoma Board of Medicine adopted guidelines for physicians who perform procedures that require anesthesia or sedation in an office setting. The Oregon Board of Medical Examiners developed standards for accreditation of facilities where minor procedures or those requiring conscious sedation are performed in an office setting. The South Carolina Board of Medical Examiners approved guidelines for office-based surgery that require such facilities to be accredited by an approved agency if level 2 or 3 procedures are performed.~~

Classification of Office-Based Surgery

Office-based surgical procedures are usually classified based on the level of anesthesia used. Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and C.[~~8~~**9**] While not uniform, these classifications are often referred to by state medical boards and state legislators; therefore, understanding the different levels is an important basis for a discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures performed under topical, local, or infiltration block anesthesia without preoperative sedation. Second, Level 2 surgical procedures are minor or major procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally, Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and require the support of bodily functions.[~~9~~**10**]

Physicians and Staff in the Office-Based Surgical Facility

One of the reasons for the large number of adverse consequences associated with office-based surgery is the fact that many individuals, both physicians and non-physicians, performing office-based surgery lack the expertise to perform the surgery and administer the anesthesia in the first place. For example, a 2010 study found that nearly 40% of physicians offering liposuction in southern California had no specific surgical training.[~~10~~**11**] Further~~more~~, **FOUR DEATHS HAVE BEEN REPORTED SINCE 2013 AT A SINGLE SOUTH**~~two~~ Florida **CLINIC** ~~ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation surgery, and several dentists have been identified as performing hair transplants and liposuction procedures~~**WHERE COSMETIC SURGERY IS PERFORMED BY PHYSICIANS WHO ARE NOT FORMALLY TRAINED OR BOARD CERTIFIED IN PLASTIC SURGERY.**[**12**] While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, such incidents may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

Equipment Required

Equipment used in office-based surgery must be kept in excellent working condition and replaced as necessary. The type of monitoring equipment required in office-based settings depends on the type of anesthesia used and individual patient needs. However, every facility must have emergency supplies immediately available, including emergency drugs and equipment appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

Transfer Agreement

Emergencies occasionally arise during surgery requiring patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a comprehensively outfitted and staffed facility **LOCATED NEARBY** should it be needed.

Adverse Incident Reporting

Adverse events that may occur in office-based surgical facilities include patient deaths, cardio-respiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes. Reporting of adverse incidents to an appropriate state entity is an important patient safety measure.

Regulation of Office-Based Surgery

Unlike hospitals and ambulatory surgery centers, not all office-based surgical facilities are subject to regulations on emergencies, fire, **SANITATION,** drugs, staff, training, and unanticipated patient transfers. Common sense dictates that states should take steps to ensure that patients who undergo surgery in physicians' offices receive the same standard of care as patients in ambulatory surgery centers or hospitals.

Conclusion

The practice of office-based surgery will likely continue to grow in the coming years. The following statements represent the AOA's position on **THE** appropriate use of office-based surgery:

The AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery;

The AOA supports state licensing boards in surveying their licensees or researching the issue of office-based surgery regulation to determine if office-based surgery rule development is necessary;

The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as ~~the Healthcare Facilities Accreditation Program~~The Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), ~~or~~ the Accreditation Association for Ambulatory Health Care (AAAHC) **OR THE AAAHC'S HEALTHCARE FACILITIES ACCREDITATION PROGRAM;** ~~the AAAHC's Healthcare Facilities Accreditation Program;~~

The AOA believes that surgery performed in a physician's office must be done by a physician or ~~health care provider~~ **NON PHYSICIAN CLINICIAN** qualified by education and training to perform that specific procedure **WITH APPROPRIATE PHYSICIAN OVERSIGHT**;

The AOA believes that only health care providers who have completed the appropriate education and training should perform office surgical procedures;

The AOA believes that ~~the~~ **A** physician **MUST** administer~~ing~~ the anesthesia or **IF A NON PHYSICIAN CLINICIAN ADMINISTERS THE ANESTHESIA, A SUPERVISING PHYSICIAN MUST BE PHYSICALLY PRESENT IN THE OFFICE-BASED SURGICAL FACILITY DURING THE ADMINISTRATION OF ANESTHESIA AND REMAIN PHYSICALLY AVAILABLE UNTIL THE PATIENT HAS FULLY RECOVERED AND** ~~supervising the administration of the anesthesia must be physically present in the office-based surgical facility during the surgery and immediately available until the patient~~ has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until **THE** ~~all~~ patient~~s~~ **IS** ~~are~~ discharged;

The AOA believes office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer's specifications;

The AOA believes physicians and ~~health care providers~~ **NON-PHYSICIAN CLINICIANS** who perform **OFFICE-BASED** surgery ~~in an office setting~~ **SHALL BE RESPONSIBLE FOR COORDINATING AND ENSURING APPROPRIATE CARE FOR PATIENTS WHO REQUIRE EMERGENT, UNEXPECTED POSTOPERATIVE TRANSFER AND/OR HOSPITALIZATION.** ~~must have a written protocol~~ **WRITTEN PROTOCOLS MUST BE** in place for **TIMELY** transfer to an accredited hospital **LOCATED** within **REASONABLE** proximity to the office. **OFFICE PERSONNEL MUST BE APPROPRIATELY TRAINED IN EMERGENCY PROTOCOLS IN ORDER TO BE ABLE TO RESPOND** when ~~extended or~~ emergency **OR EXTENDED** services are needed to protect the health or well-being of the patients;

The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure; and

The AOA supports the position that state medical licensing boards are the appropriate entity to create and implement regulations regarding office-based surgery. ~~2008~~**2019**

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[3] Midey, *Supra*; Andrews, Michelle. *In-Office Surgery: Fewer Rules Apply*, N.Y. Times, Aug. 18, 2002. https://www.nytimes.com/2002/08/18/business/money-medicine-in-office-surgery-fewer-rules-apply.html.

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[5] Id.

[6] **Ohsfeldt, Robert et al. *Outcomes of Surgeries Performed in Physician Offices Compared With Ambulatory Surgery Centers and Hospital Outpatient Departments in Florida*. Journal of Health Service Insights, Apr. 20, 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5404902/.**

[7] *Office-based Procedures*, North Carolina Medical Board, Amended May 2011. https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/office-based_procedures.

[8] **Murphy & Shtern. *What You Need to Know About Office-Based Surgery Laws*, Modern Medicine Network, Feb. 1, 2018. https://www.physicianspractice.com/law-malpractice/what-you-need-know-about-office-based-surgery-laws.**

[9] **Shapiro, Punwani & Urman. *Office-Based Surgery Regulation: Embracing Patient Safety Strategies, Journal of Medical Practice Management*, Sept. 2013.**

[10] *Guidelines for Office-Based Anesthesia, American Society of Anesthesiologists,* Oct. 21, 2009. https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia.

[11] Roan, Shari. *Study Blasts Lack Of Training in Cosmetic Surgery Marketplace*, L.A. Times, April 2, 2010. http://latimesblogs.latimes.com/Booster_Shots/2010/04/Cosmetic-Surgery-Liposuction.Html.

[12] **Schorsch, Peter. *Plastic Surgery Deaths Highlight Need for Specialty Board Certification*, Florida Politics, Dec. 19, 2017. https://floridapolitics.com/archives/252069-plastic-surgery-deaths-highlight-need-specialty-board-certification.**

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. H340-A/13 UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, sunset resolution H340-A/2013 titled "UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS" was recommended to be REAFFIRMED AS AMENDED in 2018; and

WHEREAS, sunset resolution H340-A/2013 titled "UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS" was referred to the Bureau of State Government Affairs (BSGA) for further review; now therefore be it,

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED as submitted.

H273-A/08 UNIFORM PATHWAY OF LICENSING OF OSTEOPATHIC PHYSICIANS

The American Osteopathic Association states that the examination of the National Board of Osteopathic Medical Examiners must remain as ~~an~~ **THE** avenue for the licensure of osteopathic physicians and supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the National Board of Osteopathic Medical Examiners**, TO BE EFFECTIVE AFTER 12/31/19**. 1991; revised 1993, 1998, 2003; 2008.

Explanatory Statement:

Osteopathic physicians (DOs) are currently required to complete Levels 1 and 2 of the National Board of Osteopathic Medical Examiners' (NBOME) Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX-USA) in order to graduate from osteopathic medical school, and Level 3 in order to obtain an unlimited state medical license. NBOME examinations are developed by DOs and are designed to test the competencies for osteopathic medical practice, including the unique principles and practice of osteopathic medicine, to ensure patient safety and optimize patient outcomes. COMLEX-USA includes a performance evaluation/practical component (Level 2-PE) that includes testing of osteopathic manipulative medicine and treatment. The use of COMLEX-USA for DO licensure will remain unaffected by the transition to a Single Accreditation System under the Accreditation Council for Graduate Medical Education (ACGME), and the AOA strongly supports its continuing use as the sole pathway to DO licensure as it is the only examination designed for the practice of osteopathic medicine and that has demonstrated validity for that purpose.

Further, competition for certain residency positions has led some osteopathic medical students to elect to take Steps 1 and/or 2 of the United States Medical Licensing Exam (USMLE) during medical school, in addition to COMLEX Levels 1 and 2; however, the AMA and ACGME explicitly recognize COMLEX-USA equivalently to USMLE and the AOA continues to advocate for education around COMLEX-USA for equivalent uses to USMLE by residency program directors in order to alleviate this unnecessary burden and stress on osteopathic medical students, while also assisting to preserve the integrity and distinctiveness of the profession.

Reference Committee Explanatory Statement

The Committee believes that adding an effective date will allow for grandfathering in of osteopathic physicians who obtained licensure previously through the FLEX or USMLE examinations, etc.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS – SUPPORT FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, the 2018 AOA House of Delegates adopted resolution H359 PREVENTING PHYSICIAN BURNOUT – SAFE HAVEN NON-REPORTING PROTECTION FOR PHYSICIANS which directs the Bureau of State Government Affairs to develop policy in support of safe haven non-reporting protections for physicians; now, therefore be it

RESOLVED, that the following policy paper and recommendations be adopted as the American Osteopathic Association's (AOA) position on safe haven non-reporting protections for physicians and medical students; and be it further

RESOLVED that upon approval of safe haven non-reporting as organizational policy, the AOA's Bureau of State Government Affairs will be tasked with developing a model act for consideration by the 2020 AOA House of Delegates.

AOA POLICY PAPER:
SAFE HAVEN NON-REPORTING PROTECTIONS FOR PHYSICIANS

BACKGROUND

Burnout among US medical students, residents and practicing physicians is a significant problem that negatively impacts medical professionals as well as the patients that they serve. Physicians in the US report symptoms of burnout at nearly double the rate of other US workers after controlling for work hours and other factors, and between 2011 and 2014, this percentage increased by 9%.[1] Further, twenty to forty percent of medical students, interns and residents report experiencing symptoms of burnout.[2]

Burnout is characterized by a "wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression and suicidal ideation."[3] It has also been shown to negatively impact a physician's prescribing habits, test ordering, risk of malpractice suits, and whether patients adhere to their recommendations.[4] Although the aforementioned description does not explicitly reference substance use disorders, we will hereafter reference symptoms of burnout, mental health and substance use issues (and their treatment) interchangeably.

Even when resources are available to help physicians and students address symptoms of burnout; however, both groups report similar concerns about pursuing them. For purposes of this policy paper, we will focus on concerns regarding lack of confidentiality and possible disciplinary or discriminatory action by schools, employers, state medical licensing boards and other academic or professional entities.

REPORT OF THE FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

The Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Wellness and Burnout (Workgroup) to study the issue of physician burnout and draft recommendations to help groups in the medical community better address this issue. The Workgroup found that although numerous resources exist to help medical students and physicians experiencing symptoms of burnout or impairment through academic institutions, medical licensing boards and state physician health programs, social and professional pressures make students and physicians reluctant to seek treatment or to report seeking it.[5] Both medical students and physicians cited fears that seeking help would result in documentation on academic or professional records which could lead to discrimination or denial of a medical license, and ultimately jeopardize their ability to practice medicine.

According to a poll conducted by the FSMB and the Medical Society of the State of New York, a state that does not currently include any questions about mental health or substance use on medical licensure applications, sixty-nine percent of physician respondents who were experiencing symptoms of burnout reported that they would be significantly less likely to seek treatment if they were required to report it on a licensing application or renewal.[6]

Further, despite evidence showing that a past history of mental health or substance use disorders does not reliably predict future risk to the public, most state licensing applications still contain questions about applicants' histories with these issues. As of 2017, 43 states asked questions about both mental and physical health conditions on their medical licensing applications, but just 23 limited all questions to disorders causing functional impairment and only six limited them to current problems.[71]

Although a similar number of medical licensing boards asked about both mental and physical health, questions about the latter tended to be much more lenient and vague while questions about the former were much more specific and probing.[8] Boards were significantly more likely to ask if physicians had ever been diagnosed, treated or hospitalized for a mental health or substance use disorder than for a physical disorder, and unlike questions about physical disorders, the questions were not limited to just those conditions that might *currently* affect a physician's ability to practice.

Responses by medical licensing boards to disclosures made by physicians about their mental health were also unpredictable and varied greatly from state to state. Some boards asked for a doctor's note, others requested all medical records related to an applicant's history and treatment, others required applicants to appear before the board to defend their ability to practice medicine and still others required applicants to undergo ongoing monitoring or practice under a restricted license.

In addition to the deterrent effect that questions from medical licensing boards regarding mental health appear to have on physicians' willingness to seek help when needed or report seeking it, courts have found that many such questions run afoul of the Americans with Disabilities Act (ADA). The ADA protects individuals with disabilities, including psychiatric disabilities, from discrimination. Professional licensing bodies are not exempt from the requirements of the ADA, and courts have stated that "[public entities] may not administer a licensing or certification program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability."[8] Public entities such as a medical licensing board also may not "impose or apply eligibility criteria that screen out or tend to

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[1] Gold KJ1, Shih ER, Goldman EB, Schwenk TL. "*Do US Medical Licensing Applications Treat Mental and Physical Illness Equivalently?*" Journal of Family Medicine, June 2017. 49(6):464-467. Available at: https://www.stfm.org/FamilyMedicine/Vol49Issue6/Gold464.

screen out an individual with a disability … unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."[5]

In order to encourage medical students and physicians to seek appropriate treatment for mental health and substance use disorders, and ensure that medical licensing boards comply with the ADA, the FSMB encourages medical licensing boards to adopt policies that support physician "safe haven non-reporting."

"Safe haven non-reporting" allows physicians who are receiving appropriate treatment for mental health or substance use issues who are monitored and in good standing with their confidential treatment program to (re)apply for licensure without having to disclose their treatment to the board. Only disclosures related to issues that are not being appropriately treated and could inhibit a physician's ability to safely practice medicine would be required.

RECOMMENDATIONS

The AOA adopts the following statements as its official position on "safe haven non-reporting:"

The presence or history of a mental health or substance use disorder does not automatically render a physician unfit to practice medicine, and the AOA opposes discrimination or disciplinary action against a physician or medical student based solely on the presence of such a disorder, without taking into consideration the individual's behavior or treatment.

The AOA urges state medical licensing boards to regard physical and mental health disorders similarly and refrain from asking about past history of mental health or substance use diagnoses or treatment on licensure applications or renewals. Instead, the AOA encourages boards to focus on whether any *current* physical or mental disorders are present which may impair that individual's ability to safely practice medicine. The AOA further encourages state medical licensing boards to offer a "safe haven non-reporting" option for physician applicants who are undergoing appropriate treatment for current mental health or substance use disorders. This alternative helps to ensure confidentiality of such treatment for the individual physician while ensuring patient safety.

If medical licensing boards decide to use questions related to mental health or substance use disorders on a medical licensure application or renewal, the AOA encourages boards to consider phrasing them similarly to questions about physical health. For example:

> ***"Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"***

"Appropriate treatment" includes physician participation provided through state physician health programs accredited by the Federation of State Physician Health Programs, or programs following similar standards and guidelines, and adherence to treatment recommendations.

Finally, the AOA encourages medical educational and professional entities, as well organizations throughout the medical community, to support and educate students and physicians about confidential

treatment and "safe haven non-reporting" options, in order to encourage these individuals to seek appropriate treatment without fear of documentation, disciplinary action or other repercussions.

References

1. Dyrbye, L.N., T.D. Shanafelt, C.A. Sinsky, P.F. Cipriano, J. Bhatt, A. Ommaya, C.P. West, and D. Meyers. 2017. Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. doi: 10.31478/201707b
2. Lapinski, et al. "
3. Physician Wellness and Burnout". *Federation of State Medical Boards.* April 2016. P.5. http://www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf
4. Tait D. Shanafelt and John H. Noseworthy, "Executive Leadership and Physician Well-Being," *Mayo Clinic Proceedings* 92, no. 1 (January 2017): 129–46, https://doi.org/10.1016/j.mayocp.2016.10.004.
5. *Id* at 3.
6. *Id* at 3.
7. Gold KJ1, Shih ER, Goldman EB, Schwenk TL. "*Do US Medical Licensing Applications Treat Mental and Physical Illness Equivalently?*" Journal of Family Medicine, June 2017. 49(6):464-467. Available at: https://www.stfm.org/FamilyMedicine/Vol49Issue6/Gold464.
8. https://labblog.uofmhealth.org/industry-dx/state-medical-licensing-boards-practices-may-hurt-physician-mental-health

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) FOR PATIENTS WITH PAIN CONDITIONS

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC MANIPULATIVE**
4 **TREATMENT (OMT) FOR PATIENTS WITH PAIN CONDITIONS**
5 The American Osteopathic Association affirms that OMT is a safe intervention and should be
6 considered as first-line treatment for patients with pain associated with Somatic Dysfunction
7 and other appropriate conditions. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

The American Osteopathic Association acknowledges human trafficking as a violation of human rights and a global public health problem; encourages osteopathic physicians to be aware of the signs of human trafficking and the resources available to aid them in identifying and addressing the needs of victims of human trafficking, including appropriate medical assessment and reporting to law enforcement. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES
The American Osteopathic Association (AOA) recognizes the need of same-sex households to have the same access to health insurance and health care as opposite-sex households and supports measures to eliminate discrimination against same-sex households in health insurance and health care. The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for same-sex marriages and civil unions and the children of those families. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the following policy be ~~**SUNSET**~~ **REAFFIRMED AS AMENDED**:

H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION

The American Osteopathic Association (AOA) will work with ~~**Wikipedia and other**~~ online and public information sites to ~~**develop**~~ **ENSURE THAT** content ~~**that**~~ is accurate and unbiased and encourage osteopathic physicians to notify the AOA Division of Media Relations to address misinformation ~~**on internet encyclopedias, websites, and databases**~~ regarding osteopathic medicine. 2014

Explanatory Statement:
~~**The Wikipedia rules specifically prohibit employees of an organization from creating content about the organization's focus. The AOA is only permitted to update numbers (per the OMP report) and is not allowed to edit pages or suggest edits.**~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H405-A/14 ALERT NETWORK – SILVER AND GOLD

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H405-A/14 ALERT NETWORK – SILVER AND GOLD
The American Osteopathic Association endorses the wide-spread state adoption of emergency response systems for missing mentally impaired adults throughout the United States, via "Silver Alert" and "Gold Alert" networks which are also known as "Endangered Person Advisory Networks." 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H407-A/14 ALCOHOL ABUSE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H407-A/14 ALCOHOL ABUSE
The American Osteopathic Association endorses local, state and federal legislation that would control the consumption and purchase of alcohol by individuals under the age of twenty-one; and urges that alcohol abuse prevention and treatment programs be given a high national priority. 1974; reaffirmed 1978; revised 1983, 1988, 1994, 1997, 1999, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H408-A/14 DISCRIMINATION IN HEALTHCARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H408-A/14 DISCRIMINATION IN HEALTHCARE
The American Osteopathic Association adopts a zero tolerance policy for all forms of patient discrimination; and in concert with other healthcare organizations, and the federal, state and local governments will continue to monitor, correct and prevent any future negative bias towards one or more patient groups. 1999, revised 2004; reaffirmed as amended 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H409-A/14 SUDDEN INFANT DEATH SYNDROME

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H409-A/14 SUDDEN INFANT DEATH SYNDROME
The American Osteopathic Association urges: continued research into the causes and prevention of sudden infant death syndrome (SIDS); that information based on current medical literature be made available to the public on the nature of sudden infant death syndrome and proper counseling be available to families who lose infants to this disease; and supports the US DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CENTERS FOR DISEASE CONTROL AND PREVENTION ~~Public Health Service's~~ campaigns by encouraging its members to educate the parents and care-givers of infants on strategies to reduce the risk of SIDS. 1974; reaffirmed 1980, 1985; revised 1990, 1995, 2000; 2004 reaffirmed 2005; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED

The American Osteopathic Association ~~will work with~~ SUPPORTS ~~the appropriate regulatory / environmental and public health agencies to encourage~~ the development of educational materials for the public BY THE APPROPRIATE REGULATORY/ENVIRONMENTAL AND PUBLIC HEALTH AGENCIES on the dangers of keeping unused and expired pharmaceuticals in their possession; and will ~~insure~~**ENSURE** **SUPPORTS** that such materials also include education on the proper disposal of unused and expired pharmaceuticals. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL BY ATTORNEYS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL BY ATTORNEYS

The American Osteopathic Association urges the American Bar Association to encourage its members who advertise to employ high ethical standards in their public advertisements AND AVOID INFLAMMATORY OR UNETHICAL ADVERTISING. THE AOA FURTHER ENCOURAGES PHYSICIANS, AND OTHER MEMBERS OF THE PUBLIC, TO REPORT INCIDENTS OF INAPPROPRIATE ADVERTISEMENTS TO STATE BAR ORGANIZATIONS, ATTORNEY PROFESSIONAL ORGANIZATIONS, THE FEDERAL TRADE COMMISSION AND OTHER ORGANIZATIONS WITH POTENTIAL FOR INVESTIGATION. 1989; revised 1994; reaffirmed 1999; revised 2004; reaffirmed 2009; 2014

Reference Committee Explanatory Statement:
The Committee believes that this resolution is not directly related to healthcare.

ACTION TAKEN **DISAPPROVED** *(will be sunset)*

DATE **July 27, 2019**

SUBJECT: H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH

The American Osteopathic Association (AOA) will continue to engage the osteopathic medical profession in Comparative Effectiveness Research (CER) projects and studies across private organizations and government agencies. The AOA will continue to disseminate CER findings to the osteopathic medical profession, consumers of medical information, patients, family members, and caregivers. The AOA adopts the following principles regarding comparative effectiveness research (2009; reaffirmed as amended 2014):

Physicians and Patients

- Comparative effectiveness research should enhance the ability of osteopathic physicians (DOs) to provide the highest quality care to patients utilizing the best proven and widely accepted evidence based medical information at the time of treatment.
- Comparative effectiveness research should not be used to control medical decision-making authority**,** ~~or~~ professional autonomy~~.~~ **AND SHOULD NOT BE USED TO DENY COVERAGE OR PAYMENT.**
- Comparative effectiveness research should enhance, complement, and promote quality patient care, not impede it.
- Guidelines developed as a result of comparative effectiveness research studies should be advisory and not mandatory.
- Comparative effectiveness research should be viewed as a positive development for patients and physicians and a useful tool in the physician's armamentarium, working in concert with patients.
- Physicians in practice should be included in any discussions and decisions regarding comparative effectiveness research.
- Comparative effectiveness research should focus on clinical effectiveness, not cost effectiveness~~**, and should not be used to deny coverage or payment**~~.
- The physician/patient relationship must be protected and the needs of the patients should be paramount.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H413-A/14 ~~EPIDEMIC~~ TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

The American Osteopathic Association ~~believes that~~ SUPPORTS victims of ~~an epidemic~~ terrorist attackS ~~(e.g., anthrax) are victims of a new age conflict against America and as victims of an attack against America; they should~~ TO be eligible for healthcare to be covered by the United States Government. 2004; reaffirmed as amended 2009; reaffirmed 2014

Reference Committee Explanatory Statement:
The Committee requires clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy.

ACTION TAKEN **REFERRED** *(to Bureau on Federal Health Programs)*

DATE **July 27, 2019**

SUBJECT: H414-A/14 FLUORIDATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H414-A/14 FLUORIDATION
The American Osteopathic Association supports the fluoridation of fluoride-deficient public water supply. Reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS
The American Osteopathic Association supports government expenditures for THE TITLE V ~~mM~~aternal and ~~c~~Child ~~h~~Healthcare ~~b~~Block ~~g~~Grant PROGRAM and the efficient use of ITS resources. THE AOA ~~and~~ supports ~~maintaining or increasing~~ ENSURING SUFFICIENT funding FOR THIS PROGRAM~~levels for the maternal and child healthcare block grants~~. 1988; revised 1993, 1998, 2003, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

The American Osteopathic Association supports federal legislation to reform the Employee Retirement Income Security Act (ERISA) of 1974 to ensure the ability of states to guarantee that clinical decisions be made by physicians and that patients have legal remedies in state court. THE AMERICAN OSTEOPATHIC ASSOCIATION ALSO SUPPORTS LEGISLATION THAT EXTENDS THESE PROTECTIONS TO CLINICAL DECISIONS IMPACTING PATIENT ACCESS TO PRESCRIPTION DRUGS. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE**
4 The American Osteopathic Association encourages exclusive breastfeeding by mothers in
5 methadone maintenance who are in stable recovery. 2003; reaffirmed as amended 2009;
6 reaffirmed 2014

Reference Committee Explanatory Statement:
The Committee is requesting an evaluation of breastfeeding and other forms of medical assisted treatments (MAT) for opioid addiction, not limited to methadone.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health)*

DATE **July 27, 2019**

SUBJECT: H418-A/14 RAW MILK – HEALTH RISKS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H418-A/14 RAW MILK – HEALTH RISKS
The American Osteopathic Association believes that all milk sold for human consumption should be required to be pasteurized; ~~**supports any government efforts to prohibit the sale and advertisement of raw milk to the public**~~; and ~~that~~ ENCOURAGES osteopathic physicians ~~may~~TO educate their patients~~ of both~~ ON the safety concerns and the health risks of consuming raw milk. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H419-A/14 VACCINES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H419-A/14 VACCINES**
4 The American Osteopathic Association will continue to promote evidence-based information
5 on vaccination compliance and safety. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE – DEVELOPMENT OF PROGRAMS TO PREVENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE – DEVELOPMENT OF PROGRAMS TO PREVENT

The American Osteopathic Association will continue to support the efforts of the United States Department of Health and Human Services to develop and foster programs that prevent domestic and intimate partner violence. 1989; revised 1994, 1999; reaffirmed 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H425-A/14 HEALTH CARE FRAUD

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H425-A/14 HEALTH CARE FRAUD**
4 The American Osteopathic Association urges the Center for Medicare and Medicaid Services
5 (CMS) to: (1) disclose to the public and the medical community the actual amount of "fraud" in
6 dollars, based on the reasonable definition of "fraud" omitting all denied and resubmitted
7 claims and all honest mistakes by physicians and the Medicare carriers; and (2) strongly opposes
8 the use of law enforcement agencies and auditors to enter physicians' offices without prior
9 request, warning or due process under the law for the purpose of confiscating records. 1999;
10 revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) AVAILABILITY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) AVAILABILITY

The American Osteopathic Association recommends an automated external defibrillator (AED) be placed in as many public places as possible and supports legislation that will limit the liability ~~from placement of~~ FOR INSTALLING an AED for use by the public. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H429-A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H429-A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

The American Osteopathic Association encourages an increase in the total number of URM graduates from colleges of osteopathic medicine by the year 2020 and encourages an increase in the total number of URM faculty by the year 2020. 2014

Reference Committee Explanatory Statement:
This resolution is being referred back for an update of the statistics to determine if the deadline of the goals should be extended.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health and Bureau of Osteopathic Education)*

DATE **July 27, 2019**

SUBJECT: H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT

The American Osteopathic Association (AOA) encourageS physicians and public health departments to screen children for lead based upon current recommendations and guidelines established by the US Centers for Disease Control and Prevention'S ~~and the Advisory Committee on~~ Childhood Lead Poisoning Prevention PROGRAM and, encourages the reporting of all children with elevated blood lead levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children and, encourages public health policy initiatives that identify exposure pathways for children and develop effective and innovative strategies to reduce overall childhood lead exposure. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H432-A/14 HEPATITIS C SCREENING

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H432-A/14 HEPATITIS C SCREENING

The American Osteopathic Association (AOA) publicly supports universal screening of baby boomers (those born 194**5**~~6~~-196~~5~~4) in addition to testing those at risk for hepatitis C virus (HCV), and~~,~~ ~~the will AOA support and~~ promote public educational programs that educate their members about HCV, testing strategies, and treatment. ~~**The AOA will work with Centers for Medicare and Medicaid Services to remove the restrictive language that only primary care providers can order, and be reimbursed for one-time HCV Screenings for baby boomers (1945~~**6**~~-1965~~**4**~~).~~ The AOA will work with public health entities to educate the public about the need for testing and treatment. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING

The American Osteopathic adopts the following policy ~~and recommendations as provided within the attached white paper.~~ 2014

~~**REGULATION OF E-CIGARETTES AND NICOTINE VAPING**~~

~~**BACKGROUND**~~

~~In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the last 30 years. Accordingly, the use of electronic cigarettes (e-cigarettes) has reached a rapidly expanding consumer base. E-cigarettes are often used or promoted to reduce consumption of tobacco products. Alternative tools to reach these goals are switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.~~

~~The e-cigarette name is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-hookahs, but could potentially be referred to by other terms.~~

~~Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 250 brands. Sales are expected to reach $1.7 billion by the end of 2013, according to the Attorneys General Association. Over the next decade, it is possible that sales of e-cigarettes will outstrip conventional cigarettes.~~

~~The attraction to e-cigarettes crosses many segments of the population, appealing to the tobacco cigarette smoker trying to quit and the non-smoker who wants to try nicotine without the harmful additives. Tobacco cigarette smokers can also use e-cigarettes as a source of nicotine in venues where conventional cigarettes are banned, although some states and municipalities have also started to ban e-cigarettes in these spaces.~~

~~Smoking costs the United States an estimated $96 billion annually in direct medical expenses and an additional $97 billion in lost productivity. Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death. However, the effect of long term consumption of only nicotine is unknown, and e-cigarettes have already been shown to leave behind indoor air pollution that could be both hazardous to users themselves along with second hand users. Additionally, many users of e-cigarettes are using them in a supplemental fashion, while continuing to utilize traditional tobacco cigarettes.~~

~~ANALYSIS~~

~~The Food and Drug Administration (FDA) does not currently regulate e-cigarettes. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), provides the FDA authority to regulate the manufacture, marketing and distribution of tobacco products. However, e-cigarettes are not in the purview of FDA regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes enjoy the ability to advertise on television and radio. This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.~~

~~The Composition of E-Cigarettes~~

~~The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients. It is primarily composed of a nicotine cartridge, atomizer, and a battery. The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element. When screwed onto the cartridge, the nicotine liquid from the cartridge comes into contact with the atomizer unit and is carried to the metal coil heating element. A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.~~

~~While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens and lipsticks. Often, they can be legally used where traditional tobacco products are banned.~~

~~Federal Efforts to Regulate~~

~~The FDA can regulate e-cigarettes only if the manufacturers make a therapeutic claim, such as e-cigarettes are to be used as a cessation device. The FDA jurisdictional authority covers various products including food, cosmetics, animal and human drugs, medical devices and radiological products. Currently, e-cigarettes do not fall within the jurisdiction of the FDA.~~

~~The FDA has made efforts to regulate e-cigarettes. When the FDA made a determination that certain e-cigarettes were unapproved drug/device combination products, they seized e-cigarettes being imported by Sottera, Inc., resulting in a lawsuit between the company and the FDA. The court held that the FDA lacked authority under the drug/device provisions to regulate tobacco products customarily marketed without claims of therapeutic effect.~~

~~This ruling offers new challenges to FDA regulation because of the novel method of nicotine delivery, various mechanical and electrical parts, and nearly nonexistent safety data. Consumer use, marketing, promotional claims and technological characteristics of e-cigarettes have also raised decade-old questions of when the FDA can assert authority over products as drugs or medical devices.~~

~~State Efforts to Regulate~~

~~Attorneys General from 40 states have urged the FDA to regulate e-cigarettes. The pressure is mounting because of various reasons. For example, unlike traditional tobacco products, there are no federal age restrictions that would prevent children from obtaining e-cigarettes, nor are there any advertising restrictions.~~

~~Various jurisdictions, both states and municipalities, have enacted laws requiring licenses to sell e-cigarettes and banning sales to minors. A distinctive feature of the TCA is the broad latitude expressly preserved to state and local authority to regulate tobacco products. Thirty-nine states and 3,671 municipalities already have laws in place restricting or prohibiting smoking in public places and workplaces. ; Currently, there are 100 local laws restricting e-cigarette use in 100%~~

~~smoke-free venues. However, there are only 3 state laws restricting e-cigarette use in 100% smoke-free venues and only 9 in other venues.~~

~~New Jersey became the first state to amend its public smoking laws to prohibit the use of e-cigarettes in all enclosed indoor places of public access as well as in working places. ; Minnesota enacted laws regulating the sale of e-cigarettes and impose criminal penalties for the sale of e-cigarettes to minors. New Hampshire also enacted a law that prohibits the sale of e-cigarettes and liquid nicotine to minors and distribution of free samples of such products in a public place. New Hampshire also prohibits the use of such products on the grounds of any public educational facility. Similarly, Utah enacted a regulation controlling the sale, gift and distribution of e-cigarettes by manufacturers, wholesalers, and retailers, and King County, Washington enacted an ordinance that bans the smoking of e-cigarettes in public places. Some state and local restrictions on the use of e-cigarettes are driven largely by the concern that they have similar damaging effects on bystanders as traditional cigarettes.~~

~~Arguments for E-Cigarettes~~

~~Smoking accounts for nearly 5.4 million cancer-related deaths worldwide each year. This includes 443,000 deaths in the United States. Proponents argue that e-cigarettes do not expose the user, or others close by, to harmful levels of cancer-causing agents and other dangerous chemicals normally associated with traditional tobacco products.~~

~~Various physician groups have defended the product, based on their opinion that e-cigarettes deliver nicotine without the tar and myriad of other chemicals found in regular cigarettes. At this point, no one knows whether the e-cigarette alternative to tobacco cigarettes carry any long-term detrimental health effects, however it is known that they contain less carcinogenic elements than traditional tobacco cigarettes. According to the American Lung Association there are approximately 600 ingredients in cigarettes. When burned, they create more than 4,000 chemicals. At least 50 of these chemicals are known to cause cancer, and many are poisonous. While e-cigarettes may have less component chemicals, a study found that the usage of e-cigarettes contributes to indoor air pollution. The results showed that e-cigarettes are not emission free, and that their pollutants could be a danger to both users as well as secondhand smokers.~~

~~The draw of the e-cigarette for smoking cessation is that it delivers nicotine to counter nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking because of its shape and the familiar behavior aspect of smoking. A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking. Another survey of 3,037 users of e-cigarettes revealed that 77% of them said that they used them to quit smoking or to avoid relapse. None said they used them to reduce consumption of tobacco with no intent to quit smoking. However, the overall effectiveness of e-cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.~~

~~Consequences of E-Cigarettes~~

~~Charting in unknown territory always poses the risk for consequences. Advocates contend that e-cigarettes are less risky and harness the possibility to reduce smoking or even be a complete smoking cessation. A major concern is that it appeals to youth by being flavorful, trendy and a convenient accessory. The flavorings being used, such as candy and other sweet flavorings are~~

~~particularly appealing to younger populations. For this reason, these flavorings are banned in traditional cigarettes.~~

~~Further, e-cigarette usage among children is increasing. During 2011-2012, the percentage of middle school students who have tried e-cigarettes jumped from 1.4% to 2.7%. Among high school students, the jump was from 4.7% to 10%, and 80.5% of high-school students who use e-cigarettes also smoke conventional cigarettes. These numbers could also be largely underestimating the percentage of children using e-cigarettes, as many call the devices by other names. Manufacturers and sellers of e-cigarettes have begun using other product names such as "hookah pens," "e-hookahs," or "vape pens." Even though these products differ only in name and appearance from e-cigarettes, many school age children that used these devices failed to identify them as such.~~

~~Aside from the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine. Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Nicotine addiction is a combination of positive reinforcements, including enhancement of mood and avoidance of withdrawal symptoms. E-cigarette cartridges contain up to 20 times the nicotine of a single cigarette, and the process of "vaping" lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.~~

~~Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues. E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or nicotine cartridge. Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.~~

~~E-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions. In the United States there has been at least 2 reports of e-cigarettes exploding in users' faces and hands causing severe injuries including blown out teeth, extensive burns and tissue damage to lips and tongues, burns to the hands and hearing and vision loss.~~

~~CONCLUSION~~

The AOA supports FDA and state regulation of the ingredients of all electronic cigarette cartridges, requiring ingredient labels and warnings, and eliminating the usage of flavors~~ that are banned in traditional cigarettes~~.

The AOA supports the FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 18. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.

The AOA further encourages federal, state and local government action to banning the use of electronic cigarette devices in spaces where traditional cigarettes are currently barred from use.

The AOA promotes tobacco and nicotine cessation treatment, and the usage of any such treatment that has been proven safe and effective by the FDA.

The AOA supports research by the FDA and other organizations into the health and safety impact of e-cigarettes and liquid nicotine.

THE AOA SUPPORTS PHYSICIANS CONSIDERING THE RISKS OF RECOMMENDING E-CIGARETTES TO PATIENTS, AS WELL AS REQUESTING

THAT THEIR PATIENTS SUBMIT VOLUNTARY REPORTS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SAFETY REPORTING PORTAL (WWW.SAFETYREPORTING.HHS.GOV) IF THEY SUSTAIN ADVERSE REACTIONS TO E-CIGARETTES.

~~The AOA supports physicians considering the risks of recommending e-cigarettes to patients, as well as requesting that their patients submit voluntary reports to the U.S. department of health and human services safety reporting portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.~~

~~References:~~
~~Jordan Paradise, No Sisyphean Task: How the FDA Can Regulate Electronic Cigarettes, 13 Yale J. Health Pol'y L. & Ethics 326, 329 (2013).~~
~~Id. at 330.~~
~~Jordan Paradise at 329.~~
~~Id.~~
~~Dan Radel, Healthy or Harmful? Smoking out the truth about e-cigarettes, *available* at http://special.app.com/article/20131027/NJLIFE04/310270144/Healthy-or-harmful-Smoking-out-the-truth-about-e-cigarettes~~
~~Id.~~
~~Id. at 331.~~
~~CDC, Smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 2000-2004, 57 morbidity & mortality wkly. rep., 1226, 1226-28 (2008).~~
~~Jordan Paradise at 333.~~
~~Schober W, Szendrei K, Matzen W, Osiander-Fuchs H, Heitmann D, Schettgen T, et al, Use of Electronic Cigarettes (E-Cigarettes) Impairs Indoor Air Quality and Increases FeNO Levels of E-Cigarette Consumers, International Journal of Hygiene Environment and Health, December 2013, available at http://www.ncbi.nlm.nih.gov/pubmed/24373737~~
~~Available at http://publichealthlawcenter.org/sites/default/files/resources/tclc-fs-ftc&tobacco-2012.pdf~~
~~15 U.S.C. § 1335.~~
~~Stuart Elliots, E-Cigarette Makers' Ads Echo Tobacco's Heyday, New York Times, August 29, 2013, available at http://www.nytimes.com/2013/08/30/business/media/e-cigarette-makers-ads-echo-tobaccos-heyday.html~~
~~Jordan Paradise at 353.~~
~~Id. at 353.~~
~~Tobacco fact sheet: Electronic Cigarettes (E-Cigarettes), Legacy for Longer Healthier Lives, available at http://www.legacyforhealth.org.~~
~~Jordan Paradise at 354.~~
~~Id.~~
~~Available at http://www.smokingeverywhere.com/cartridge.php.~~
~~Jordan Paradise at 354.~~
~~Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).~~
~~Food, Drug, and Cosmetic Act (FDCA), Pub. L. No. 75-717, 52 Stat. 1040 (1938).~~
~~Troutman Sanders, Federal, State, and Local Lawmakers Take Aim at E-Cigarettes, available at www.Tobaccoretailer.com~~
~~Sottera, Inc. v. FDA, 627 F.3d 891 (D.C. Cir. 2010).~~

~~Jordan Paradise at 329.~~
~~Id. at 331.~~
~~Dan Radel supra.~~
~~Id., The National Association of Attorneys General letter to the FDA.~~
~~Jordan Paradise at 374.~~
~~21 U.S.C. § 387g(a)(1)(A).~~
~~Jordan Paradise at 373.~~
~~American Nonsmokers' Foundation., U.S. State and Local Laws Regulating Use of Electronic Cigarettes. www.no-smoke.org.~~
~~Id.~~
~~N.J. Stat. Ann. SEC 26:3D-58.~~
~~Troutman Sandra supra.~~
~~Id.~~
~~Id.~~
~~Id.~~
~~Id.~~
~~Jordan Paradise at 335.~~
~~Tobacco free initiative: tobacco facts, WHO available at~~
~~http://www.www.who.int/tobacco/mpower/tobacco_facts/en/index.html~~
~~CDC, Current Cigarette Smoking Among Adults – United States, 2011, 309 JAMA 539, 539-40 (2013).~~
~~Daniel J. Denoon, E-cigarettes under fire, No-Smoke Electronic Cigarettes draw Criticism from FDA, quoting Craig Youngblood, president of InLife, e-cigarette company available at www.webmd.com/smoking-cessation/features/ecigarettes-under-fire.~~
~~Troutman Sanders supra.~~
~~Dan Radel, supra quoting Robert Lahita, Chair of Medicine at New Beth Israel Medical Center.~~
~~Dan Radel, supra quoting Thomas Kiklas, Co-Founder of The E-Cigarette Association~~
~~Id.~~
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Explanatory Statement:
The conclusions in the white paper are still relevant, with one additional edit. The analysis in the body of the white paper is outdated and therefore should be deleted.

Reference Committee Explanatory Statement:
The Committee requests an updated policy paper.

ACTION TAKEN **REFERRED** *(to Bureau of State Government Affairs)*

DATE **July 27, 2019**

SUBJECT: H406-A/14 FIREARM SAFETY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H406-A/14 FIREARM SAFETY
THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) RECOMMENDS THAT ~~**DURING ROUTINE PATIENT CARE,**~~ **WHEN APPROPRIATE,** PHYSICIANS ASK PATIENTS AND/ OR CAREGIVERS ABOUT THE PRESENCE OF FIREARMS IN THE HOME AND COUNSEL PATIENTS WHO OWN FIREARMS ABOUT THE POTENTIAL DANGERS INHERENT IN GUN OWNERSHIP, ESPECIALLY IF **VULNERABLE INDIVIDUALS** CHILDREN AND ADOLESCENTS ARE PRESENT. The AOA RECOMMENDS ~~supports and encourages~~ strategies such as secure storage and the use of safety locks TO ELIMINATE ~~for eliminating~~ the inappropriate access to firearms by **VULNERABLE INDIVIDUALS** children and adolescents and RECOMMENDS ~~supports and encourages~~ all physicians to educate families in the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014

Explanatory Statement:
This policy was amended to strengthen the recommendation that physicians routinely counsel and provide education on safe use and storage for patients who own firearms and have children in the home.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING **FOR EMERGENCY MEDICAL CARE**

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, varying state laws to address balance billing have garnered the interest of federal law makers to mandate a federal standard to address the practice of balance billing; and

WHEREAS, 14 percent of emergency department visits are likely to include balance billing[1, 2]; and

WHEREAS, 20 percent of patients admitted to the hospital via the emergency department are likely to receive balance billing[1, 2]; and

WHEREAS, we believe that it is important that patients be protected from egregious balance billing practices; and

WHEREAS, we recognize that physicians practice under a variety of compensation arrangements, e.g., independent contractor, salary, hourly compensation, percentage of gross or net billing, or a combination of these; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) ~~will~~ support**S** patients' right to access emergency medical ~~**procedures**~~ **CARE** at a **REASONALBE** cost ~~**that is based on competitive private market rates**~~; and, be it further

RESOLVED, that the AOA, in ~~**an**~~ emergency medical ~~**procedure**~~ **CARE**, supports a system in which patients are removed from the process of resolving outstanding medical expenses that is beyond their cost sharing responsibilities **FOR IN-NETWORK CARE; AND, BE IT FURTHER**

RESOLVED, THAT DISPUTES OVER THE REASONABLE COST FOR OUT OF NETWORK EMERGENCY CARE BE DETERMINED BY AN INDEPENDENT, THIRD PARTY OR ARBITRATION.

References

1. C. Garmon and B. Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," Health Affairs Web First, published online Dec. 14, 2016.
2. Cooper, Zack, Fiona Scott Morton. 2016. "Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise," N Engl J Med 2016; 375:1915-1918.

Reference Committee Explanatory Statement:

"Surprise billing" results from insurance companies passing out-of-network payment responsibilities to patients. The best practice for resolving payment disputes between insurance companies and care providers is the use of independent third party databases or an Independent Dispute Resolution

process using a third party arbiter. This resolution advocates for the inclusion of these best practices in any legislation.'

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-403 - A/2018: H403-A/13 ~~AIRBAGS IN AUTOMOBILES~~ **OCCUPANT PROTECTION IN PASSENGER VEHICLES**

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-403 - A/2018 titled "AIRBAGS IN AUTOMOBILES" was referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to develop a white paper on all automotive safety, including airbags; now therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that H-403 - A/2018 be reaffirmed as amended and the following white paper, titled "OCCUPANT PROTECTION IN PASSENGER VEHICLES", be adopted:

Occupant Protection In Passenger Vehicles

INTRODUCTION

Today, almost every vehicle on the road has safety features that help drivers to be safer, either through protecting drivers and passengers involved in a crash or to preventing passenger vehicle crashes. This paper will provide information on all vehicle safety features and whether or not the feature is federally mandated, as well as recommend associated policy for adoption by the AOA.

OCCUPANT PROTECTION IN PASSENGER VEHICLES

Occupant protection includes safety belts, lower anchor and tethers for children (LATCH), airbags, and active head restraints. These features were designed to protect both drivers and passengers.

In 2016, National Highway Traffic Safety Administration (NHTSA) developed a fact sheet with information on passenger vehicle occupant protection, which included the use of restraints and benefits of safety belts, frontal airbags, and child restraints. According to the fact sheet, safety belts saved an estimated 14,668 lives of passenger vehicle occupants 5 years old and older in 2016, frontal air bags saved an estimated 2,756 lives, and car seats saved an estimated 328 lives of children under the age of 5 years.[1] NHTSA estimated that lap/shoulder safety belts, when used, reduce the risk of fatal injury among front-seat passenger vehicle occupants by 45%; moderate to critical injury to front-seat passenger vehicle occupants by 50%; fatal injury in front-seat light truck occupants by 60%, and moderate to critical injury to front-seat light truck occupants by 65%.[1]

Frontal airbags, combined with lap/shoulder bags offer effective safety protection for passenger vehicle occupants. NHTSA estimated that the use of frontal airbags without safety belts reduced the fatality risk by 11%, and when using safety belts, fatality drops further by 14%. In 2016, frontal airbags saved an estimated 2,756 lives. From 1987, when airbags first began to be installed in passenger vehicles, through 2016, 47,648 lives were saved. [1]

NHTSA estimated that car seat use in passenger vehicles reduce the risk of fatal injury by 71 % for infants younger than 1 year of age and 54 % for toddlers age 1 to 4 years. For infants and toddlers, the risk of fatal injury in light trucks is 58 % for infants younger than 1 year, and 59 % for toddlers ages 1 to 4 years. In 2016, car seat restraints saved an estimated 328 lives of children age 4 years and younger (313 associated with the use of car seats and 15 with the use of adult safety belts). NHTSA estimated that an additional 42 lives could have been saved (a total of 370 children age 4 and younger). Since 1975, the lives of 11,274 children 4 years old and younger involved in automobile accidents were saved because of child restraint use. [1]

There is an abundance of technology available to protect occupants of passenger vehicles. Most of the advancements have been in place for many years. As technology progressed, many of the features improved, resulting in more saved lives.

Safety-Belt Features

While the seat belt is the most important piece of automotive safety equipment, enhanced features have helped the seat belt do its job more efficiently.[2]

On March 1, 1967, the first Federal Motor Vehicle Safety Standard (FMVSS) mandate required that all passenger vehicles have safety belts. FMVSSs are United States federal regulations specifying the design, construction, performance, and durability requirements for passenger vehicles safety-related components, systems, and design features. FMVSSs are developed and enforced by the National Highway Traffic Safety Administration (NHTSA), pursuant to the National Traffic and Motor Vehicle Safety Act of 1966.

Safety belts now have belt tensioners; a device designed to pull a seat belt tight in an accident. This feature helps position passengers properly to take full advantage of a deploying airbag. [2]

Force limiters, companions to belt tensioners, reduce the force of the seat belt above a certain threshold and, in conjunction with belt tensioners and airbags, lessen the risk of upper body injuries to front seat passengers. [2]

Other seatbelt enhancements include inflatable seatbelts and adjustable shoulder anchors. Some car models have inflatable safety belts in the rear seat that reduces the force of the seat belt on passengers involved in an accident. Inflatable safety belts help protect the elderly and children who are the primary rear seat occupants. [2]

Safety belts also have adjustable shoulder anchors that help position the belt across the chest instead of the neck, which helps prevent neck injuries. [2]

Latch (Lower Anchors and Tethers for Children)

All passenger vehicles are now required to have the LATCH system. This system not only encourages the use of child safety seats but also integrates lower anchors and top tether attachment points. These anchors and attachment points allow the installation of the car safety seat to be effortless and eliminate the challenges and incompatibilities of installing a car safety seat. However, in some cars and trucks, the LATCH system is challenging to use correctly. [2]

NHTSA developed a traffic fact sheet that contains information on the fatal motor vehicle crashes and facilities, based on the Fatality Analysis Reporting System (FARS). Assuming that all passenger vehicle crashes have the LATCH system, in 2017, there were 23,351 passenger vehicle occupants killed in fatal crashes, 794 (3.3%) were infants (less than 1 year) to age 14. Of the 794 children killed, 244 (31%) were in a child restraint seat, 202 (25%) were in a lap belt only or shoulder, and lap belt and 103 (13%) were unknown. Of the 39,822 passenger vehicle occupants who survived in fatal crashes, 4,700 (11.8%) were infants (less than 1 year) to age 14 and 509 (11%) was unrestrained. Of the 63,373 passenger vehicle occupants involved in fatal crashes, 5,494 (8.7%) were infants (less than 1 year) to age 14, and 776 (15%) was unrestrained.[3]

Airbags

Since 1998, front airbags have been standard on all new cars, and since 1999, airbags have been standard on light trucks. The on-board computer-connected crash sensors detect a frontal collision and trigger the bags. In a few milliseconds, the bag inflates, then immediately deflates. [2]

Airbags have saved thousands of lives, but they also have the potential to cause children or occupants who do not use a seat belt to suffer injury or even death. [2] "From 1987 to 2015, frontal air bags saved 44,869 lives. That is enough people to fill a major league ballpark."[4] In 2016, the estimated number of lives saved by frontal airbags were 2,756. [4]

According to a Special Crash Investigations Report released in January 2009, from 1990 through January 1, 2009, there have been 296 airbag-related fatalities, (191 children, 92 adult drivers, and 13 adult passengers).[5] Also, the Takata airbag defection has caused 16 deaths in the U.S.; and 24 deaths and 300 injuries worldwide.[4]

Adaptive or dual-stage front airbags were introduced in 2003 and became the standard by 2007. Most airbag systems now have sensors that detect weight and the seat position of the driver and front passenger. The airbag

system will deactivate if it senses that the driver is positioned too close to the wheel or the front passenger or child is out of position. This system minimizes injury from an accident. [2]

Side Airbags. Side-impact airbags protect the torso of front seat passengers. (Consumer Reports 2016) Depending on the passenger vehicle model, side airbags are offered as standard or optional equipment on many new passenger vehicles. [4]

Side Curtain Airbags. Side curtain airbags are designed to prevent occupants from hitting their heads and shielding them from flying debris. They remain inflated longer than other airbags to keep people from being ejected during a rollover or a high-speed side crash. [2]

A standard enacted late in 2007 and effective September 1, 2009, NHTSA mandated that all automakers phase in additional side-impact protection as a standard feature for their cars, trucks, and SUVs by 2013.[7]

Active Head Restraints

In a rear crash, active head restraints move up and forward to cradle the head and absorb energy to diminish whiplash injury. [2]

ACCIDENT AVOIDANCE SYSTEMS

The automotive industry is continually developing traffic safety technologies that will help drivers avoid crashes. Some of these technologies have a warning system and rely on the driver to take corrective action, while others are designed to automatically brake or steer, thus taking an active action approach to accident prevention. These features are expected to contribute to an overall improvement in traffic safety.

AAA Foundation for Traffic Safety developed a research brief that presented the probable safety benefits of various advanced driver assistance systems and provided estimates regarding the numbers of crashes, injuries, and deaths that such systems could have potentially helped to prevent based on the characteristics of the crashes that occurred on U.S. roads in 2016.[8]

According to the brief, the Forward Collision Warning (FCW) could theoretically have prevented an estimated 69-81% of all rear-end crashes, 76-81% of angle crashes, and 23-24% of single-vehicle crashes, totaling approximately 2.3 million crashes and 7,166 fatal crashes per year between 2002 and 2006. In 2016, there were an estimated 1,994,000 crashes, 884,000 injuries and 4,738 deaths that could have been prevented or mitigated by the FCW system if it were a standard feature in all vehicles. [8]

The brief estimated that Lane Departure Warning (LDW) and Lane Keeping Assistance (LKA) technology equipped in passenger vehicles could have theoretically addressed 179,000 crashes and 7,529 fatal crashes annually between 2004 and 2008. In 2016, there were an estimated 519,000 crashes, 187,000 injuries, and 4,654 deaths that could have been prevented or mitigated by LDW or LKA systems. [8]

The brief estimated that blind spot warning systems (BSW) could have prevented approximately 24% of all lane-changing crashes between 2004 and 2008. In 2016, there were an estimated 318,000 crashes, 89,000 injuries, and 274 deaths that could have been prevented by the BSW system. [8]

There is also an abundance of advanced driver assistance technology available. This technology is designed to prevent crashes. The features are relatively new; thus, they will have varying levels of NHTSA recognition.

Forward Collision Prevention/Warning (FCW)

Adaptive Headlights. Adaptive headlights are primarily intended to move side-to-side to help illuminate curves and corners. "These headlights use electronic sensors that can detect your steering angle to swivel based on the direction your car is heading."[9]

Bicycle Detection. The bicycle detection feature alerts the driver to a potential collision with a bicyclist ahead. NHTSA has not set any performance specifications for this feature.[10]

Forward-Collision Warning (FCW). Forward-collision warning utilizes cameras, radar or laser to scan for autos ahead and alert the driver that they are moving toward a vehicle in their path excessively quick and an accident is inescapable. Most Forward-Collision warning systems alert the driver with a visual and or audible

signal to a potential accident, allowing time for a reaction.[2]

This system meets NHTSA performance specifications but is an option on many new cars, SUVs, and trucks.[11]

Left Turn Crash Avoidance. Left turn car avoidance feature monitors traffic when the driver turns left at low speeds. The sensor automatically activates warning sounds, dash lights, and brakes when a driver turns left into another car's path. NHTSA has not set any performance specifications for this feature.[12]

Obstacle Detection. Obstacle detection uses sensors mounted on the front and/or rear bumpers to determine the distance between the car and a nearby object. If an object is detected, the sensor automatically slows down the passenger vehicle. NHTSA has not set any performance specifications for this feature.[13]

Pedestrian Detection. This system utilizes the features of the Forward-Collision Warning system and automatically initiates the car's braking system to protect pedestrians from being hit. The car's camera or radar looks for a pedestrian in the path of the vehicle. Some systems will alert the driver with an audible or visual alert, and some systems will automatically initialize the emergency braking system if the collision is deemed high.[2]

NHTSA has not set any performance specifications for this feature but recognized that this is a promising technology. This system is currently an option on many new cars, SUVs, and trucks.[2]

Breaking, Tire Pressure, and Anti-Rollover

Brake Assist. Brake Assist helps detect when a driver is braking to maximum strength. In conjunction with anti-lock brakes, the system allows braking without locking the wheels. Studies have shown that most drivers are not braking as hard as they can, so Brake Assist intervenes to reach the shortest stop distance possible.[2]

Traction Control. Traction control electronically controls the wheels spinning motion during acceleration to obtain the maximum traction. This system is useful in wet, icy, or snowy conditions.[2]

Electronic Stability Control (ESC). Electronic stability control (ESC) is a step beyond traction control. In order to avoid sliding or skidding, this system helps keep the vehicle on its intended path during a turn. ESC uses a series of sensors connected to a computer to detect wheel speed, steering angle, side movement, and yaw (rotation). If the car drifts outside the intended path, the stability control system momentarily brakes one or more wheels and reduces the power of the engine to pull the car back on track depending on the system.[2]

ESC is particularly useful for tall, heavy-duty vehicles such as sports equipment pickups; helping to keep the vehicle from rollover.[2]

The federal government required stability control on all vehicles by the 2012 model.[2]

Anti-Lock Braking System (ABS). Before the invention of the anti-lock braking system (ABS), car wheels easily locked during hard braking which caused the front tires to slide and made steering impossible; which is dangerous on slippery surfaces. ABS prevents this from occurring. ABS uses sensors that are controlled by a computer on each wheel. The system maximizes the breaking action on each wheel to avoid locking the wheel which results in the driver maintaining control of the car to avoid hitting obstacles.[2]

"Over the past 10 years, most car manufacturers have made ABS standard in their vehicles. The federal government required all new cars to have ABS by September 1, 2011."[14]

Automatic Emergency Braking (AEB). AEB adds to the advantages of forward-crash cautioning. AEB will detect a potential crash, and if the response time is moderate, the vehicle will start braking.[2] This system engages Dynamic Brake Support and Crash Imminent Braking technology.

> **Dynamic Brake Support (DBS) and Crash Imminent Braking (CIB).** If the driver does not brake hard enough to evade a crash, the DBS system will automatically supplement the driver's breaking to avoid the collision. If the driver does not take any action to prevent the accident, the CIB system will automatically apply the car's brakes to slow or stop the vehicle. (National Highway Traffic Safety Administration n.d.) This system has been available on some car models since 2006 but is typically an optional feature on many new cars, SUVs, and trucks.[15] NHTSA does recommend the CIB and DBS system if it meets NHTSA's performance specifications.

Temperature Warning. Temperature warning alerts the driver when the outside temperature is detected to be at or below freezing, which can affect road conditions. NHTSA has not set any performance specifications for this feature.[16]

Hill Descent Assist. Hill descent assist works with the passenger vehicle's existing braking systems to block the driver from going past a certain speed while traveling downhill or on treacherous terrain. If the vehicle begins accelerating past a safe downhill speed, this feature further applies the brakes. NHTSA has not set any performance specifications for this feature.[17]

Hill Start Assist. Hill start assist uses sensors in the vehicle to detect when a vehicle is on an incline. For a set time, the system maintains the brake pressure as the driver switches from the brakes to the gas pedal. Once the driver presses the accelerator, it releases the brake. In cars with a manual transmission, the Hill Start Assist also maintains brake pressure until the driver lets up on the clutch. NHTSA has not set any performance specifications for this feature.[18]

Driver State Monitoring

Tire-Pressure Monitor System. Tire pressure monitoring systems (TPMS) warn drivers of under or overinflated tires. The system helps to increase the car's fuel economy and potentially prevent a tire blowout which can be dangerous at high speeds and lead to a car accident. The federal government required all new vehicles to include this system starting in late 2007.[19]

Curve Speed Warning. Curb speed warning uses Global Positioning System (GPS) to alert the driver of upcoming sharp turns. This feature tracks the passenger vehicle speed and location and warns the driver to slow down when approaching curves and exits. NHTSA has not set any performance specifications for this feature.[20]

High-Speed Alert. High-speed Alert uses a built-in speed sensor and GPS to compare a database of known road speed limit against the driver's actual speed and alerts the driver if they are speeding. Some versions may track school and work zones. Future versions may be able to read limits through a camera. NHTSA has not set any performance specifications for this feature.[21]

Adaptive Cruise Control (ACC). ACC utilizes lasers, radar, cameras, or a blend of these to keep a steady distance between the driver and the vehicle ahead. If the traffic slows, some systems automatically stop the car and automatically accelerate to full speed when the traffic returns to normal. The system allows the driver to lose their focus on driving, which is a hazard. [2]

Push Button Start. Push Button Start simplifies turning the passenger vehicle on and off using a key fob unique to the vehicle. NHTSA has not set any performance specifications for this feature.[22]

Drowsiness Alert. Drowsiness alert borrows some of the sensors from lane departure warning systems to track lane markings and the automobile's lane position. Many versions of this feature will track how often the driver departs from the lane over a short period to determine if the driver may be drowsy. This feature may alert the driver using a coffee cup or other symbol on the dash suggesting that the driver take a break and when it will be safe to pull over. NHTSA has not set any performance specifications for this feature.[23]

Automatic High Beams. Automatic high beam lights switch from high to low and back again to improve nighttime visibility and as conditions warrant. [2]

Parking and Backing Assistance

Backup Camera. The backup camera assistance system is activated when the driver of a passenger places the gear in reverse. The monitor is in the center console of the passenger vehicle and displays items behind the car. This system is primarily used as a parking aid or spotting a child or pedestrian concealed in the blind zone. [2]

NHTSA required this life-saving technology on all new vehicles in May 2018. [11]

Back-up Warning. Back-up warning uses sensors mounted to the rear bumper. These sensors detect objects in the path of the vehicle. The system may beep or vibrate if an object is in the way.[24]

At this time, this is not a new car standard. As stated above, NHTSA required this life-saving technology on all new vehicles in May 2018.[15] In the future, manufacturers are expected to pair the back-up warning and the back-

up camera systems in new cars.

Parking Assist System. Parking assist incorporates sensors in the car's front, rear, or both bumpers. The system alerts the driver that light poles, walls, shrubbery, and other obstacles are close when the passenger vehicle is moving at a slow speed (parking speed). [2]

Automatic Parallel Parking. Automatic parallel parking can detect objects in front and back of a car while parking. It provides audible warnings when detecting one or more objects. Advanced sensors read the gaps between vehicles in the area where the driver chooses to park. The feature will not activate if there is insufficient room to parallel park, which helps ensure that the car does not bump into any nearby vehicles. When initiated, this feature takes over some of the vehicle's steering and acceleration functions needed to park.[25]

Rear Cross-Traffic Alert. Rear cross-traffic alerts sense traffic crossing the path of a passenger vehicle as the driver backs out of a parking space or driveway. Some systems automatically brake to prevent an accident. [2]

The Rear cross-traffic alert system is not a standard feature for passenger vehicles, but the federal government does mandate the feature for such vehicles as buses and trucks. However, manufacturers often pair rear cross traffic alert with back-up cameras; so the mandate may increase the popularity of rear cross traffic alert features soon.[26]

Lane and Side Assistance

Lane-Departure Warning (LDW). Lane-departure warning alerts the driver when the car drifts out of its lane without activating the turn signal. The system uses a camera or lasers to monitor lane markers. The system will chime, the dashboard will blink, or the steering wheel or seat will vibrate to warn the driver that they are drifting into another lane.[2] This system meets NHTSA's performance specifications and is an option on many new cars, SUVs, and trucks. [15]

Lane-Keeping Assist (LKA). Lane-keeping assist will generate mild steering to put the driver back in their lane. This system also senses when the driver leaves their lane. [2]

NHTSA has not set performance specifications for this technology, but this technology may be available on new cars, SUVs, and trucks. [15]

Blind-Spot Warning (BSW) or Blind Spot Detection (BSD). BSW utilizes radars or cameras and shines a light or symbol in or adjacent to the outside mirrors to warn the driver that another vehicle is driving in the parallel lane in an area that the drivers outside mirrors cannot detect. This system will sound an audible warning if the driver attempts to change lanes or uses their turn signal to indicate that they plan to change lanes. There are additional advanced systems that can initiate the braking system or the steering system in order to move the vehicle back towards the center of the lane. [2]

NHTSA has not set performance specifications for BSW, but NHTSA recognizes this as a promising technology. On many new cars, SUVs, and trucks, this system is an option and can help avoid a crash.[14]

Side View Camera. Side view cameras improve visibility on the passenger side, and in some cases provide the driver with a circuit view of the surrounding area of the car. The driver can use this feature to protect bumpers, side mirrors, trim, and wheel rims from damage at low speeds. This camera also provides an expanded view of a lane beside the driver when the driver uses their turn signal or when the driver manually activates this feature. This feature is similar to the blind spot monitor.[27]

Communication

911 Notification - Automatic Crash Notification (ACN). ACN is technology designed to notify emergency responders that an accident has occurred and provide the location. This system uses sensors to detect a deployed airbag or detect a dramatic and sudden deceleration. Once this is detected, the system will automatically connect to an operator who will be able to talk with the accident victims.[15]

This system has the potential to reduce death and disability by reducing the time it takes for emergency medical services to reach an accident scene and transport victims to a hospital.[15]

NHTSA has not set performance specifications for this technology. This system is available as an option on

many new cars, SUVs, and trucks.[15]

Telematics. Telematics is the use of cellular, Global Positioning Satellite (GPS), and other technology (e.g., GM OnStar, BMW Assist, Hyundai Bluelink, Kia UVO, Lexus Safety Connect, Mercedes-Benz's mBrace, and Toyota Safety Connect) to gather and transmit data. "This system allows the driver to communicate with a central dispatch center at the touch of a button. This center knows the location of the vehicle and can provide route directions"[28] of emergency aid on request.[2]

CONCLUSION

There are many safety features to prevent automobile accidents and protect drivers. Because some do carry the potential risk of harm, these features continue to evolve. Research is regularly conducted to ensure that passenger vehicles are able to lessen the impact of crashes, reduce injuries and help drivers prevent crashes. However, consumer education is needed on the proper use of existing safety features. NHTSA, for example, not only conducts research and establish standards, but insurance companies and not-for-profit agencies such as AAA Foundation for Traffic Safety conduct research.

Although some crashes are unavoidable, the probability that passenger vehicle crashes**, INJURIES, AND DEATH** will continue to decrease is high because of the ongoing research, available educational opportunities, and existing and future advanced technologies.

After review of the existing literature on automotive safety, including airbags, the American Osteopathic Association (AOA) adopts the following policies: The American Osteopathic Association:

(1) supports the ongoing efforts of the National Safety Council (NSC), the National Highway Traffic and Safety Administration (NHTSA), the National Transportation Safety Board (NTSB) and other responsible safety organizations to educate the public regarding the proper use of all occupant protection devices in passenger vehicles, including safety belts, child safety seats, and airbags;
(2) urges continued corporate development and research into safer airbags and monitoring of adult and child fatalities resulting from airbag deployment; and
(3) encourages the National Safety Council, the National Highway Traffic and Safety Administration, the National Transportation Safety Board, and other responsible safety organizations to educate the public regarding the benefits and potential dangers of all occupant protection equipment and accident avoidance systems.

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-421 - A/2018: H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-421-A/2018 titled "H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE" was referred to the Bureau on Scientific Affairs and Public Health (BSAPH); now, therefore be it

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED.

H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. ~~THE AOA RECOMMENDS THAT DURING ROUTINE PATIENT CARE, PHYSICIANS ASK PATIENTS AND/ OR CAREGIVERS ABOUT THE PRESENCE OF FIREARMS IN THE HOME AND COUNSEL PATIENTS WHO OWN FIREARMS ABOUT THE POTENTIAL DANGERS INHERENT IN GUN OWNERSHIP, ESPECIALLY IF CHILDREN ARE PRESENT.~~ 2013

Explanatory Statement:
The HOD Reference Committee referred this sunset policy to BSAPH in July 2018, stating that the amendment, as written, is a separate resolution (unrelated to the Tarasoff ruling) and should be resubmitted as such. BSAPH added an edited version of this statement to H406-A/14 FIREARM SAFETY which is submitted as a sunset policy for the 2019 HOD meeting.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: CMS RULES ON PSYCHOTROPIC MEDICATIONS IN NURSING FACILITIES

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has initiated several regulatory initiatives to decrease the use of antipsychotic and other psychotropic medications in Nursing Facilities (NFs); and

WHEREAS, in November of 2017, CMS announced several regulatory changes for nursing facilities including an expanded definition of psychotropic medication and new limitations on the use of as needed (PRN) psychotropic medications[(1)]; and

WHEREAS: the definition psychotropic medications now includes "any drug that affects brain activities associated with mental processes and behavior". These drugs include, but are not limited to, the following drug categories: antipsychotic, antidepressant, antianxiety, hypnotic, as well as medication classes that may affect brain activity. This expanded list of psychotropic medications includes central nervous system agents, mood stabilizers, anticonvulsants, muscle relaxants, anticholinergic medications, antihistamines, N-methyl-D- aspartate receptor modulators, and over-the-counter natural or herbal products[(1)]; and

WHEREAS: CMS has placed a 14-day limit on the duration of use of "psychotropic medications" when prescribed for PRN. For antipsychotics, a 14-day limitation is applied to all PRN orders; as a result, these orders may not be extended beyond the 14-day limit. To continue their use, a new order for the PRN antipsychotic may be written if the prescribing practitioner directly examines and assesses the resident and documents clinical rationale. This clinical rationale must include the benefit of the medication for that resident. This documentation is required every 14 days for a resident receiving a PRN antipsychotic <u>without exception, including hospice patients</u>.[(1)]; and

WHEREAS: hospice patients are often residents in a NFs, and psychotropic medications are often employed for symptom relief and comfort measures; and

WHEREAS: CMS rules requiring repeated direct examination, re-documentation of clinical rationale, and re-ordering of medication which can result in delayed treatment or care; and

WHEREAS, osteopathic physicians desire to ensure our patients receive the care they need in a timely manner; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) petition The Centers For Medicare And Medicaid Services (CMS) to exclude hospice patients from the CMS rules for use of psychotropic and antipsychotic medication in NFs; and, be it further

RESOLVED, that the AOA work with CMS to refine the rules governing the PRN use of antipsychotic and **OTHER** psychotropic medications **FOR ANY NURSING FACILITY PATIENT** to improve the continuity of patient care, decrease costs, and ease physician burden, based on scientific evidence and valid clinical studies.

References:

1. Centers for Medicare & Medicaid Services (CMS). Revision to State Operations Manual (SOM) appendix PP for phase 2, F-tag revisions, and related issues, Section F757. CMS website. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf. Accessed November 10, 2017.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: OPPOSITION TO PATIENT DISCRIMINATION OF OSTEOPATHIC PHYSICIANS BECAUSE OF RACE, COLOR, RELIGION, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY OR NATIONAL ORIGIN

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association (AOA) has historically taken a strong position against osteopathic physicians discriminating against patients because of, but not limited to their race, color, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, the AOA Code of Ethics assures that patients have autonomy and freedom of choice when selecting an osteopathic physician; and

WHEREAS, some patients have refused to allow a physician treat them based solely on the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, physicians have no similar protections against patients refusing to receive care from a physician due to the physician's race, color, creed, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, this discrimination is an abuse and misinterpretation by the patient of their protected autonomy; and

WHEREAS, physicians, especially those in areas with limited physician availability may be called upon to treat a patient who has previously declined to be treated by a particular physician are compelled by medical ethics to provide emergency treatment to these patients; and

WHEREAS, without the intervention of these physicians, the patient would be at great risk of loss of life or limb; and

WHEREAS, physicians acting in these situations place themselves at significant risk of being accused of acting unethically; and

WHEREAS, the AOA has no statement supporting these physicians in providing life or limb saving treatment despite the patient expressing a desire not to be treated by the physician due solely to the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) deems it ethical for osteopathic physicians to provide care to a patient in LIFE THREATENING

EMERGENCIES even when the patient has refused treatment from the physician because of the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) supports the education of the public that osteopathic physicians should be evaluated by their skill and knowledge rather than by race, color, religion, gender sexual orientation, gender identity or national origin.

Reference Committee Explanatory Statement:
The Committee believes that the content in this resolution violates the Patient's Bill of Rights and state laws that address this issue vary.

ACTION TAKEN **REFERRED** *(to the Iowa Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the World Health Organization recognizes "the highest attainable standard of health as a fundamental right of every human being," and states "the right to health includes access to timely, acceptable, and affordable health care of appropriate quality"[1]; and

WHEREAS, the United States ranks 33rd out of 34 countries in the Organization for Economic Co-operation and Development (OECD) in percentage of insured population (with 88.5%), with nearly every other country at > 98%[2]; and

WHEREAS, 25-30 million Americans are still uninsured after implementation of the Affordable Care Act (ACA), and the non-partisan Congressional Budget Office estimates that this number would increase to 48 million, and continue to increase annually, with an ACA repeal[3]; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes that health care is a human right for every person[4], not a privilege.

References:

1. World Health Organization Media Center. "Health and Human Rights." Fact Sheet N°232, Dec 2015. Accessed Feb 2017. http://www.who.int/mediacentre/factsheets/fs323/en/
2. OECD (2015), Health at a Glance 2015: OECD Indicators, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en
3. Congressional Budget Office. "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums." Jan 2017. https://www.cbo.gov/publication/52371
4. Bauchner, H. "Health Care in the United States: A Right or a Privilege." JAMA. 2017; 317(1):29. http://jamanetwork.com/journals/jama/fullarticle/2595503 - Journal of the American Medical Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional societies will "speak with a single voice and say that health care is a basic right for every person, and not a privilege to be available and affordable only for a majority."

Reference Committee Explanatory Statement:
The committee believes that the resolution, as written, lacks clarity and direction.

ACTION TAKEN **REFERRED** *(to the Michigan Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC PHYSICIANS AND THE AVAILABILITY OF NALOXONE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, opioid deaths are at epidemic proportion. In 2017, the number of overdose deaths involving opioids was six times higher than in 1999; and

WHEREAS, on average 130 Americans die every day from an opioid overdose; and

WHEREAS, rapid administration of naloxone can potentially reverse the effects of opioid overdose; and

WHEREAS, studies have shown naloxone administration by bystanders significantly improves the odds of recovery compared to no naloxone administration; now, therefore be it

RESOLVED, that physicians discuss naloxone and how to obtain it with their patients and patients' families, struggling with opioid addiction, and encourage them to have these kits available at all times.

Explanatory Statement:
References:
(ref. Wide-ranging online data for epidemiological research (WONDER). Atlantic, Ga.: CDC, National Center for Health Statistics; 2017.

(ref. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis, Rebecca Giglio, et al. Injury Epidemiology. 2015 Dec: 2(1): 10.

Reference Committee Explanatory Statement
The Committee believes this resolution is covered under H632 A/18.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: PHYSICIAN AWARENESS OF FIREARM SAFETY IN OLDER PERSONS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, in 2016, gun violence in America was declared a public health crisis; and

WHEREAS, there have been 4.2 deaths every day due to gun violence in the Commonwealth of Pennsylvania; and

WHEREAS, 27% of adults older than 65 years of age own one or more firearms and more than 37% reside in a home where a firearm is present; and

WHEREAS, it is estimated that older individuals are those most likely to develop vision and hearing loss, dementia, physical disability and other conditions incompatible with safe firearm us; and

WHEREAS, males over age 65 are the group most likely to successfully complete suicide using a firearm; and

WHEREAS, under federal law a person suffering from mental illness is not prohibited from purchasing a firearm unless they have been committed to a mental institution; and

WHEREAS, there are numerous reports of innocent individuals, including loved ones and caregivers, who have been unintentionally or mistakenly injured or killed at the hands of an older person; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) develop materials to ensure physicians are made fully aware of the staggering statistics of the gun crisis in American as related to the population of older individuals; and be it further

RESOLVED, that AOA develop educational programs to ensure that physicians are taught about the importance of asking questions about firearm safety as part of clinical responsibility; and, be it further

RESOLVED, that AOA develop or partner with appropriate groups to provide appropriate screening tools regarding firearm safety; and, be it further

RESOLVED, that the AOA encourage discussion regarding gun safety so that it is viewed by physicians as a routine part of health care for older adults and vulnerable persons.

Explanatory Statement:

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate attention. The policy recommendations in this

paper *Reducing Firearm Injuries and Deaths in the United States: A Position Paper from the American College of Physicians* build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014, based on analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence

The following physician associations - American College of Surgeons, American College of Obstetricians and Gynecologists, American Public Health Association, American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American Bar Association supported a call to action to address gun violence as a public health threat, which was subsequently endorsed by 52 additional organizations that included clinician organizations, consumer organizations, organizations representing families of gun violence victims, research organizations, public health organizations, and other health advocacy organizations.

The position paper is attached for your consideration.

Reference Committee Explanatory Statement
This subject is addressed in H-425. Additionally, the white paper only addresses individuals with dementia; it does not specifically address older persons.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OPPOSING ZERO-TOLERANCE IMMIGRATION POLICIES AND THE SEPARATION OF FAMILIES AT THE BORDER

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, a zero-tolerance immigration policy is defined as the immediate prosecution and detention of adults entering the country illegally, without exception for those seeking asylum or accompanied by minors;[1] and

WHEREAS, zero-tolerance immigration policies have the added effect of separating children from their families at the time of detention;[1] and

WHEREAS, according to the American Academy of Pediatrics in 2017, the basic standards of care for immigrant children in detention in the US were not met; specifically there were "egregious conditions in processing centers included inadequate bathing and toilet facilities, constant light exposure, children sleeping on concrete floors, confiscation of belongings, insufficient food, denial of access to thorough medical care, lack of mental health support plus physical and emotional maltreatment;" [2] and

WHEREAS, children accumulating Adverse Childhood Experiences (ACEs), such as the trauma of being separated from their families and being placed in separate detention centers that do not adequately meet their basic needs, experience increased risks of cancer, heart disease, mental health disorders, other diseases, and early death[1, 4, 5]; and

WHEREAS, separation of families fleeing persecution in their home countries led to an increase in depression/anxiety and posttraumatic stress disorder[6] ;and

WHEREAS, there is evidence that this separation from their families can damage the children's attachment relationships, cause toxic stress, and even led to greater health disparities[1]; and

WHEREAS, alternative approaches to detention centers exist and are more humane and less expensive[3]; and

WHEREAS, there is no empirical evidence to demonstrate that threats of detainment deter individuals from seeking asylum[7]; and

WHEREAS, statements condemning the separation of immigrant families have already been issued by the Royal College of Pediatrics and Child Health, the American Academy of Pediatrics, the Canadian Pediatric Society, the American Medical Association, the Canadian Medical Association, and the International Society for Social Pediatrics & Child Health[6]; and

WHEREAS, according to the American Osteopathic Association's code of ethics, section 13, "A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health"[8]; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) oppose zero-tolerance immigration policies, especially policies where children are separated from their families; and, be it further

RESOLVED, that the AOA act to discourage existing and future efforts to create, enforce, or legislate similar zero-tolerance immigration policies.

References

1. Wood, L.C.N. (2018). Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. BMJ Paediatrics Open, 2 (1). Retrieved from: doi:10.1136/bmjpo-2018-000338
2. Linton, J., Griffin, M., Shapiro, A. (2017) Detention of Immigrant Children. Retrieved from: http://pediatrics.aappublications.org/content/139/5/e20170483.long.
3. A Guide to Children Arriving at the Border: Laws, Policies and Responses. In (June 2015 ed.). American Immigration Council.
4. Felitti, V.J., Anda, R.F., Nordenberg, D., et al (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4), 245-258.
5. About Adverse Childhood Experiences. https://www.cdc.gov/violenceprevention/acestudy/about_ace.html. Accessed January 31, 2019.
6. Miller, A., Hess, J.M., Bybee, D., et al (2019). Understanding the mental health consequences of family separation for refugees: Implications for policy and practice. American Journal of Orthospychiatry, 88(1), 26-37.
7. There are alternatives: A handbook for preventing unnecessary immigration detention. (2015). International Detention Coalition.
8. American Osteopathic Association Code of Ethics. (July 24, 2016). Retrieved from https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/

Reference Committee Explanatory Statement

The Committee believes the resolution does not focus actionable healthcare issues.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: RECOGNIZING FOOD INSECURITY AS A PUBLIC HEALTH ISSUE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, food insecurity is defined as "the disruption of food intake or eating patterns because of lack of money and other resources"[1]; and

WHEREAS, the United States Department of Agriculture (USDA) has reported that 11.8 percent (15 million) of U.S. households experienced food insecurity during 2017[2]; and

WHEREAS, in 2017[2] food insecurity was inequitably experienced at high rates in households with children headed by single women (30.3 percent), Black (non-Hispanic) households (21.8 percent), Hispanic households (18 percent), and households with children headed by a single man (19.7 percent); and

WHEREAS, scientific literature has "consistently found food insecurity to be negatively associated with health outcomes" including increased likelihood of childhood asthma and earlier onset of limitations in activities of daily living for seniors[3]; and

WHEREAS, a constitutional objective of the American Osteopathic Association is to "to promote the public health"; now, therefore be it,

RESOLVED, that the American Osteopathic Association recognizes food insecurity as a public health issue.

References

1. U.S. Department of Human and Health Services: Office of Disease Prevention and Health Promotion. (2019, February 11). Food Insecurity. Retrieved February 11, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity
2. Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2018. Household Food Security in the United States in 2017, ERR-256, U.S. Department of Agriculture, Economic Research Service.
3. Gundersen, C., & Ziliak, J. P. (2015). Food Insecurity And Health Outcomes. Health Affairs, 34(11), 1830–1839. https://doi.org/10.1377/hlthaff.2015.0645

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: COMMUNITY PHARMACIES; REQUIRED NOTIFICATION OF PRIMARY CARE PROVIDERS REGARDING VACCINATION ADMINISTRATION

SUBMITTED BY: Illinois Osteopathic Medical Society

REFERRED TO: Committee on Public Affairs

WHEREAS, immunizations currently prevent between 2 – 3 million deaths each year worldwide; and

WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates worldwide; and

WHEREAS, vaccines not only provide individual protection for those persons who are vaccinated, they also provide community protection by reducing the spread of disease within a population; and

WHEREAS, physicians and patient care providers have a responsibility/duty to promote immunizations to all eligible people for vaccine preventable illnesses; and

WHEREAS, **IN SOME STATES** vaccinations can be administered by pharmacists educated in the practice of immunization delivery; and

WHEREAS, community pharmacies provide a convenient and accessible option for people to receive needed immunizations; now, therefore be it

RESOLVED, that the American Osteopathic Association support measures that would require pharmacists to provide documentation of immunizations, administered in the community-based pharmacy setting, to the patient's primary care physician **IN APPROPRIATE REGISTRIES**.

Explanatory Statement:

Requiring pharmacists and/or delegated pharmacy technicians at community based pharmacies to provide documentation of immunizations administered to patients directly to their primary care provider would reduce the number of duplicate vaccinations received by patients, enhance provider awareness and readiness to assist patients experiencing vaccine-related adverse events, and increase appropriate reporting of vaccine-related events in the Vaccine Adverse Event Reporting System (VAERS) by primary care providers.

References

1. 10 facts on immunization. (2018, March). Retrieved from World Health Organization: https://www.who.int/features/factfiles/immunization/en/
2. Bach, A. a. (2015, July 1). The role of community pharmacy-based vaccination in the USA: current practice and future directions. Integrated Pharmacy Research and Practice, pp. 67 - 77.

3. Orenstein, W. a. (2017, April 10). Simply put: Vaccination saves lives. Proceedings of the National Academy of Sciences of the United States of America, pp. 114 - 116.
4. Vaccines & Immunizations: What Would Happen If We Stopped Vaccinations? (2018, June 29). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/vac-gen/whatifstop.htm

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: FIREARM VIOLENCE

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

~~**WHEREAS, nearly two-thirds of deaths by firearm are related to suicide; and**~~

~~**WHEREAS, of the remaining one-third of firearm deaths 83% are related to gangs or the drug trade; and**~~

~~**WHEREAS, the right to keep and bear arms is a constitutionally protected right; and**~~

~~**WHEREAS, legally owned firearms are used for self-defense 2.4 million times per year, much more than they are used for suicide or to commit crimes; and**~~

WHEREAS, current American Osteopathic Association (AOA) firearm violence policy is represented by ~~**9 separate**~~ **MULTIPLE** policies, several of which are due for sunset review in 2020; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy ~~**that addresses the core causes of violence and the criminality associated, as well as the mental health issues associated with suicide while upholding the civil rights of law abiding citizens**~~; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) present it for consideration by the 2020 AOA House of Delegates.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS – BUREAU OF EMERGING LEADERS AND NEW PHYSICIAN IN PRACTICE

SUBMITTED BY: AOA Bureau of Emerging Leaders

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the proposed amendments were presented to the July 2018 House of Delegates for its first reading; now, therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Constitution & Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article VIII – Board of Trustees and Executive Committee - Section 1 D

Pages 2-3 - Lines 41-8

D. ONE POSTDOCTORAL TRAINEE, TO INCLUDE INTERN, RESIDENT, OR A FELLOW, member elected by the ~~h~~House of ~~d~~DelegateS to serve for one year. Candidates for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be enrolled in an ACGME OR AOA-approved internship, residency or~~, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-Approved residency~~ FELLOWSHIP. Candidates for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be nominated by the ~~council of interns and residents~~BUREAU OF EMERGING LEADERS. CANDIDATES SHOULD BE MEMBERS IN GOOD STANDING OF THE AOA.

Article VIII – Board of Trustees and Executive Committee - Section 3

Page 3 – Line 25-26

For all trustees, with the exception of the President, President-Elect and the Past Presidents for the preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12) years, with the exception that a trustee may complete the term in which twelve (12) years or more of service is completed. Time served as a student member, ~~intern/resident~~POSTDOCTORAL TRAINEE member, or as new physician in practice member shall not be included in calculating the twelve years of service.

AOA Bylaws

Article V – House of Delegates – Section 1 – Certification of Delegates and Alternates – Part B – Specialty Colleges

Page 9 - Lines 41-42

Each AOA recognized specialty college shall elect one delegate and at least one alternate to the AOA House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate or alternate shall ~~also be a member of the divisional society's delegation to~~ CONCURRENTLY SERVE AS A DELEGATE FOR A DIVISIONAL SOCIETY AT the AOA's House of Delegates. The Secretary of each specialty college shall certify the name of its

delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this association and his specialty college.

Article V - House of Delegates - Section 11 - Representation of Osteopathic ~~Physicians In~~ Postdoctoral ~~Training~~TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE

Page 11 - Lines 20-36

Section 11-Representation of Osteopathic ~~Physicians In~~ Postdoctoral ~~Training~~TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE

Osteopathic ~~physicians in~~ postdoctoral ~~training~~ TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs OR CURRENTLY A NEW PHYSICIAN IN PRACTICE AS DEFINED BY THE ASSOCIATION. The two individuals and their alternates shall be selected by vote of the AOA's ~~Council of Interns and Residents~~BUREAU OF EMERGING LEADERS (BEL). The delegates (and alternate delegates) selected by the ~~Council of Interns and Residents~~BEL shall serve as the representatives of osteopathic ~~physicians in~~ postdoctoral ~~training~~TRAINEES AND NEW PHYSICIANS IN PRACTICE. ~~and THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA's~~ INDIVIDUALS SERVING AS A BEL DELEGATE SHALL NOT CONCURRENTLY SERVE AS A DELEGATE FOR ANY OTHER GROUP AT THE AOA House of Delegates. The ~~chair of the Council of Interns and Residents~~ CHAIR OF THE BEL shall certify the nameS of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

AMERICAN OSTEOPATHIC ASSOCIATION
CONSTITUTION & BYLAWS

CONSTITUTION

Article I - Name
The name of this Association shall be the American Osteopathic Association.

Article II - Objectives
The objectives of this Association shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of Osteopathic medical education.

Article III - Divisional Societies
This Association shall be a federation of divisional societies organized within state or foreign country boundaries, or within the uniformed services of the United States, which may be chartered by this Association as provided by the Bylaws, and all such organizations or divisions now a constituent part of the American Osteopathic Association are declared to be chartered as federated units of this Association.

Article IV - Affiliated Organizations
Affiliated organizations may be organized in conformity with the Bylaws of the Association.

Article V - Membership
The membership of this Association shall consist of Osteopathic physicians and of such others as have met the requirements prescribed by the Bylaws of the American Osteopathic Association.

Article VI - House of Delegates
The House of Delegates shall be the legislative body of the Association, shall exercise the delegated powers of the divisional societies in the affairs of this Association, and shall perform such other functions as are set forth in the Bylaws.

Section 1-Composition
The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the Association and of such other members as may be provided for in the Bylaws.

A. Divisional Societies and Uniformed Services Society Four hundred seventy-three delegate positions shall be allocated among the divisional societies for each of the states and the District of Columbia and the affiliated organization that represents osteopathic physicians serving in the uniformed services as follows: each divisional society and the uniformed services affiliate shall be entitled to one delegate and one alternate delegate. The remaining delegate positions shall be allocated among divisional societies and the uniformed services affiliate based on the proportion of members of this association who are located in the state represented by that divisional society or, in the case of the uniformed services divisional society, the proportion of members of this association currently serving on active duty in the uniformed services of the United States. The allocation of additional delegates shall be recalculated each year.

B. Student Council Representation in Divisional Societies Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine

accredited by this Association and located in the state represented by that divisional society, such student delegate to be elected according to the Bylaws of the American Osteopathic Association.

C. Specialty Affiliates Each AOA recognized Specialty College shall be represented by one delegate to be selected as provided in the bylaws of the American Osteopathic Association.

Section 2-Presiding Officer
The presiding officer of the House of Delegates shall be the Speaker and, in his absence or at his request, the Vice Speaker shall preside.

Article VII – Officers
Section 1-Elected Officers
The elected officers of this Association shall be the President, President-Elect, First Vice-President, Second Vice-President and Third Vice-President. The First Vice-President shall be a person who has had previous experience as a member of the Board of Trustees. The officers shall be elected annually by the House of Delegates for a term of one year, or until their successors are elected and installed. The President-Elect shall automatically succeed to the presidency upon his installation, during the annual meeting of the House of Delegates following his election to the office of President-Elect. In the case of the inability upon the part of the president to serve during the term of office for which he/she has been elected, and therefore the office becomes vacant, the President-Elect shall become president for the unexpired portion of the term and continue in that office for the term in which the President-Elect was originally elected. In such case, if the President-Elect is unable to serve for the full unexpired term of the president's office, then the responsibility of filling the office of President shall devolve upon the Board of Trustees.

Section 2-Administrative Officers
The administrative officers shall be Chief Executive Officer, a Controller, a General Counsel, and an Editor who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Article VIII - Board of Trustees and Executive Committee
Section 1-Board of Trustees
The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-nine members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the house of delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for one year. Candidates for the new physician in practice position shall be osteopathic physicians who have completed their postdoctoral training within the past five years or received the DO degree within the previous ten years shall be nominated by the council of new physicians in practice;

D. ONE POSTDOCTORAL TRAINEE, TO INCLUDE INTERN, RESIDENT, OR A FELLOW, member elected by the ~~h~~House of ~~d~~DelegateS to serve for one year. Candidates for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be enrolled in an ACGME OR AOA-approved internship, residency or~~, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-Approved residency~~FELLOWSHIP. Candidates for the ~~intern/resident~~POSTDOCTORAL TRAINEE position shall be nominated by the ~~council of interns and residents~~BUREAU OF EMERGING LEADERS. CANDIDATES SHOULD BE MEMBERS IN GOOD STANDING OF THE AOA.

E. One student member elected by the House of Delegates to serve for one year. Candidates for the student position shall be nominated, in altering years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA); and

F. One public member elected by the House of Delegates to serve for a three-year term, with a one-term limit. Candidates for the public member position shall not be physicians and shall be nominated by the committee on administrative personnel.

Section 2-Executive Committee

The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs, Business Affairs, Governmental Affairs, Professional Affairs, Research, Quality and Public Health, and the Chair and Vice-Chair of the Department of Educational Affairs.

Section 3-Term Limit

For all trustees, with the exception of the President, President-Elect and the Past Presidents for the preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12) years, with the exception that a trustee may complete the term in which twelve (12) years or more of service is completed. Time served as a student member, ~~intern/resident~~POSTDOCTORAL TRAINEE member, or as new physician in practice member shall not be included in calculating the twelve years of service.

Article IX - Amendments

This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by first class mail, postage prepaid, to each divisional and specialty society entitled to and voting representatives to the house of delegates, posted on the AOA's website, and published in *the Journal of the American Osteopathic Association* not less than two months or more than four months prior to the meeting at which they are to be acted upon.

Article X - Gender Disclaimer

The American Osteopathic Association is open to persons of both sexes and does not discriminate against any persons because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.

BYLAWS

Article I - Divisional, District and Affiliated Societies

Section 1-Divisional Societies

Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given area.

Section 2-District Societies

Divisional societies may, within their own areas, organize district societies whose relationship to the divisional society shall in all respects conform to that existing between the division and this Association.

Section 3-Affiliated Organizations

Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any presently affiliated organization. All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.

Section 4-Amendments to Governing Documents

Any amendments to the Constitution, Bylaws, Code of Ethics, and other governing documents, by whatever name called, of such a divisional society or affiliated organization shall be submitted to the Board of Trustees of the American Osteopathic Association, who shall review such amendments to determine whether, with the proposed amendments, the Constitution, Bylaws, Code of Ethics, or other governing documents would continue to conform generally to those of this Association and, with respect to the divisional society only, whether the organizational structure would continue to conform generally to those of this Association. Until such proposed amendments are given written approval of the Board of Trustees of the American Osteopathic Association, the divisional society or affiliated organization shall continue to operate under its previously approved Constitution, Bylaws, or other governing documents.

Article II – Membership

Section 1-Classification

The members of this Association shall be classified as follows:

a. Regular Members
b. Honorary Life Members
c. Life Members
d. Associate Members
e. Student Members

f. Honorary Members
g. International Physician Members
h. Allied Members

Section 2-Membership Requirements

a. Applicants for Regular Membership

An applicant for regular membership in this Association shall be a graduate of a college of osteopathic medicine approved by the American Osteopathic Association and shall be eligible for licensure as an osteopathic physician and/or surgeon or shall be in a training program, which is a prerequisite for his licensure.

Application shall be made on the prescribed form and shall be accompanied by payment of the appropriate dues amount.

Unless specifically noted, an applicant whose completed application and payment of appropriate dues has been received and processed shall be enrolled as a regular member. An applicant whose membership in this Association has previously been withdrawn for reasons other than failure to meet CME requirements or non-payment of dues, or who has previously been convicted of a felony offense or whose license to practice has at any time been revoked, shall be further required to obtain the endorsement of the secretary of the divisional society in the state, province, or foreign country in which the applicant resides (or the endorsement of the secretary of the uniformed services divisional society in the case of applicants currently serving in the uniformed services of the United States), or, lacking this endorsement, an applicant who is in good standing in his community shall provide letters of recommendation from three members of the Association and provide a personal written statement as to why membership in the Association should be extended or restored. Such information and application shall be carefully reviewed by the Committee on Membership, which shall make an appropriate recommendation for reinstatement to the Board of Trustees.

An applicant whose license to practice is revoked or suspended, or who is currently serving a sentence for conviction of a felony offense, shall not be considered eligible for membership in this Association.

b. Honorary Life Member

Honorary life membership shall be conferred on each president upon conclusion of his term of office.

Such honorary life membership shall not exempt the holder thereof from the maintenance of regular membership in his divisional society or from assessments levied by this Association.

Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the Committee on Membership. Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.

c. Life Member

Life membership may be granted to any regular member who has reached the age of 70 years, or who has completed 50 years of osteopathic practice, whichever comes first, and who has been in good standing for 25 consecutive years immediately preceding. The Committee on Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year in which the age of 70 is attained.

Life membership may also be granted by the Board of Trustees or its Executive Committee on recommendation of his divisional society, to any regular member who has become permanently totally disabled. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments.

d. Associate Member

By specific action of the Board of Trustees, or its Executive Committee, associate memberships may be granted to the following:

Graduates of accredited schools of medicine, dentistry or podiatry holding teaching, research or administrative positions in AOA accredited healthcare facilities and colleges or who practice jointly with regular members of this Association;

Doctors of philosophy or education and other nondoctoral personnel holding teaching, research or administrative positions in AOA accredited healthcare facilities or colleges; administrative employees of this Association, affiliated organizations and divisional societies; and any other professionals as determined by the Board of Trustees, excepting osteopathic physicians and students in colleges of osteopathic medicine.

Such associate members shall be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary online subscription to the Association's publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

Associate members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory of the Osteopathic Profession* shall be provided.

e. Student Member

Student membership status shall be granted to each undergraduate student in an approved college of osteopathic medicine.

At such time as a student member graduates from his osteopathic college, he shall automatically become enrolled as a regular member of the Association. Each student member shall receive such publications and other literature, except the *AOA Yearbook and Directory*, as may be directed by the Board of Trustees or the House of Delegates.

f. Honorary Member

By specific action of the Board of Trustees, honorary membership may be granted to individuals, not eligible for any other category of membership, who support the goals and objectives of this Association. Such honorary members shall not be required to pay dues or assessments. They shall receive complimentary copies of the Association's publications and such other services as authorized by the Board of Trustees. Honorary members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.

Such membership, when conferred, shall remain in full force and effect unless revoked by action of the Board of Trustees of the American Osteopathic Association.

g. International Physician Members

By specific action of the Board of Trustees, or its Executive Committee, international membership may be granted to the following allopathic physicians who are:

Graduates of schools of medicine located outside of the United States on an official list of schools recognized by the AOA, and holding a license for unlimited scope of medical practice including the

authority to prescribe without limitation in their country of practice, and these allopathic physicians reside and practice outside of the United States and who support the goals and objectives of the AOA and the AOA Code of Ethics

Such International Physician Members will be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary subscription to the Association's publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

International Physician Members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.

b. Allied Member

By specific action of the Committee on Membership, allied membership may be granted to those licensed allied healthcare providers who are currently employed, with an active member of the AOA, contribute to the practice of that member, are not eligible for any other category of membership and who support the goals and objectives of this Association.

Such allied members shall be required to pay dues and assessments as determined by these Bylaws. They shall be eligible for such benefits as may periodically be determined by the Board of Trustees.

Allied members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* will be provided.

By specific action of the Committee on Membership, allied membership may be granted to allopathic physicians holding an MD degree and licensed to practice in the United States who support the AOA mission and subscribe to its Code of Ethics.

Individuals who have received their training and/or degree in osteopathic medicine from a school that is not accredited by the AOA Bureau of Professional Education are not eligible for membership in the AOA.

Section 3-Disciplinary Action

The membership of any member of the Association who, in the opinion of the Executive Committee of the Association, purposely and persistently violates the established policy of the Association or who seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive Committee of the Association upon the recommendation of the Committee on Membership, after the member has been given notice and an opportunity to be heard before such action is taken. Any individual whose membership has been so revoked, suspended, or placed on probation shall have the right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of the action of the Executive Committee, and the Board of Trustees, on review, may in its discretion take such action in regard thereto as it deems appropriate.

Section 4-Continuing Medical Education

Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.

Article III - Dues and Assessments

Section 1-Payment of Dues
The annual dues of regular members of the Association shall be payable in advance on or before 1 June, the beginning of the fiscal year.

A member whose dues shall remain unpaid for three months shall become suspended. He may be reinstated upon payment of dues and assessments provided such payments are received prior to the end of the current fiscal year, or, if later, by applying as a new member.

Section 2-Dues Rates
a. Members
The annual dues of all members of the Association (except for allied members discussed in section 2c and student members discussed in section 2d, below) shall be determined by the House of Delegates and administered by the Board of Trustees.

b. Hardship Cases
Upon recommendation of the Committee on Membership, the Board of Trustees, or its Executive Committee, may remit a part or all of the annual dues of a member in good standing who, because of physical disability, maintain a limited practice or no practice. For just cause, properly authenticated, similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular members not otherwise specifically covered by other provisions of this Article.

c. Allied Members
The annual dues rates for allied members shall be determined and administered by the Board of Trustees.

d. Student Rate
Student members shall not be liable for dues or any assessment.

e. International Physician Members
The annual dues rates for International Physician Members shall be determined and administered by the Board of Trustees.

Section 3-Assessments
To meet emergencies the Board of Trustees may levy such assessments as may be necessary, provided that the total of such assessments in any one-year shall not exceed the amount of the annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues. Those dropped from membership for nonpayment of dues during the fiscal year in which an assessment is levied shall be required to pay the assessment prior to reapplying for membership.

Section 4-Refunding Dues
No dues will be refunded if a membership is terminated for cause or because of resignation.

Article IV - Code of Ethics

Section 1
The House of Delegates shall establish a Code of Ethics for the information and guidance of the members. Members of the Association, in their daily conduct, shall comply with the provisions of the Code of Ethics. The Code shall cover duties of physicians to patients, duties of physicians to other physicians and to the profession at large, and responsibilities of physicians to the public. The House of Delegates shall not adopt any provisions of the Code of Ethics, which may be in conflict with the Constitution or Bylaws of the Association.

Section 2

The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds vote of the total number of delegates accredited for voting, provided a copy of the proposed amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting at which it is to be voted upon.

It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by first class mail, postage prepaid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in *The Journal of the American Osteopathic Association* not later than one month before the annual meeting at which the amendment is scheduled for consideration.

The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician's ethical and professional responsibilities to patients, to society, to the AOA, to others involved in healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Article V - House of Delegates

Section 1-Certification of Delegates and Alternates

a. Divisional Societies

The Chief Executive Officer of this Association shall furnish to the secretary of each divisional society, 75 days before the first day of the annual meeting of the House of Delegates, a statement of the number of regular members of this Association located in the area represented by that divisional society or, in the case of the uniformed services divisional society, the number of regular members of this Association currently serving in the uniformed services of the United States.

Based on that statement, each divisional society shall select, in a manner prescribed by its Constitution and Bylaws, the number of delegates (and their alternates) to the House of Delegates of this Association to which it is entitled under the provisions of the Constitution of the American Osteopathic Association. Delegates and alternates must be regular or student members in good standing of this Association and of the divisional societies, which they represent. Delegates (and their alternates) shall serve during the annual meeting of the House of Delegates and during the interim between annual meetings or until their successors are elected. The secretary of each divisional society shall certify its delegates and alternates to the Chief Executive Officer of this Association in writing at least 30 days prior to the first day of the annual meeting of the House of Delegates.

In the event that any state, provincial or foreign osteopathic association does not become a chartered divisional society, the regular members of this Association in that jurisdiction, at a regularly called meeting, may elect or appoint one delegate (and alternate) as their representative in the House, and such delegate (and alternate) shall be accredited in the same manner and have the same privileges as those of a divisional society.

b. Specialty Colleges

Each AOA recognized specialty college shall select one delegate and at least one alternate to the AOA House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate or alternate shall ~~also be a member of the divisional society's delegation to~~ CONCURRENTLY SERVE AS A DELEGATE FOR A DIVISIONAL SOCIETY AT the AOA's House of Delegates.

The Secretary of each specialty college shall certify the name of its delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this association and his specialty college.

Section 2-Voting

Each delegate shall have one vote in the House, except when one-fourth of the members present shall call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording such vote each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area represented by that divisional society (or in the case of the uniformed services divisional society, one vote for each 20 regular members of the American Osteopathic Association currently serving in the uniformed services of the United States), as certified to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1 of this Article, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide.

Section 3-Committee on Credentials

The Committee on Credentials shall consist of three or more members appointed by the President and it shall be the duty of the Committee to receive and validate the credentials of the delegates to the House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall furnish the Credentials Committee a list showing the number of delegates to which each divisional society is entitled. In case any organization has selected more than its legal representation, the Chief Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of his action.

Section 4-Seating of Delegates

A delegate having been seated shall remain the accredited delegate throughout the meeting. In the event that an accredited delegate has failed to qualify and assume his seat when the House convenes on the second day of the meeting, his accredited alternate may be seated. If a delegate, having been seated, finds himself unable to be present on account of physical disability or other cause acceptable to the House, his alternate may be seated for that roll call period and shall continue as delegate until the previously seated delegate shall return for duty at a subsequent roll call. In that case the alternate delegate who has been seated may, by direction of the House, be dropped from the roll and the previously seated delegate shall return to his seat in the House.

Section 5-Annual Meeting

The annual meeting of the House of Delegates shall be held during June, July or August, and separate from the annual convention or clinical assembly of the Association, upon call of the President. Special sessions of the House of Delegates may be called by the President. The delegates shall be given at least two weeks notice and the object or objects shall be stated in the call of such special meeting.

Section 6-Presiding Officer

The Speaker of the House of Delegates shall be its presiding officer. The Vice Speaker shall preside over the House of Delegates in the absence of or at the request of the Speaker and assume all duties of the Speaker.

Section 7-New Business

No new business shall be introduced on the last day of the meeting of the House of Delegates except by a two-thirds consent of those members present, provided two-thirds of the seated

delegates are in attendance.

Section 8-Quorum

One-half of the accredited delegates of the House shall constitute a quorum.

Section 9-Governing Rules

The meetings of the House of Delegates and of all other bodies of this Association shall be governed by Robert's Rules of Order Newly Revised, except in such instances as are specifically provided for in the Constitution and Bylaws of the Association or in the order of business which may be adopted from time to time. The order of business and any special rules adopted at the beginning of the meeting shall govern the procedure unless unanimously suspended.

Section 10-Representation of Student Councils

The student council of each accredited college of osteopathic medicine and each branch campus may be represented in the House of Delegates by its president (and such president's alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the secretary of the appropriate divisional society.

Section 11-Representation of Osteopathic ~~Physicians In~~ Postdoctoral ~~Training~~TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE

Osteopathic ~~physicians in~~ postdoctoral ~~training~~ TRAINEES AND/OR NEW PHYSICIANS IN PRACTICE may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs OR CURRENTLY A NEW PHYSICIAN IN PRACTICE AS DEFINED BY THE ASSOCIATION. The two individuals and their alternates shall be selected by vote of the AOA's ~~Council of Interns and Residents~~BUREAU OF EMERGING LEADERS (BEL). The delegates (and alternate delegates) selected by the ~~Council of Interns and Residents~~BEL shall serve as the representatives of osteopathic ~~physicians in~~ postdoctoral ~~training~~TRAINEES AND NEW PHYSICIANS IN PRACTICE. ~~and THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA's~~ INDIVIDUALS SERVING AS A BEL DELEGATE SHALL NOT CONCURRENTLY SERVE AS A DELEGATE FOR ANY OTHER GROUP AT THE AOA House of Delegates. The ~~chair of the Council of Interns and Residents~~ CHAIR OF THE BEL shall certify the nameS of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.

Section 12–Representation of Student Osteopathic Medical Association

The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member's alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA delegate or alternate shall also be a member of a divisional society's delegation representing the state in which such SOMA Board member's osteopathic college is located. The SOMA delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional

society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.

Article VI—Elections

Section 1--Qualifications

Except where positions are designated as public members, membership in both the AOA and a divisional society shall be a requisite for qualification for any officer or for any member of any department, division, bureau or committee of the Association, however selected, if the incumbent shall be an osteopathic physician.

Section 2--Nominations

Nomination of all officers and trustees of this Association, and nomination of the Speaker and Vice Speaker of the House of Delegates, excepting nomination of those otherwise provided for in the Constitution, shall be a regular order of business in the House of Delegates at the annual meeting of the House. Nominations may be made from the floor immediately preceding the balloting. Nominating speeches shall not exceed two minutes.

Section 3--Method of Election

Election of such officers and trustees as are elected by the House of Delegates shall take place during the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this section and a majority of all votes cast shall be necessary to elect. In recording such vote, each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area or serving in the uniformed services of the United States represented by that division, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide. If there shall be but one nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or until their successors are elected and installed.

Section 4--Installation

The officers who have served throughout that meeting shall complete all business of the annual meeting so far as is practicable. The officers-elect shall be installed as the final order of business and shall assume the authority of their respective offices upon adjournment of the meeting.

Article VII--Board of Trustees

Section 1--Duties

The Board of Trustees shall:

a. Direct the management of the affairs of the Association between annual meetings. It shall meet coincident with the annual meeting of the House of Delegates and at other times on call of the President, shall make all arrangements for the annual meetings, shall appoint all standing and special committees not otherwise provided for in these Bylaws, and may fill by appointment any vacancy occurring in its own membership or any other elective office until the time of the next meeting of the House of Delegates. A quorum of the Board shall be a majority of the members thereof.

b. Appoint a Chief Executive Officer, a Controller, a General Counsel, and an Editor, and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, Controller, General Counsel, Editor and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the

Association and not fixed by these Bylaws.

c. Have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, all expenditures thereof. It shall appoint a certified public accountant to audit the financial records of the Association and certify to the accuracy of the statement of financial condition of the Association to be reported at the annual meetings.

No appropriation shall be made by the House of Delegates except upon recommendation of the Bureau of Finance approved by the Board of Trustees, and all resolutions, motions or otherwise, having for their purpose the appropriation of funds, shall first be referred without discussion to the Bureau of Finance of the Board of Trustees. An adverse ruling on such motions may be overruled by a three-fourths vote of the House of Delegates.

d. Provide for the publication of an official journal of the Association and such other publications as are deemed necessary or shall be directed by the House of Delegates

e. Maintain and revise the Administrative Guide annually. The general purpose of this manual shall be to provide a handy reference book of concise statements of the duties of all officials, committees, departments, bureaus and employees of the Association, to the end that there shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be furnished to each divisional society and affiliated organization as well as officers of the American Osteopathic Association and other groups or individuals as directed by the Board of Trustees of the Association.

f. Establish such departments, committees, bureaus, councils, and commissions, and authorize the president's creation of such task forces, as shall be necessary to further the policies of the Association and determined by the House of Delegates and shall determine the duties and powers of such departments, committees, bureaus, councils, commissions and task forces.

g. Approve from its own membership, based on the President's appointment, the chairs of the departments. The department chairs shall direct the activities of their respective departments. However, the public member of the board shall not be eligible to serve as a department chair. The Board shall also approve, based on the President's appointment, the members of the various committees, bureaus, councils, commissions and task forces under the departments

h. Decide finally all questions of an ethical or judicial character. It shall have investigated by the Committee on Ethics all charges or complaints of violation of the Constitution, Bylaws, or of grossly unprofessional conduct of any member. The Board shall have the power to censure, place on probation for not exceeding a three-year period, suspend for not exceeding a three-year period or expel a member, as the findings warrant. A member may be cited to appear before it by the Board of Trustees or the Committee on Ethics to answer charges or complaints of unethical or unprofessional conduct. Upon the final conviction of any member of an offense amounting to a felony under the law applicable thereto, or the final revocation of, or suspension of, his license to practice in a state on the grounds of having committed a violation of a disciplinary provision of the licensing law by a duly constituted state licensing agency, or the voluntary surrender of his license while under charges of having committed said violation, such member shall automatically be deemed expelled from membership in this Association; a conviction shall be deemed final for the purposes hereof when affirmed by an appellate tribunal of final jurisdiction or upon expiration of the period allowed for appeal. The Committee on Membership shall be granted the authority to restore to membership a

doctor whose license was revoked, and later retroactively reinstated by his licensing board.

If, because of a breach of the Code of Ethics, a member shall have been suspended, or expelled from a divisional society or affiliated organization by proper action of such divisional society or affiliated organization, the Board of Trustees of this Association shall review the record of such decision. The decision may first be referred to the Committee on Ethics for recommendations. If the Board shall concur in the action of the divisional society or affiliated organization, such member shall be suspended for the same period of time or expelled from this Association upon the same basis as in the decision of the divisional society or affiliated organization. The Board is authorized to adopt and amend from time to time, in the manner directed by the Board, a Guide for Administrative Procedure regulating the procedure applicable to matters involving violations of the Code of Ethics.

Section 2--Appeal

A minority of one-third or more members of the Board of Trustees present at any session may appeal to the House of Delegates from the decision of the majority on any question at the current meeting.

Section 3--Executive Committee

The Executive Committee shall transact the business of the Board of Trustees between meetings.

Section 4--By-Mail Vote

Between meetings of the Board of Trustees and of the Executive Committee, a by-mail vote, or vote by other means of electronic communications, on any urgent matter may be taken of the members of the Board of Trustees, or Executive Committee, if a consent in writing setting forth the action so taken shall be signed by all of the trustees or members of the Executive Committee entitled to vote with respect to the subject matter thereof, any such vote to be entered into the records at the next meeting of the Board.

Section 5--Indemnification

Each trustee, officer, and employee of this Association now or hereafter in office and his heirs, executors, and administrators, and each trustee, officer, and employee of this Association and his heirs, executors, and administrators who now acts, or shall hereafter act at the request of this Association as employee, trustee, director, or officer of another corporate entity controlled by this Association, shall be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in which he may be or become involved by reason of his acts of omission or commission, or alleged acts of omission or commission as such trustee, officer, or employee, or, subject to the subsequent provisions of the section, any settlement thereof, whether or not he continues to be such trustee, officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts, provided that such indemnification shall not apply with respect to any matters as to which such trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of Trustees has determined that such settlement and reimbursement appear to be for the best interests of this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs)

by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in addition to and not exclusive of any and all other rights as to which any such trustee, officer, or employee may be entitled under any bylaw, agreement, or otherwise.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Association in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized in this section.

The Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of any person who is or was a trustee or employee of the Association or is or was serving at the request of the Association as a trustee, director, officer, employee, or agent of another corporate entity controlled by the Association against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Association would have the authority or power to indemnify him against such liability under the provisions of this section.

Article VIII--Duties of Officers

Section 1--President

The President shall be the chairman of the Board of Trustees and of the Executive Committee and shall perform the duties usually pertaining to his office. He shall nominate, subject to approval by the Board of Trustees, all appointive officers, unless otherwise specified in the Bylaws and in accordance with the directives contained in the Administrative Guide or as established by the Board of Trustees or the House of Delegates.

Section 2--President-elect

The President-elect shall perform the duties of the office of the President in the absence of or at the request of the President.

Section 3--Vice-Presidents

The Vice-Presidents, in the order of their designation and in the absence or at the request of the President and President-elect, shall perform the duties of the office of the President.

Section 4--Speaker/Vice-Speaker of the House of Delegates

The Speaker or the Vice-Speaker of the House of Delegates shall perform such duties as custom and parliamentary usage require. The Speaker shall appoint reference committees of the House to perform functions for which they are created subject to the approval of the House. He shall have such other privileges and duties as may be assigned to him by the House of Delegates, which privileges and duties shall not be in conflict with the privileges and duties assigned by the Constitution and Bylaws to other officers of the Association. The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker in his absence or at his request.

Section 5--Chief Executive Officer

The Chief Executive Officer shall:

a. Be the chief administrative officer of the Association and of the central office. He shall be the executive and recording secretary of the Association. He shall counsel with the other administrative officers and with the heads of departments in the central office to produce the greatest possible cooperation and efficiency in the conduct of the affairs of the Association under the President and the Board of Trustees. He shall cooperate with the chairmen of various agencies of the Association in the execution of the policies of the

Association as outlined by the House of Delegates. It shall be his duty to coordinate the work performed by the various departments, bureaus, and committees of the Association.

b. Direct the joint activities of the Association and the divisional societies as provided by the Bylaws, and may select one or more of the trustees or like officers of the divisional societies, to assist him in this work in their respective areas.

c. Be responsible for the correspondence of the Association and shall keep accurate record of the proceedings of the House of Delegates and the Board of Trustees. d. Be responsible for the supervision of assistance to the divisional societies in all matters according to the policies laid down by the Association and for the supervision of the execution of plans of the Association with regard to colleges, affiliated organizations and campaigns.

d. Keep on file an accurate record of all transactions of his office, which shall at any time be subject to examination by the President or the Board of Trustees, shall make an annual report to the House of Delegates and Board, and shall perform such other duties as are prescribed by the Board not in conflict with the Constitution and Bylaws of this Association.

e. Be the statistical officer of the Association, and shall have charge of the archives, including legal, historical and scientific records of value to the Association.

f. Be authorized to provide such assistance as is necessary for the proper conduct of the central office, subject to the directives of the Board of Trustees, and at the expiration of his term shall deliver to his successor all property and papers pertaining to his office. He shall file bond with such surety company and in such amount as the Board of Trustees shall determine.

Section 6--Controller

The Controller shall:

a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive Officer and Editor under the direction of the Board of Trustees, and disburse such funds only in the manner prescribed by the Board of Trustees.

b. Be responsible for the collection of dues and assessments as provided in these Bylaws; shall cooperate with like officers of the divisional societies and may delegate them to assist him in their respective societies.

c. Keep on file accurate records of the transactions of his office, which shall at all times be subject to examination by the Board of Trustees. He shall prepare reports quarterly for the Board of Trustees and annually for the House of Delegates and the Board, and at the expiration of his employment; he shall deliver to his successors or to the Board, or their assigned agent, all monies, records and other property of the Association subject to his jurisdiction. He shall perform such other duties as may be prescribed by the Board consistent with the Constitution and Bylaws of the Association.

d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer. He shall file bond with such surety company and in such sum as the Board of Trustees may determine.

Section 7--General Counsel

The General Counsel shall:

a. Be the chief legal officer of the Association, responsible for oversight and management of all legal services provided to the Association, its trustees, officers and staff to ensure protection

of the Association's legal rights and maintenance of its operations consistent with the limits established by law.

b. Provide legal advice and guidance to the trustees, officers, and staff, bureaus, councils, task forces, commissions and committees of the Association on the legal implications of matters relevant to the Association, including compliance with federal, state, and local laws and regulations applicable to a tax-exempt, not-for-profit membership organization and adherence to internal organizational policies and procedures.

c. Draft and review contracts and other legal documents, policies and procedures; research pertinent to legal issues; prepare written and oral opinions and position statements on issues identified by the Association's trustees, officers, staff, bureaus, councils, task forces, commissions and committees;

d. Represent or coordinate the representation of the Association in judicial and administrative proceedings; and

e. Select and retain outside counsel, as required, to obtain legal opinions or to handle claims and litigation. Supervises legal work of other Association attorneys and outside counsel.

Section 8--Editor

The Editor shall:

a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of *The Journal of the American Osteopathic Association*, other periodical publications of the Association and of the *AOA Yearbook and Directory*, under the general supervision of the Chief Executive Officer, and shall cooperate with all departments of the central office.

b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.

Article IX--Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association's departments shall include the Departments of Affiliated Affairs, Business Affairs, Educational Affairs, Governmental Affairs, Professional Affairs, and Research, Quality & Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

Article X--Conventions and Meetings

Whenever referred to in this Constitution and Bylaws, the words annual meeting shall refer to the annual meetings of the Board of Trustees or of the House of Delegates, respectively, and the words annual convention or clinical assembly shall refer to the annual clinical assembly of the Association.

Section 1--Annual Clinical Assembly

The annual clinical assembly shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-

thirds vote of the total number of delegates accredited for voting.

Section 2--Annual Meetings
The annual meetings of the Board of Trustees shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Article XI—Amendments

Section 1--Bylaws
These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by first class mail, postage paid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA's website, and published in *The Journal of the American Osteopathic Association* at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

Section 2--Articles of Incorporation
The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes to be effected thereby shall be posted on the AOA's website and delivered not less than five nor more than 40 days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each delegate entitled to vote at such meeting.

Written or printed notice shall include the printing of the amendment in the electronic and/or printed issue of *The Journal of the American Osteopathic Association* published not less than five days or more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

Article XII--Gender Disclaimer
The American Osteopathic Association is open to persons of both sexes and does not discriminate against any person because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.

SUBJECT: AMENDMENT TO THE AOA CONSTITUTION – CHANGE TO TERM LIMIT FOR MEMBERS OF THE BOARD OF TRUSTEES

SUBMITTED BY: Committee on AOA Governance & Organizational Structure (CAGOS) / CAGOS Constitution & Bylaws Subcommittee

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Board of Trustees in July 2017 approved a resolution calling for a reduction of the term limit for service on the Board of Trustees from 12 years to 9 years; and

WHEREAS, changing the term limit requires an amendment to the AOA Constitution; and

WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for its first reading; now, therefore be it

RESOLVED, that the following amendment to the AOA Constitution be approved:

Old material crossed out (~~crossed out~~) | New material in CAPS

Article VIII—Board of Trustees and Executive Committee
Section 3—Term Limit
For all trustees ELECTED PRIOR TO JULY 2019, with the exception of the President, President-Elect and the Past Presidents for the preceding two years, the aggregate terms of the Office of Trustees shall be limited to twelve (12) years, with the exception that a trustee may complete the term in which twelve (12) years or more of service is completed. FOR ALL TRUSTEES ELECTED IN OR AFTER JULY 2019, WITH THE EXCEPTION OF THE PRESIDENT, PRESIDENT-ELECT, AND THE PAST PRESIDENTS FOR THE PRECEDING TWO YEARS, THE AGGREGATE TERMS OF OFFICE OF TRUSTEES SHALL BE LIMITED TO NINE (9) YEARS, WITH THE EXCEPTION THAT A TRUSTEE MAY COMPLETE THE TERM IN WHICH NINE (9) YEARS OR MORE OF SERVICE IS COMPLETED. Time served as a student member, intern/resident member, or as new physician in practice member shall not be included in calculating the ~~twelve~~ years of service ON THE BOARD OF TRUSTEES.

HOD Reference Committee Explanatory Statement:
The Committee believes that the proposed nine-year term limit would not provide sufficient time to ensure proper maturation of Trustees before ascending to the position of President-elect and President. The additional three years under the current term limit allows for time needed to develop the breadth of expertise and leadership competence.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: EXECUTIVE COMMITTEE OF THE AOA BOARD OF TRUSTEES, COMPOSITION OF

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Board of Trustees in July 2017 approved a resolution calling for the elimination of the position of Vice Chair of the Department of Educational Affairs, to be effective in July 2020, following significant completion of the transition to a single accreditation system; and

WHEREAS, the defined composition of the Executive Committee of the American Osteopathic Board of Trustees includes the Vice Chair of the Department of Educational Affairs; and

WHEREAS, there will no longer be a Vice Chair of the Department of Educational Affairs in July 2020; and

WHEREAS, the Board of Trustees has approved the following amendment to the AOA Constitution for consideration of the AOA's House of Delegates in July 2019; and

WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for its first reading; now, therefore be it

RESOLVED, that the following amendment to the AOA Constitution be approved:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article VIII—Board of Trustees and Executive Committee

Section 2—Executive Committee

The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate ~~Affairs~~ RELATIONS, Business Affairs, EDUCATIONAL AFFAIRS, Governmental Affairs, Professional Affairs, AND Research, Quality, and Public Health~~, and the Chair and Vice-Chair of the Department of Educational Affairs~~.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: AOA BOARD OF TRUSTEES – PUBLIC MEMBER POSITION

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the American Osteopathic Association (AOA) has not filled the public member position on the Board of Trustees since the position was first authorized by the Board of Trustees; and

WHEREAS, the AOA recognizes the value of a public member on those bureaus, councils and committees that are directly involved in public functions, such as accreditation and certification; and

WHEREAS, there are public members on the Commission on Osteopathic College Accreditation and the Bureau of Osteopathic Specialists; and

WHEREAS, the AOA's Board of Trustees engages in certain private organizational decisions regarding the future of the osteopathic profession; and

WHEREAS, the AOA Board of Trustees will retain the ability to invite appropriate experts and other resources to join its discussions when such input is desired, without formally designating such individuals as a public member; and

WHEREAS, the proposed amendment were presented to the July 2018 House of Delegates for its first reading; now, therefore be it

RESOLVED, that the AOA eliminate the public member position from the Board of Trustees; and be it further

RESOLVED, that the following amendment to the AOA Constitution and the AOA Bylaws be approved:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Constitution

Article VIII - Board of Trustees and Executive Committee
Section 1-Board of Trustees
The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of TWENTY-EIGHT ~~twenty-nine~~ members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the House of Delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for one year. Candidates for the new physician in practice position shall be osteopathic physicians who have completed their postdoctoral training within the past five years or received the DO degree within the previous ten years shall be nominated by the council of new physicians in practice;
D. One intern/resident member elected by the house of delegate to serve for one year. Candidates for the intern/resident position shall be enrolled in an AOA-approved internship or residency or, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-Approved residency. Candidates for the intern/resident position shall be nominated by the council of interns and residents; AND

E. One student member elected by the House of Delegates to serve for one year. Candidates for the student position shall be nominated, in altering years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA)~~; and~~

~~F. One public member elected by the House of Delegates to serve for a three-year term, with a one-term limit. Candidates for the public member position shall not be physicians and shall be nominated by the committee on administrative personnel~~

AOA Bylaws

Article VII - Board of Trustees
Section 1-Duties
The Board of Trustees shall:
g. Approve from its own membership, based on the President's appointment, the chairs of the departments. The department chairs shall direct the activities of their respective departments. ~~However, the public member of the board shall not be eligible to serve as a department chair.~~ The Board shall also approve, based on the President's appointment, the members of the various committees, bureaus, councils, commissions and task forces under the departments.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: AOA HOUSE OF DELEGATES VOTING RULES

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

RESOLVED, that the following proposed amendments to the American Osteopathic Association (AOA) Bylaws will provide for all voting of the AOA House of Delegates to be one vote per delegate system; and be it further

RESOLVED, that the following amendment to the AOA Bylaws be approved:

Old material crossed out (~~crossed out~~) | New material in CAPS

AOA Bylaws

Article V – House of Delegates
Section 2-Voting
Each delegate shall have one vote in the House.~~, except when one-fourth of the members present shall call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording such vote each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area represented by that divisional society (or in the case of the uniformed services divisional society, one vote for each 20 regular members of the American Osteopathic Association currently serving in the uniformed services of the United States), as certified to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1 of this Article, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide~~.

Article VI - Elections
Section 3-Method of Election
Election of such officers and trustees as are elected by the House of Delegates shall take place during the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this section and a majority of all votes cast shall be necessary to elect.~~ In recording such vote, each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area or serving in the uniformed services of the United States represented by that division, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide~~. If there shall be but one nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or until their successors are elected and installed.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H506-A/14 AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT

SUBMITTED BY: Bureau of Membership / Ethics Subcommittee

REFERRED TO: Committee on Constitution & Bylaws

RESOLVED, that the Bureau of Membership and Ethics Subcommittee recommend that the following policy be REAFFIRMED:

H506-A/14 AOA RULES AND GUIDELINES ON PHYSICIANS' PROFESSIONAL CONDUCT

The American Osteopathic Association (AOA) supports the AOA Rules and Guidelines on Physicians' Professional Conduct and recognizes that it is a separate and distinct document from the AOA's Code of Ethics. 2014

American Osteopathic Association:
Rules and Guidelines on Physicians' Professional Conduct

Professionalism and Physician Responsibilities

Professionalism is a core competency expected of all physicians. Physicians are among the most highly educated and trained professionals in our society and should enjoy the respect of their peers and the community. Society expects them to perform various roles. As healthcare providers, they diagnose and treat patients; as advisors, they provide patients with an understanding of their health status and the potential consequences of decisions regarding treatment and lifestyles; as advocates, physicians communicate with patients, their caregivers, and their health insurers the needs of the patient; and as counselors, they listen to their patients and discuss their condition with family members and others involved in health-care decision-making. Physicians are entrusted by their patients and their patients' families with private and confidential information, much of which is related to healthcare, but frequently includes other personal details.

Osteopathic physicians, in order to enjoy the continued respect and trust of society, recognize the responsibilities and obligations they bear and in order to maintain their status as professionals, must act accordingly. Medical ethics includes many tenets that should guide osteopathic physicians in their professional and personal activities. Although ethics and professionalism encompass broad concepts, some of the recognized elements are:

- Non-maleficence – first, do no harm
- Acting as a positive role-model
- Displaying respect in interactions with others
- Legal and ethical behavior
- Appropriate management of potential conflicts of interest
- Beneficence – a physician should act in the best interest of the patient/altruism/placing the needs of the patient first
- Autonomy – the patient has the right to refuse or choose their treatment

- Dignity – the patient (and the medical professional involved with their care) has the right to dignity, truthfulness and honesty
- Participation in self-evaluation programs and acceptance of constructive criticism from others.

The AOA's Code of Ethics offers rules to guide physicians in their interactions as physicians with their patients, with society, and with the AOA. This document is intended to supplement the Code of Ethics by providing rules and guidance for physicians' conduct as professionals in the broader context beyond the traditional role in the delivery of care. Some of the Rules and Guidelines are mandatory (i.e., "shall" or "shall not"), while others are permissive (i.e., "may," "should," "should not" or "may not") and recognize a physician's discretion to assess the specific context and situation and exercise professional judgment.

Finally, the Rules and Guidelines are designed by the AOA to provide guidance to physicians in appropriate professional behavior and to provide a structure for regulating conduct. Any assessment of a physician's conduct must be made with due consideration to the facts and circumstances that existed at the time of the conduct in question and recognize that a physician may have had to act based upon uncertain or incomplete information. The Rules and Guidelines are not intended to be a basis for civil liability. Rather, perceived failure of a physician to comply with an obligation or prohibition imposed by the Code of Ethics or these Rules and Guidelines is a basis for invoking the AOA's disciplinary process through the Bureau of Membership's Subcommittee on Ethics.

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1. A physician's conduct shall be consistent with the requirements of the law, whether providing medical/professional service to patients or in conducting business and personal affairs.
2. Physicians should use their status as professionals only for legitimate purposes and not to take advantage of economic or social opportunities or to harass or intimidate others.
3. A physician has an obligation to pursue a patient's best interests and to be an advocate for the patient. In so doing, physicians shall conduct themselves in a civil manner. When appropriate, physicians should disclose and resolve any conflict of interest that might influence decisions regarding care.
4. Patients may come from any of a broad spectrum of cultures and beliefs. Physicians should conduct themselves with appropriate respect for their patients' social and cultural needs and provide necessary care without regard to gender, race, color, religion, creed, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, gender identity or sexual orientation.
5. Physicians are allowed limited autonomy to govern conduct within their own profession through participation on state licensing boards, hospital credentialing committees and in peer review processes. Physicians should fully participate in self-regulation by setting, maintaining, and enforcing appropriate practice standards. Regulations and rules with respect to healthcare delivery shall be developed with the best interests of patient care in mind rather than advancing private interests or protecting friends or colleagues from adverse action.
6. Physicians are responsible for observance of the Code of Ethics and these Rules and Guidelines on Professional Conduct. While compliance depends primarily upon understanding of and voluntary compliance with these obligations, physicians should also make efforts to secure their observance by other physicians through expression of formal or informal peer opinion or, when necessary, invocation of disciplinary proceedings. Where a protected peer review process is available, adverse events and medical errors should be fully disclosed.
7. Physicians should be aware of disparities in medical care within the United States and internationally. Where possible, physicians should assist those less fortunate in securing access to appropriate medical care.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

Charles Milligan, DO, Chair JH/GM/LM
Eric Goldsmith, DO, Vice chair

Michol Negron, DO	Massachusetts
Bernadette Riley, DO	New York
George Scott, DO	New Jersey
Larry Suess, DO	Kentucky
Jennifer Kendall, DO	Minnesota
LeRoy E. Young, DO	Oklahoma

STAFF
Jennifer Hersh
Gabe Miller
Lisa Miller

SUBJECT: H600-A/14 HOSPICE – FEDERAL REIMBURSEMENT FOR REQUIRED FACE-TO-FACE VISITS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H600-A/14 HOSPICE – FEDERAL ~~REIMBURSEMENT~~ PAYMENT FOR REQUIRED FACE-TO-FACE VISITS

The American Osteopathic Association supports reasonable federal ~~reimbursement~~ PAYMENT to hospice organizations for federally required face-to-face visits for patients enrolled in hospice ~~prior to the start of their third hospice benefit period~~. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H601-A/14 PALLIATIVE CARE – FEDERAL FUNDING FOR SUPPORT SERVICES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H601-A/14 PALLIATIVE CARE – FEDERAL FUNDING FOR SUPPORT**
4 **SERVICES**
5 The American Osteopathic Association supports federal funding for chaplain, social work and,
6 home health aide provider services for palliative care patients. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H602-A/14 MEDICARE TRANSITION CARE CODES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H602-A/14 MEDICARE TRANSITION CARE CODES**
4 The American Osteopathic Association encourages the Centers for Medicare & Medicaid
5 Services to simplify and clarify the rules for submission of Transition Care Codes. 2014

Explanatory Statement:
The BSA recommends to sunset H602-A/14. On March 17, 2016, CMS published a document titled "Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services" that clarify rules for submission of these codes. The Transitional Care Management services were resurveyed in 2018. According to Medicare claims data, there has been increased use of these services, which indicates an understanding of the codes.

https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf

ACTION TAKEN **APPROVED (for sunset)**

DATE **July 27, 2019**

SUBJECT: H605-A/14 REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

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:

H605-A/14 REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

The American Osteopathic Association (AOA) supports a new risk-based oversight framework for clinical software, developed through a multi-stakeholder consensus-based process. The framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility. Patient safety and appropriate improvements in quality, effectiveness, and efficiency of care delivery should be paramount. This framework should not conflict with or duplicate the medical device regulation framework. The AOA does not support ~~federal regulation of health software because it poses the lowest risk of potential harm and~~ data ~~should not be~~ treated as a medical device regardless of the category of health information technology associated with the data. The AOA supports a national network for reporting patient safety events, WHERE DATA CAN BE ACCESSED, ANALYZED, AND COMMUNICATED IN A TIMELY MANNER. ~~which should be able to analyze data that can be communicated quickly.~~ Existing programs should be leveraged and utilized. The AOA supports a common data structure that will enable interoperability; setting a clear course of action, supporting an exchange infrastructure, and adopting standards that will make it easier to share information so that physicians and patients can make informed decisions. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H606-A/14 EMERGING STATES – ASSISTANCE BY OTHER STATES AND THE AOA

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H606-A/14 ~~EMERGING~~ STATE~~S~~ AFFILIATES IN NEED – ASSISTANCE BY OTHER STATE~~S~~ AFFILIATES AND THE AOA

The American Osteopathic Association encourages liaison between state AFFILIATE organizations whether formal or informal and supports assistance to ~~emerging~~ state AFFILIATE organizations IN NEED. 1979; revised 1984, 1989; reaffirmed 1994; revised 1999; reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H607-A/12 OSTEOPATHIC TERMINOLOGY - GLOSSARY OF

SUBMITTED BY: Bureau of Membership

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED:

H607-A/12 OSTEOPATHIC TERMINOLOGY, GLOSSARY OF
The American Osteopathic Association designates the entries in the Glossary of Osteopathic Terminology as the AOA's official terms and definitions; whenever terms or definitions in the Glossary of Osteopathic Terminology conflict substantively with AOA policy, AOA branding guidelines or AOA publications' style guidelines, the AOA will seek to resolve the conflict through the Glossary of Osteopathic Terminology's standard process for revision and external input; and the JAOA-The Journal of the American Osteopathic Association's "Instructions for Authors" will advise authors to use the terms and definitions in the Glossary of Osteopathic Terminology. 2012

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE
The American Osteopathic Association strongly recommends that any intervention by FEDERAL, **STATE** OR PRIVATE third party payers ~~(Medicare, Medicaid and other third-party insurers),~~ shall not IMPOSE A FINANCIAL PENALTY ON ~~penalize~~ any physician without proper peer review and opportunity for appeal, ~~without prejudice or penalty;~~ and encourages the continued availability of judicial review of claims ~~of Part B Medicare and other third-party payers~~. 1985; revised 1990, 1994; reaffirmed 1999; revised 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING**
4 **HOMES**
5 The American Osteopathic Association supports drug therapy surveyor guidelines regarding
6 inappropriate drug use in nursing facilities be developed in collaboration with professional
7 organizations possessing clinical expertise in geriatrics and long-term care medicine. 1999;
8 revised and reaffirmed 2004; reaffirmed 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H609-A/14 CENTERS FOR MEDICARE AND MEDICAID (CMS) COMMUNICATIONS WITH PHYSICIANS

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:

H609-A/14 CENTERS FOR MEDICARE AND MEDICAID (CMS) COMMUNICATIONS WITH PHYSICIANS

The American Osteopathic Association supports the distribution of thorough and current written information by all Medicare administrative contractors on the correct preparation and coding of Medicare claims to all physicians and supports communication to the physician of the complete ~~reasons~~ JUSTIFICATION for the ~~rejection~~ DENIAL of any Medicare claims.~~ be communicated to the physician.~~ 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H610-A/14 MANDATED PATIENT CARE – ASSIGNMENT OF

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:

H610-A/14 MANDATED PATIENT CARE – ASSIGNMENT OF
The American Osteopathic Association strongly opposes any attempt by a third-party payer, business, institution or government to mandate a patient be seen and managed by any individual, including a hospitalist, or anyone other than the patient~~'s~~ **AND THEIR** physician in any setting without the concurrence of the patient's physician. 1999; revised 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H611-A/14 INVESTMENT TAX

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H611-A/14 INVESTMENT TAX

~~Policy of t~~The American Osteopathic Association notes that it is the responsibility of all osteopathic associations with 501{c}(6) tax status to urge their state legislators, U.S. senators and ~~congressmen~~REPRESENTATIVES, to defeat any proposed expansion of the tax on unrelated business income to include dividends, capital gains and/or interest income on reserves and current operational funds, under the 501{c}(6) tax status. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H613-A/14 OMT – OSTEOPATHIC MANIPULATIVE TREATMENT

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
2 the following policy be REAFFIRMED:

3 **H613-A/14 OMT – OSTEOPATHIC MANIPULATIVE TREATMENT**
4 The American Osteopathic Association urges that in all forms of communication the term
5 OMT shall always be "Osteopathic Manipulative Treatment." 1999; revised 2004; reaffirmed
6 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS – ACCOUNTABILITY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be REAFFIRMED:

3 **H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS –**
4 **ACCOUNTABILITY**
5 The American Osteopathic Association supports the disclosure of the origin of utilization
6 review criteria used by third-party payers. 1994; revised 1999, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H615-A/14 MAIL ORDER PHARMACY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H615-A/14 MAIL ORDER PHARMACY
The American Osteopathic Association opposes pharmaceutical programs that require all medications be delivered to the patient's residence as failing to act in the best interests of the patient**.;** ~~and that mm~~aintenance medication prescriptions ~~may~~ SHOULD be obtainable **BY THE MEANS PREFERRED BY THE PATIENT**~~at a pharmacy at the patient's discretion~~. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H617-A/14 MEDICARE PHYSICIAN PAYMENT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H617-A/14 MEDICARE PHYSICIAN PAYMENT**
4 The American Osteopathic Association will work with the Centers for Medicare and Medicaid
5 Services (CMS), Congressional Committees of jurisdiction and the Medicare Payment Advisory
6 Commission (MedPAC) to reform the Medicare physician reimbursement formula to protect
7 and enhance the ability of osteopathic physicians to provide quality care and protect Medicare
8 beneficiaries access to physician services; and will identify and aggressively pursue the
9 enactment of long-term remedies to the sustainable growth rate (SGR) formula that protect and
10 maintains quality patient care. 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement:
The BSA recommends to sunset. In April 2015, the Medicare Sustainable Growth Rate (SGR) formula for physician payment was permanently repealed and replaced by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ACTION TAKEN **APPROVED (for sunset)**

DATE **July 27, 2019**

SUBJECT: H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS
The American Osteopathic Association advocates that all third party payers automatically enrolling physicians in all products of an acquiring company should notify the physician of the products offered and permit physicians to reject one or all of the products of the acquiring company. 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H619-A/14 FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H619-A/14 FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

The American Osteopathic Association supports the federal Health Information Technology (HIT) initiatives by assisting its members through education and other services necessary for them to adopt the appropriate technology which would be cost effective for their practices. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H622-A/14 LOCAL COVERAGE DETERMINATION

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:

H622-A/14 LOCAL COVERAGE DETERMINATION
The American Osteopathic Association encourages public and private insurance carriers, as well as the Centers for Medicare and Medicaid Services to utilize the local coverage determination (LCD) adopted in the State of Florida as a guide when determining coverage requirements for osteopathic manipulative treatment. [Editor's note: All Medicare Local Coverage Determination (LCD) policies are accessible via the Internet at http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H623-A/14 LATEX ALLERGY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
2 following policy be REAFFIRMED:

3 **H623-A/14 LATEX ALLERGY**
4 The American Osteopathic Association strongly encourages hospitals and other healthcare
5 facilities to provide non-latex alternatives. 1999; revised 2004; reaffirmed 2009; reaffirmed as
6 amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

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:

H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN
The American Osteopathic Association supports efforts to combine tiered formulary and open access models with expanded use of variable co-pays that reflect the total costs of these programs and supports efforts to design benefits that align consumer needs and accountability and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Reference Committee Explanatory Statement:
The policy should be referred to the BSA for clarification on intent of the resolution, definition of "open access models", and relevance of the resolution.

ACTION TAKEN **REFERRED** *(to Bureau of Socioeconomic Affairs)*

DATE **July 27, 2019**

SUBJECT: H625-A/14 FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE RELATIONSHIP MODIFICATION

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau on Federal Health Programs recommend that the following
2 policy be REAFFIRMED:

3 **H625-A/14 FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE**
4 **RELATIONSHIP MODIFICATION**
5 The American Osteopathic Association supports legislation amending the Family Medical
6 Leave Act (FMLA) Basic Leave Entitlement 'To care for the employee's spouse, son or
7 daughter, or parent, who has a serious health condition' to include responsible designee; and
8 requests the Department of Labor to include these changes at the federal level. 2009; reaffirmed
9 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY

The American Osteopathic Association supports environmentally responsible packaging of PHARMACEUTICAL samples. 1991, reaffirmed 1994, 1999; revised 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H627-A/14 INDUSTRY TRANSPARENCY STANDARDS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H627-A/14 INDUSTRY TRANSPARENCY STANDARDS
The American Osteopathic Association AOA: (1) acknowledges the contributions made by pharmaceuticals, biologics, and medical devices to the improved health, management of disease, and enhanced life function for millions of patients cared for by ~~**osteopathic**~~ physicians**AS DISTINGUISHED IN H-346-A/16 AND AS OUTLINED IN H-623-A/18**; (2) acknowledges concerns regarding the perception that pharmaceutical and device companies have undue influence over physicians; (3) affirms its commitment to providing all osteopathic physicians, their patients, and the public timely, accurate, and relevant information on advances in medical science, treatment of disease, prevention, wellness, and other information that advances mental and physical health; (4) continues its commitment to life-long learning for all osteopathic physicians; (5) supports transparency in its industry partnerships by ~~creating a public web site that discloses~~ DISCLOSING all industry partnerships entered into to advance life-long learning; (6) will further advance transparency by encouraging all partners to disclose fully their relationship with the AOA and other organizations; (7) directs the Council on Continuing Medical Education to adopt and implement transparency standards; (8) discourages business practices that interfere with the patient-physician relationship, attempt to unduly influence the practice of medicine, or attempt to inappropriately persuade patients to seek services or products; and (10) stands resolute that our commitment to advancing medical science, quality health care, the treatment of disease, and transparency in our actions, along with the ethical code by which our members serve, are the principles by which we engage industry partners. 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H630-A/14 ELECTRONIC HEALTH RECORDS SOFTWARE – REPORTING ERRORS TO PHYSICIANS

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:

H630-A/14 ELECTRONIC HEALTH RECORDS SOFTWARE – REPORTING ERRORS TO PHYSICIANS

The American Osteopathic Association ~~will request that~~ SUPPORTS **PROMPT** NOTIFICATION **BY** ELECTRONIC HEALTH RECORD (EHR) vendors ~~of electronic health records notify~~ TO physician clients of reported software errors and PROVISIONS OF ~~provide~~ software updates THAT CORRECT THESE ERRORS, in a systematic, COST-EFFECTIVE and timely fashion **AT NO COST TO THE EHR USER** ~~as is standard in other industries that correct these errors to enhance patient safety~~. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H631-A/14 ELECTRONIC MEDICAL RECORD/PROFESSIONAL CREDENTIALS – SIGNATURE FOR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy
2 be SUNSET:

3 **H631-A/14 ELECTRONIC MEDICAL RECORD/PROFESSIONAL**
4 **CREDENTIALS – SIGNATURE FOR**
5 The American Osteopathic Association (AOA) will work with Electronic Health Record (EHR)
6 vendors and the Healthcare Information and Management Systems Society to change the
7 commonly used designation on EHR signature lines from "ordering MD" to "ordering
8 physician/provider". The AOA encourages all certified EHR vendors to provide a mechanism
9 so documenting professionals can appropriately designate their degree or other professional
10 credential. 2014

Explanatory Statement:
The BSA recommends to sunset H631-A/14. The ONC has confirmed that requirements in the certification criteria for the 2014 and 2015 edition of certified electronic health record technology (CEHRT) are agnostic to any specific professional credential.

ACTION TAKEN **APPROVED** *(for sunset)*

DATE **July 27, 2019**

SUBJECT: H635-A/14 BEER'S CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS-USE OF

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H635-A/14 BEER'S CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS-USE OF

The American Osteopathic Association recognizes the limitations of the Beer's Criteria as published by the American Geriatrics Society, ~~due to the limitations and intent of the criteria as a measure of physician quality of care~~**AS GUIDELINES AND NOT MANDATES TO LIMIT OR PROHIBIT ACCESS TO MEDICATIONS DEEMED APPROPRIATE BY THE PATIENT'S PHYSICIAN**. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H637-A/14 PHYSICIAN TESTING PROCESS FOR UNLIMITED LICENSURE – COLLABORATION TO PROTECT THE INTEGRITY OF THE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

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1 RESOLVED, that the Bureau of State Government Affairs recommend that the following
2 policy be ~~REAFFIRMED~~**SUNSET**:

3 **H637-A/14 PHYSICIAN TESTING PROCESS FOR UNLIMITED LICENSURE –**
4 **COLLABORATION TO PROTECT THE INTEGRITY OF THE**
5 The American Osteopathic Association will collaborate with the American Medical Association,
6 the Scope of Practice Partnership and the Federation of State Medical Boards to ensure that the
7 National Board of Medical Examiners maintains and preserves the integrity of the testing
8 process used to license only physicians (DO / MD) for the unlimited practice of medicine.
9 2009; reaffirmed 2014

ACTION TAKEN **APPROVED** ***(for sunset)***

DATE **July 27, 2019**

SUBJECT: H638-A/14 MAINTENANCE OF LICENSURE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED; and, be it further;

RESOLVED, that policy number H227-A/17 be deleted:

H638-A/14 MAINTENANCE OF LICENSURE

The American Osteopathic Association (AOA) (1) supports the development of state level maintenance of licensure (MOL) programs to demonstrate that ~~osteopathic~~ **ALL** physicians are competent TO ~~and~~ provide quality care **THAT INCORPORATES RELEVANT TECHNOLOGICAL AND SCIENTIFIC ADVANCEMENTS** over the course of their career. Flexible pathways for achieving MOL should be maintained. The requirements for MOL should balance transparency with privacy protection and not be overly burdensome or costly to physicians or state licensing boards. (2) ~~The AOA will c~~ContinueS to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels as well as ongoing physician assessment through Osteopathic Continuous Certification (OCC)~~ and the AOA Clinical Assessment Program (CAP) or its equivalent~~. (3) ~~The AOA will c~~ContinueS to work with State Osteopathic Affiliates, the American Association of Osteopathic Examiners and other stakeholders to establish~~,~~ AND implement MOL policies that promote patient safety and the delivery of high quality of care. (4)~~**THE AOA,**~~ **THROUGH ITS BUREAUS, COUNCILS AND COMMITTEES, WILL CONTINUE TO ENSURE THAT OCC IS** ~~**COMPARABLE TO OTHER MAINTENANCE OF CERTIFICATION PROGRAMS SO IN TERMS OF QUALITY AND CONTENT THAT OCC CAN BE**~~ RECOGNIZED BY THE FEDERAL GOVERNMENT, STATE GOVERNMENTS AND OTHER REGULATORY AGENCIES AND CREDENTIALING BODIES AS EQUIVALENT TO OTHER NATIONAL CERTIFYING BODIES' "MAINTENANCE" OR "CONTINUOUS" CERTIFICATION PROGRAMS. (5) WHILE ~~**THE AOA**~~ SUPPORT**ING**~~S~~ THE USE OF BOARD CERTIFICATION AS A ~~**MARK**~~ **RECOGNITION** OF QUALITY AND EXCELLENCE, SIGNIFYING THE HIGHEST PHYSICIAN ACHIEVEMENT IN A PARTICULAR SPECIALTY; ~~**THE AOA**~~ OPPOSES ANY EFFORTS TO REQUIRE OCC AS A CONDITION **OF** MEDICAL LICENSURE**;**~~.~~ (6) ~~**THE AOA DEFERS TO**~~ **COLLABORATES WITH** ENTITIES PROPERLY QUALIFIED FOR AND TASKED WITH DECISION-MAKING REGARDING INSURANCE ~~**REIMBURSEMENT**~~**PAYMENT**, HOSPITAL PRIVILEGES, NETWORK PARTICIPATION, MALPRACTICE INSURANCE COVERAGE, PHYSICIAN EMPLOYMENT, TO DETERMINE THE ROLE OF PHYSICIAN BOARD CERTIFICATION AND OCC OR OTHER "MAINTENANCE OF CERTIFICATION" PROGRAMS IN SUCH DECISIONS**;**~~.~~ (7) ~~**THE AOA THROUGH THE BUREAU OF OSTEOPATHIC SPECIALISTS WILL**~~ CONTINUE**S** TO **INNOVATE AND**

IMPROVE THE OCC PROCESS~~REVIEW THE OCC PROCESS SO AS TO MAKE IT MORE MANAGEABLE AND ECONOMICALLY FEASIBLE~~. 2010; REVISED 2015; REVISED 2017. ~~2010 [See also H258-A/08]; approved as amended 2014~~

Explanatory Statement:
Combined with H227-A/17 EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION. Recommend deletion of H227-A/17.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED RES. NO. H-636 - A/2018 STANDING AGAINST RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS IN THE US

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, sunset resolution H-636 - A/2018, titled "STANDING AGAINST RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS IN THE US", was referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to study the frequency and impact of solitary confinement and isolation on juvenile well-being; now, therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the attached white paper, titled, "OPPOSING RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS IN THE U.S.", be adopted:

Opposing Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S.

Introduction

Every day approximately 53,000 youth under the age of 18 are sent to correctional facilities as a result of juvenile or criminal justice involvement.[1] Correctional facilities generally offer limited medical and mental health care, resulting in harmful health outcomes, such as increased violence, mental illness, cognitive impairment, and increased risk of disease. It is not uncommon for incarcerated youth to be housed in solitary confinement or restrictive housing while in these facilities. The use of solitary confinement further compromises the quality of the health care detainees receive, and results in long-lasting, adverse physical, psychological, and social effects. Thus, the use of such housing has become a major public health concern in the U.S.

For many individuals who are committed to improving health outcomes for juvenile youth, there has been an urgent need for interventions and reformation programs that encourage humane alternatives and movement towards the abolishment of juvenile solitary confinement in the U.S. In fact, several professional and human rights organizations have taken positions in favor of limiting or eliminating solitary confinement.

The purpose of this paper is to discuss the frequency and impact of solitary confinement (isolation) on juvenile well-being and to present the AOA's position opposing restrictive housing and solitary confinement for juvenile inmates in the U.S.

Solitary Confinement

The term, solitary confinement, is often used interchangeably with the terms segregation, isolation, and restrictive housing. The National Commission on Correctional Health Care refers to solitary confinement, or isolation, as the housing of an adult or juvenile with minimal to rare meaningful

contact with other individuals. Additionally, the United States Department of Justice defines restrictive housing as any type of detention that involves one of the following:[2]

1. Removal from the general inmate population, whether voluntary or involuntary.
2. Placement in a locked room or cell, whether alone or with another inmate.
3. Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.

There are several forms of restrictive housing. High security facilities that contain solitary confinement units are called supermaximum ("supermax") facilities.[3] These facilities house inmates who have engaged in violent behavior aimed at other inmates or staff in another institution or those who were not compliant at lower-security prisons. Some supermax facilities also house inmates in protective custody or those considered to be a "special population" , such as prisoners on death row. In addition to these facilities, there are facilities that contain solitary confinement cells, known as segregated housing or secured housing units, in institutions that are not considered supermax facilities.[3]

By design, solitary confinement restricts human contact and environmental simulation. The facilities commonly have minimal natural light, leaving detainees exposed to constant artificial light, and inmates experience punitively distasteful meals, have limited personal items, and are denied opportunities to communicate with others.[3]

Public Health Implications

Though data on the frequency and duration of solitary confinement is scant, the Office of Juvenile Justice and Delinquency Prevention reports that half of the individuals in the juvenile penal system were isolated for more than four hours at a time.[4] Exact statistics are not readily available, since the federal government does not require prisons to report the number of juveniles in solitary confinement, the frequency, or the amount of time they are isolated.[3]

In some jurisdictions, youth may be detained in solitary confinement for several weeks or months. In addition to the harms associated with adults in solitary confinement, youth may also lack educational options or interaction with their families, and they may experience the beginning of mental illnesses that commonly occur during late adolescence.[5]

Many studies have underscored the troubling realities of physical and mental health outcomes directly related to the increase of solitary confinement. While incarceration alone yields unintentional but inevitable consequences on wellness, especially mental health issues, solitary confinement amplifies the risk of anxiety, depression, psychosis and self-harm, as supported by both the American Psychological Association and American Academy of Child and Adolescent Psychiatry.[6]

The practice of placing youth in solitary confinement is especially troubling since children and young adults are still developing physically, mentally, and socially and are more vulnerable to the noted long-lasting negative effects of solitary confinement. Accordingly, mental health problems are more prevalent among youth inmates compared to adult inmates, with 95% of youth in the juvenile penal system having at least one mental health problem, and 80% of youth developing more than one mental health illness.[7]

Furthermore, the Centers for Disease Control and Prevention reports that suicide is the 3rd leading cause of death for youth, resulting in approximately 4,600 deaths per year.[8] However, young people in prisons are 18 times more likely to commit suicide than their counterparts in the community.[7] Thus, isolation of juveniles increases the risk of both mental illness and suicide for adolescents and young adults. Thus, concerns about the use of solitary confinement have mounted.

In a July 14, 2015, speech at the NAACP National Convention, President Barack Obama announced that he had asked Attorney General Loretta Lynch to conduct a review of "the overuse of solitary

confinement across American prisons." The President directed that the focus not only on understanding how, when, and why correctional facilities isolate certain prisoners from the general inmate population, but also that it includes strategies for reducing the use of this practice throughout our nation's criminal justice system.

Among other findings, the study report summary noted that implementation of solitary confinement and the length of time an inmate is isolated is the discretion of correctional officers, not decided by a court or jury. The report also recommended that the Bureau end the practice of placing juveniles in restrictive housing, pursuant to the standards proposed in the Sentencing Reform and Corrections Act of 2015.[2]

The United Nations has also taken a stance against solitary confinement and considers isolation within juvenile facilities a form of torture. The U.N. has encouraged the U.S. to create federal and state legislature ratifying the Convention on the Rights of the Child , an international agreement set forth by the U.N. to protect children from abuse. To date, only seven U.S. states have placed any prohibition on juvenile solitary confinement.[3]

The American Academy of Child and Adolescent Psychiatry highlights the code of ethics surrounding the psychiatrist's responsibility to not only reduce the harmful impacts of the behavior of others but the community and social effects as well.[7] Often, correctional facilities have a culture of their own that produce a different code of ethics for the survival and safety of juvenile inmates; this can create a dilemma for clinicians as it relates to providing quality care to inmates.

Racial and Gender Disparities

Within the issue of solitary confinement in juvenile detention facilities, there is a concern that certain races/ethnicities are disproportionally exposed to these practices than youth from other races/ethnicities. Across the nation, the youth rate of incarceration is 152 per 100,000. However, the Black youth placement rate is nearly three times higher than the national rate at 433 per 100,000. Comparatively, the White youth placement rate is 86 per 100,000, nationally. According to the Department of Justice, Black youth are five times more likely to be detained compared to Whites. When examining the system further, Black males and Native American females are an over-represented population in the U.S. juvenile prison system. Currently, in the U.S., Black males under the age of 18 make up 14% of the total population; however, 43% of Black males under 18 years of age are in juvenile facilities. Nationally, Native Americans make up less than 1% of all youth, but 3% of Indian females are in juvenile facilities.[7]

Over the last decade, the racial disparity in youth placed in the juvenile penal system has increased by nearly 22%.[9] As a result of disparities in the number of justice-involved juveniles, minority youth detainees are more likely to suffer severe psychological/mental health issues and live in restrictive facilities away from home. Black juveniles, specifically, are experiencing worse health outcomes, especially mental health outcomes, due to disparities in the juvenile penal system.[9]

Social and Societal Impact

Family support and love are essential for the development of juveniles social identity.[9] However, visits, phone calls, and sometimes even letters are prohibited during solitary confinement, creating additional separation between inmates, their families, and the outside world in general.

Isolation due to incarceration creates separation from society that makes it very difficult to form a social identity. Solitary confinement exacerbates the social complexities and behaviors of re-entering into society by aggravating preexisting depression or anxiety due to separation from home or the community. Consequently, isolation hinders the development of juveniles making it extremely difficult for them to reintegrate into the community easily or productively.[3]

Additionally, author, Jessica Lee, highlights that solitary confinement also negatively impacts the physical growth of juveniles by restricting much needed exercise and nutrition.[3]

Reformation Efforts

The impact of juvenile solitary confinement has led to a call for reform by legislators and scientific scholars.[3] Although some states have been successful in abolishing or reducing solitary confinement, it is still practiced within the juvenile penal system.[4] This call for reform regarding solitary confinement has the potential to shift the juvenile justice system toward a more ethical and just model.

- **Federal Reformation Efforts**

U.S. Representative Cedric Richmond presented a bill calling for a study across the nation on the impacts that solitary confinement has on mental health. The intent of this bill, known as the Solitary Confinement Study and Reform Act of 2014, was to reduce the use of solitary confinement.[3] The bill died and was reintroduced to the House in 2015.

In 2015 Senator Cory Booker introduced, Maintaining Dignity and Eliminating Unnecessary Restrictive Confinement of Youth, commonly known as the Mercy Act. The Mercy Act entails the following:

1. Prohibits the use of solitary confinement of juveniles in federal custody, except for a maximum of three hours, if the juvenile harms any individual.
2. Requires that facilities first use less restrictive measures to control behavior before placing the juvenile into solitary.
3. If, after the maximum three hours of solitary have ended, the juvenile still poses a risk of physical harm to themselves or anyone else, then the juvenile can be transferred to a different juvenile facility or "internal location" where he or she can be treated without the use of solitary.

The Mercy Act was introduced to the Senate in 2017, but no further action has been taken.[3]

- **State & Local Reformation Efforts**

In the state of New York, legislators agreed to ban solitary confinement for inmates younger than 21 at Riker's Island and implement a practice where inmates between the ages of 18-21 undergo counseling and classes in a different facility as an alternative.[3] The reason for this reform was to combat the psychological effects that solitary confinement has on young adults and youth. Other states have joined in on State and Local reformation with varying approaches to the public health issue. For instance, in Pennsylvania mentally ill inmates will no longer be placed in solitary confinement; instead, they will be placed in special treatment units.

Although these laws are progressive, they do not address all of the concerns about solitary confinement among youth. There has been a huge push by activists and researchers for Congress and the U.S. Department of Justice to bring forth uniformity across the nation's legislation to provide a standard and just approach to juvenile inmates regarding solitary confinement in the U.S. prison system.[10]

- **Educational Efforts**

Many medical and research organizations, such as the National Alliance for Suicide Prevention, have developed recommendations and interventions for "improving the level and quality of collaboration between the juvenile and mental health systems, primarily for suicide prevention."[11] These collaborative efforts are tailored to promoting education, awareness, and prevention support and services for youth in the juvenile prison system. In these educational programs, organizations and researchers identify protective factors to decrease mental illness and suicide. In so doing, many organizations also are promoting data collection and inmate screening/assessment tools to increase information on solitary confinement in an effort to better understand and combat the psychological and social impacts of solitary confinement. More information and knowledge will allow health care professionals and public

health practitioners to monitor the social development and health outcomes for inmates in juvenile facilities.[13]

Opposition To Reformation Efforts

Despite evidence of deleterious effects of solitary confinement in the juvenile penal system, there is still some opposition to reformation efforts. Opponents suggest that solitary confinement serves pragmatic purposes. For example, when prisons are overloaded with inmates, there is no physical space for them, or enough staff to run the prison. In this instance, solitary confinement provides additional housing space for inmates.[12] Others contend that solitary confinement aids in the rehabilitation of character as it becomes a means of reflection for inmates. Another viewpoint is that solitary confinement offers prison safety for inmates who are a threat to staff, other inmates, or the public.[13] Finally, some believe that solitary confinement provides guards/officers with the means to discipline and maintain order within the prison walls.[15]

Conclusion

Nearly half of juveniles placed in the U.S. Prison system experience solitary confinement. As a result, the majority of these juveniles also have detrimental, long-lasting, physical and psychological health outcomes. Education, counseling, and rehab programs are all positive alternatives to solitary confinement that raises health outcomes for youth. Increased State and Federal legislation that actively opposes juvenile solitary confinement will not only positively impact youth outcomes, but society as well when inmates reintegrate into their communities. Opposing solitary confinement and restrictive housing would be a significant step forward in saving lives and improving health and well-being outcomes.

American Osteopathic Association Policy

Given the research surrounding the negative impacts of restrictive housing and solitary confinement, the American Osteopathic Association adopts the following policy statements as its official position on opposing restrictive housing and solitary confinement for juvenile inmates of the prison system in the U.S.:

1. The official position of the American Osteopathic Association (AOA) is that youth incarceration is meant to be rehabilitation and that the use of juvenile solitary confinement and/or restrictive housing imparts serious psychological and physical harms.
2. The American Osteopathic Association encourages increased research and data collection surrounding the prevalence of the use of solitary confinement /restrictive housing among juveniles.
3. The American Osteopathic Association opposes the use of solitary confinement and/or restrictive housing among juveniles in the penal system and supports the abolishment of the use of solitary confinement and isolation for incarcerated youth set forth at the United Nations Convention on the Rights of the Child.

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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: CLINICAL DATA REGISTRIES AND QUALIFIED CLINICAL DATA REGISTRIES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, clinical data registries and qualified clinical data registries (QCDRs) are used to collect patient information on various diseases, conditions, exposures, or procedures; and data can be used for various purposes including quality improvement, clinical research, disease surveillance, and value-based reimbursement; and

WHEREAS, clinical data registries and QCDRs not only play an important role in improving population health, while also playing an increasingly important role in physician reimbursement through quality payment reporting programs; ~~**and**~~

~~**WHEREAS, approximately 53% of clinical data registries report using their data for quality measure development, 61% report using data for clinical decision support development, 39% report being qualified clinical data registries for MIPS reporting, and 17% of registries report that their data is used to help determine payment for health services;**~~[1] now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports the development of clinical data registries to improve the quality of patient care, improve population health, and promote high-value care and, be it further

RESOLVED, that the AOA will support efforts to make reporting more simplified and efficient and expand participation in clinical data registries and Qualified Clinical Data Registries (QCDRs) for the benefit of population health**; AND, BE IT FURTHER**

RESOLVED, the AOA will advocate to ensure that (1) participation in clinical data registries and QCDRs does not place a substantial cost burden on physicians; (2) data is used to improve quality of care for patients; (3) registry data is not used to penalize physicians; (4) that measures developed for reporting through clinical data registries and QCDRs are developed in collaboration with physicians and specialty groups; and (5) that physicians play an integral role in the oversight of clinical data registries and QCDRs.

~~**References**~~

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: COMMUNICATION TECHNOLOGY-BASED AND REMOTE EVALUATION SERVICES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, Centers for Medicare and Medicaid Services finalized policy for new communication technology-based and remote evaluation services in the 2019 Physician Fee Schedule that will pay physicians, rural health clinics (RHCs) and federally qualified health centers (FQHCs) for virtual check-in appointments, remote evaluation of pre-recorded (store and forward) patient information, and telephone or internet consultations services furnished using communication technology; and

WHEREAS, the new policy will allow payment to physicians, RHCs and FQHCs for use of telecommunication technology and are not meant to substitute for in-person services;

WHEREAS, the new communication technology-based and remote evaluation services are distinct from Medicare telehealth services as set forth in section 1834(m) of the Social Security Act and are not subject to the same statutory requirements; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will work to ensure that the use of new communication technology-based and remote evaluation services, which resemble other Medicare telehealth and remote monitoring services are paid at a rate consistent with the time and work involved for the physician.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: INCIDENT TO BILLING BY PHYSICIAN ASSISTANTS AND ADVANCE PRACTICE REGISTERED NURSES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association advocates to preserve the physician-led, team-based model of care as the most effective approach to delivering high-quality care; and

WHEREAS, decreasing physician oversight of patient care can result in overutilization of diagnostic services[1], overprescribing of medications[2], unnecessary or inappropriate referrals[3], and ultimately poorer outcomes; and

WHEREAS, the Medicare Payment Advisory Commission has recently advised the Centers for Medicare & Medicaid Services to eliminate from federal regulation the provision allowing APRNs and PAs to bill "incident to" physician services has the potential to drive further scope of practice expansions; and

WHEREAS eliminating the "incident to" billing provision for APRNs and PAs may financially harm independent practices, as services billed by non-physicians practitioners under their own provider identification number are reimbursed at 85 percent of the Medicare physician fee schedule rate; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports maintaining the "incident to" billing provision for APRNs and PAs in order to preserve the physician-led, team-based model of care; and, be it further

RESOLVED, that the AOA will advocate to ensure that physicians who collaborate with advance practice registered nurses and physician assistants in their practices will continue to be able to earn full reimbursement for their collaborative efforts through "incident to" billing; and, be it further

RESOLVED, that the AOA will advocate to ensure that reimbursement for any APRN and PA services billed under the non-physician practitioner's provider identification number will be reimbursed at an appropriate rate based on the provider's background and training.

References

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3. https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/abstract

Explanatory Statement:
The AOA does not have clear policy on the "incident to" billing provision or appropriate levels of reimbursement for APRNs and PAs by CMS.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: PATIENT MATCHING OF ELECTRONIC HEALTH RECORD DATA

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, identification and duplication of patient records is a growing problem within the US electronic health record (EHR) ecosystem; and

WHEREAS, the mismatching of patient records can result in inadequate or inappropriate care that harms patient outcomes; and

WHEREAS, no national standards currently exist for patient matching; now, therefore be it

RESOLVED, that the American Osteopathic Association adopt the following policy paper on patient matching of EHRs:

Policy Brief on Patient Matching

Overview:

As patient electronic health information can be more easily shared between physicians, health information exchanges, and payers, patient identification (patient matching) remains a persistent problem in ensuring that electronic health record (EHR) data is complete and accurate. Errors and missing information remain common in the electronic health record ecosystem, with approximately 8% of all records being split or duplicate. This error rate is higher (14% to 16%) within large health systems that store vast amounts of data for a large number of patients.[1] When excluding matching within organizations to analyze patient matching rates between organizations, the match rate can drop to 50%.[2] These high duplication and mismatch rates often translate into unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate information. A 2016 report indicated that 4% of duplicate records result in negative clinical care and outcomes.

Robust and accurate information exchange is central to delivering high quality, cost effective care. Although it requires significant investment, improving patient matching rates will provide benefits to the greater healthcare system that extend far beyond individual encounters. Being able to effectively capture, track, and share data relating to patients' social determinants of health is crucial to delivering high-value care management and promoting well-being outside of a hospital. Not only would accurate capture and sharing of patient data promote better care coordination once a patient is back in their community, but it also supports better population level analytics.[3] Despite the need to improve patient matching, no clear standards for patient matching exist, and there are numerous legal and operational barriers to driving standardization across the healthcare landscape.

Past and Current Proposals

Policy efforts to improve the matching of patient records in an increasingly digital health care system date back to the mid-1990s. As part of the Health Information Portability and Accountability Act (HIPAA) in 1996, Congress directed the Department of Health and Human Services (HHS) to develop a unique identifier for each individual, employer, provider, and plan within the US healthcare system. However, following the passage of HIPAA, there was significant pushback against this provision due to privacy and security concerns. As a result,

Congress walked back the proposal by inserting language into appropriations bills that prohibited HHS from using federal funds to develop unique patient identifiers (UPIs) for individuals.

As the number of digital patient records across the US health care system proliferates, it is becoming increasingly important that providers can de-duplicate records and effectively match them to the proper patient. As of March of 2019, as part of the HHS Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator's (ONC) Proposed Rule on Interoperability and Information Blocking, HHS is proposing to improve patient matching by establishing standards for EHR developers regarding demographic data elements necessary within EHRs for patient matching. The rule also includes a request for information on what data elements would be useful in ensuring accurate patient matching and whether national standards for patient identification would be useful. Without a UPI, the most effective way to ensure accuracy of matched patient records is through the use of social security numbers. A study published in Perspectives in Health Information Management asserts that creating a field for at least the last 4 digits of a patient's social security number, and capturing a patient's full middle name, would increase match accuracy substantially.[4]

Challenges of Each Approach

While there is a great amount of discussion around national standards for patient demographic data and the need for additional identifying information, there is disagreement on whether it would be more appropriate to encourage the use of social security numbers or to seek legislative action to create unique patient identifiers.

Inclusion of social security numbers in patient records would improve patient matching, and standards that require fields for social security numbers in EHRs would not require legislative action. However, various challenges exist to achieving widespread adoption of this practice. First, individuals are often reluctant to provide SSNs out of concern for identity theft. Under this approach, patients would likely have various records with different providers containing their SSNs, increasing their exposure to identity theft risk. Although this perceived risk may be marginal, the fear is likely to be a deterrent to patients offering this information. Second, many states outlaw the collection of social security numbers for health care purposes, and a federal standard that included SSN collection would not apply in these states. Third, as a result of federal legislation, Medicare now provides patients with Medicare cards and is actively shifting away from having patients provide social security numbers. Alternatively, the use of Medicare cards can improve patient matching for this particular population.[5]

As an alternative to social security numbers, various groups have proposed using different unique patient identifiers, including numbers that would be issued by CMS, encouraging the use of biometrics as an additional authenticator, or incorporating additional personal authenticators within patient records that patients would then confirm (personal questions or text message authentication). However, these changes would be costly to implement and there is no consensus on what approach would be best.

Position of the AOA

In light of the current debate regarding the most effective way to match patient data that does not present privacy and security risks, the AOA supports efforts to develop national standards with appropriate safe guards for authentication, and collection of patient demographic data. In order to make the sharing of patient data more efficient and accurate, all health care organizations must collect the same information and enter it in a standardized format. The AOA will support policies that will achieve standardization of identifying data in patient records.

Additionally, because patient health data is particularly sensitive information and patient records contain large amounts of identifying information, the AOA will support the strengthening of privacy and security standards for the certification of EHRs and application programming interfaces.

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ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: POST-PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18 referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, the Ad Hoc Committee on July 21, 2018 referred H615-A/13 POSTPARTUM DEPRESSION to the Bureau on Scientific Affairs and Public Health to produce a report on outcomes; and

WHEREAS, the policy encourages American Osteopathic Association members to participate in continuing medical education programs on postpartum depression (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part of their educational offerings; and endorses the use of screening tools and encourage the measurement of outcomes in their use; now, therefore, be it

RESOLVED, that Bureau on Scientific Affairs and Public Health (BSAPH) receive additional time to collect the requested data from American Osteopathic Association's internal sources as well external key stakeholders (e.g., COMS, osteopathic state and specialty associates); and, be it further

RESOLVED, that BSAPH develop and administer a survey to its external stakeholders to collect the requested information and provide a final report to the House of Delegates in July 2020.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: COOPERATION OF THE VETERANS ADMINISTRATION AND NON-VA CLINICIANS

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, there is always a need to improve the quality of healthcare worldwide; and

WHEREAS, this goal can be in part accomplished by sharing medical records between all Providers involved in patient care; and

WHEREAS, there is difficulty in sharing of Healthcare records between VA clinicians and Non-VA clinicians; and

WHEREAS, this failure to share records may cause unnecessary duplication of services in both systems which affects patient care; and

WHEREAS, in the Non-VA system there is an impact on the reporting of quality measures because of missing information or disinformation; and

WHEREAS, this missing information impacts the accuracy of HEDIS reporting as well as the overall status of complete healthcare received now; therefore be it

RESOLVED, ~~that the leadership of~~ the American Osteopathic Association ~~coordinate with the leadership of the VA to~~ **SUPPORTS** ~~expedite~~ the development and implementation of methodology for the ~~easy~~ **EFFICIENT AND SECURE** sharing of the data in patient records between all VA and Non-VA clinicians~~; and, be it further~~

~~**RESOLVED, that both organizations work to ensure that the data be available to ALL interested third parties (CMS, ACOs, Insurance Companies, etc.) in an acceptable fashion for accurate data reporting regarding individual patients.**~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, insurers, pharmacy benefit managers (PBMs), and third party administrators (TPAs), collectively Payors, continue to use the prior authorization (PA) to deny patients medically necessary medications; and

WHEREAS, one of the ways Payors accomplish this is to make the PA process more complicated and cumbersome than needed so as to discourage use of the PA process; and

WHEREAS, one of the techniques used by Payors to complicate the PA process is to require prescribers to obtain the patient's written permission to act as their agent in the PA process; and

WHEREAS, completing the PA process requires a significant knowledge of medicine and medication, a level of knowledge not usually possessed by the patient; and

WHEREAS, requiring a signed patient authorization to allow the physician to complete the PA process serves no purpose other than to delay or complicate the PA process; and

WHEREAS, one of the roles of a physician is to be an advocate for the patient within a complex healthcare system; now, therefore be it

RESOLVED, that the American Osteopathic Association advocate with insurers, pharmacy benefit managers (PBMs), third party administrators (TPAs), legislators and administrative agencies to allow the physician to complete the entire prior authorization process on behalf of the patient without the patient's written authorization.

Reference Committee Explanatory Statement:
The committee believes that this resolution adds detail not encompassed by existing AOA policy on prior authorization, H-640-A/16, regarding advocating on behalf of the patient. Per H-637-A/18, policies on prior authorization will be consolidated in 2020.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, obesity is a public health crisis which costs the US over $147 billion annually as of 2008 in lost productivity, medical care, morbidity and disability; and

WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016[1]; and

WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death; and

WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to reduce morbidity and mortality of the population; and

WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this condition and obesity is not currently a payable diagnosis for primary care; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) publicly affirms and advocates that all diagnosis codes for obesity and morbid obesity be a billable and reimbursable diagnostic code for any and all practicing primary care physicians; and, be it further

RESOLVED, that the AOA work with insurers, payors, legislators, and other stakeholders to ensure access to treatment for obesity to address this public health epidemic.

References

1. Centers for Disease Control Overweight and Obesity, https://www.cdc.gov/obesity/data/adult.html; Accessed March 15, 2019.

Reference Committee Explanatory Statement:
The Bureau of Socioeconomic Affairs should review the feasibility of obtaining payment for the treatment of obesity as a primary diagnosis and whether new CPT and diagnosis codes need to be created for payment purposes.

ACTION TAKEN **REFERRED** *(to Bureau of Socioeconomic Affairs)*

DATE **July 27, 2019**

SUBJECT: PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, according to an American Medical Association (AMA) survey, more than 90% of physicians said prior authorizations including, but not limited to, prescriptions, procedures and durable medical equipment, had a significant negative clinical impact, with 28 percent reporting that prior authorizations had led to a serious adverse event such as a death, hospitalization, disability, permanent bodily damage, or another life-threatening event for a patient in their care;[1] and

WHEREAS, the vast majority of physicians (86 percent) described the administrative burden associated with prior authorization as "high or extremely high," and 88 percent said the burden has gone up in the last five years; and

WHEREAS, 66% of prescriptions that get rejected at the pharmacy require a prior authorization, only 29% of patients end up with the original prescribed medication and 40% of patients end up abandoning the treatment altogether; and

WHEREAS, formulary changes are made indiscriminately and capriciously without notification to prescribers or patients and insurance enrollment periods are limited but policy and formulary changes by insurers can be made at any time; and

WHEREAS, nonmedical switching, when patients are switched to an alternative drug because the drug was removed from the formulary, worsened outcomes for 95% of chronic disease patients; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) adopt the following policy statement and affirm its tenets as a priority for advocacy:

The American Osteopathic Association (AOA) asserts that physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order without being subjected to the need to obtain prior authorizations. The AOA further maintains that a physician's attestation of clinical diagnosis or order should be sufficient documentation of medical necessity for durable medical equipment. In rare circumstances when prior authorizations are clinically relevant, the AOA upholds they should be evidenced-based, transparent, and efficient to ensure timely access and ideal patient outcomes. Additionally, physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.

The AOA affirms that prior authorizations should be standardized and universally electronic throughout the industry to promote uniformity and reduce administrative burdens. Prior authorizations create significant barriers for physicians to deliver timely

and evidenced-based care to patients by delaying the start or continuation of necessary treatment. The manual, time-consuming and varied processes used in prior authorization programs burden physicians, divert valuable resources away from direct patient care, and lead to negative patient outcomes.

The AOA believes that generic medications should not require prior authorization. The AOA further affirms that step therapy protocols used in prior authorization programs delay access to treatments and hinder adherence. Therefore, the AOA maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans. Additionally, the AOA asserts that health plans should restrict utilization management programs to "outlier" physicians whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors; and, be it further

RESOLVED, that the AOA assert and advocate to legislators, insurance companies, and insurance regulatory bodies that formulary changes should not occur more than 1 time per year and that any change require a 90 day written notice to the patient and prescribing physician that includes rationale for the change, and where the prescribed device or medication can be obtained; and, be it further

RESOLVED, that the AOA formally join other stakeholders in publicly supporting & affirming the "Prior Authorization and Utilization Management Reform Principles" (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-with-signatory-page-for-slsc.pdf) in addition to the aforementioned policy statement; and, be it further

RESOLVED, that the AOA consider adoption of the above policy statement in addition to the AOA's existing policy on prior authorization (H640-A/16 PRIOR AUTHORIZATION, etc.).

References

1. "1 in 4 doctors say prior authorization has led to a serious adverse event" in AMA News, https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse February 5, 2019. Accessed March 15, 2019.

Reference Committee Explanatory Statement:
The AOA policy compendium contains multiple policies relating to prior authorization, including H640-A/17 and H632-A/17 which overlap significantly, but not entirely, with the proposed policy. The BSA should report to the House on how existing policy could be enhanced by incorporating elements of the proposed policy not already covered.

ACTION TAKEN **REFERRED** *(to Bureau of Socioeconomic Affairs)*

DATE **July 27, 2019**

SUBJECT: ADDRESSING THE GENDER PAY GAP IN THE MEDICAL PROFESSION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, the average female practicing physician can expect to earn as much as 37% less than her average male colleague [1-5]; and

WHEREAS, a recent study reports that female physicians working with an academic appointment at public medical schools in the US can expect to earn, on average, 19.8% less than their male colleagues[3]; and

WHEREAS, in a recent survey it was reported that female resident physicians can expect to earn, on average, as much as $900 less than their male colleagues and where other studies have shown that newly practicing female physicians can earn as much as 17% less than their male colleagues[4,6]; and

WHEREAS, these disparities in income persist despite current United States federal law mandating the equal compensation of men and women for equal work in the same establishment and with due respect to permissible 'affirmative defenses' under the Equal Pay Act of 1963[9]; and

WHEREAS, literature supports that these disparities in income persist even when factors that may contribute to them, including but not limited to, choice of specialty, family dynamics, working environment, and individual earning characteristics are controlled for [1-3,6-7]; and

WHEREAS, these disparities in income are likely to appear early in a woman's career, persist throughout it, and even widen as women continue to practice throughout their career[6,8]; and

WHEREAS, these disparities in income between women and men, referred to as the "gender pay gap", may result from a system of inequality at the detriment of women in the medical profession; and

WHEREAS, AOA Policy H207-A/17 NON-GENDER DISCRIMINATION, reads, "The American Osteopathic Association requires all of its recognized training institutions, both osteopathic and allopathic, to provide equally for their physicians and students"; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) acknowledge the existence of the "gender pay gap" between male and female physicians in the United States; and, be it further

RESOLVED, that AOA shall support the adoption of policies and practices that ensure the equitable compensation of physicians **WHO WORK THE SAME JOB** regardless of gender ~~**who work with the same job title and job description, and with equivalent or comparable credentials and qualifications, requiring the same responsibility, effort, and skill, and under similar working circumstances in the academic, clinical, and support programs that are promoted by, accredited by, endorsed by, or otherwise funded by the AOA**~~.

References

1. American College of Physicians. (2017). "Research on Compensation Equity and Transparency in the Field of Medicine".
2. Butkus, R. et al. (2018). "Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians". Annals of Internal Medicine. 168: 721-723.
3. Jena, A. , Olenski, A., Blumenthal, D. (2016). "Sex Differences in Physician Salary in US Public Medical Schools". JAMA Internal Medicine. 176(9):1294-1304.
4. Doximity. (2018). "2018 Physician Compensation Report" American Medical Association House of Delegates Resolution 10(A-18). (2018) "Gender Equity in Compensation and Professional Advancement"
5. Lo, A., Richards, M., Chou, C., Gerber, S. (2011). "The $16,819 Pay Gap For Newly Trained Physicians: The Unexplained Trend Of Men Earning More Than Women". Health Affairs. 30,2:193-201.
6. Freund, K. et al. (2016). "Research Report - Inequities in Academic Compensation by Gender: A Follow-up to the National Faculty Survey Cohort Study". Academic Medicine. 91,8:1-6.
7. Bowles, HR. et al. (2005). "Constraints and triggers: Situational mechanics of gender in negotiation." J Pers Soc Psychol. 89:951–965.
8. United States. Department of Labor. Office of the Solicitor. (1963). Equal Pay Act of 1963 EPA. Pub. L. 88-38. 29 U.S. Code Chapter 8 § 206(d). Washington..

Explanatory Statement:

Please note that the use of the phrase "evidence-based" throughout this resolution is intended to specify that any policies or actions that arise from the adoption of this resolution ought to be based on available evidence and analysis rather than anecdote or conjecture. Further, note that the phrase "affirmative defenses" used in line 12 is a legal term used to describe those permissible discrepancies in compensation which are based on factors other than sex that include seniority, merit, quantity or quality of production by which employees may be compensated differently as established in the Equal Pay Act of 1963.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: BUDGET ADJUSTMENT PARAMETERS

SUBMITTED BY: Joint Board House Budget Review Committee

REFERRED TO: AOA House of Delegates

WHEREAS, the House of Delegates met in July, 2016 and approved the following Budget Adjustment Parameters Policy:

"RESOLVED, that without explicit approval of the Joint Board/House Budget Review Committee the AOA Board of Trustees may take no financial actions between meetings of the AOA House of Delegates which when taken together either decrease AOA's cash or increase its long term or recurring short term debt (to include operating leases and other contractual obligations) to an aggregated amount greater than 10% of the AOA's total equity as audited in the prior year; and, be it further

RESOLVED, that this policy will be reviewed by the Joint Board/House Budget Review Committee every three years.", and

WHEREAS, the Finance Committee reviewed the Budget Adjustment Parameters Policy and believes it remains relevant and appropriate; now, therefore, be it

RESOLVED, that the Finance Committee re-affirms its support of the Budget Adjustment Parameters Policy; and be it further

RESOLVED, that this resolution be forwarded to the Joint Board/House Budget Review Committee for consideration.

Explanatory Statement:
The above budget adjustment parameters were initially approved by the Joint Board/House Budget Review Committee in July 1995. These parameters were re-affirmed by the Joint Board/House Budget Review Committee in July 1998, July 2001, July 2004, July 2007, July 2010, July 2013, July 2016 and July 2019. These budget adjustment parameters were reviewed and approved by the Joint Board/House Budget Review Committee in July, 2019 as part of the three-year review process as required by the initial resolution.

Continuation of this policy is in accord with the specific subset of the budget adjustment provision contained in the Reserve Requirement Policy.

ACTION TAKEN **APPROVED**

DATE **July 28, 2019**

****EDITORIAL NOTE:** Per the HOD Speaker, due to the nature and timing of this resolution it will not need to be addressed by the Rules & Order of Business Reference Committee as a late entry.******

SUBJECT: FY 2020 WAIVER FROM RESERVE REQUIREMENT POLICY

SUBMITTED BY: Joint Board House Budget Review Committee

REFERRED TO: House of Delegates

WHEREAS, the AOA Reserve Requirement Policy RES. NO. H-701 – A/2013 requires that the AOA's operating budget be balanced on an annual basis; and

WHEREAS, the AOA anticipates a significant decline in FY2020 dues revenue from FY2019 and prior years because of the decrease in annual membership dues (regular membership dues category reduced by $90 beginning in FY 2020) and the elimination of the $90 annual certification maintenance fee; and

WHEREAS, the extent to which membership – and therefore membership dues revenue - will decline in FY2020 because of the decoupling of membership from certification is uncertain and unpredictable; and

WHEREAS, the AOA's revenues from accreditation of postdoctoral training programs will continue to decline as the transition to the single postdoctoral accreditation system continues; and

WHEREAS, the AOA budget contained an operating deficit of $6.4 million when the Finance Committee met on June 24, 2019 to review the budget; and

WHEREAS, the reserve balance at May 31, 2020 is projected to be 78.4 percent of total operating expenses two years earlier as compared to a reserve requirement of 75 percent; and

WHEREAS, the AOA Finance Committee will continue to attempt to balance the operating budget in FY 2020 and FY 2021; now, therefore, be it

RESOLVED, that the AOA House of Delegates waives the requirements contained in the Reserve Requirement Policy for Fiscal Year 2020 (June 1, 2019 – May 31, 2020) to fund the budgeted net operating deficit of $4.5 million from reserves; and, be it further

RESOLVED, that the Joint Board/House Budget Review Committee will report back to the House of Delegates at its annual business meeting in 2020.

ACTION TAKEN **APPROVED**

DATE **July 28, 2019**

****EDITORIAL NOTE:** Per the HOD Speaker, due to the nature and timing of this resolution it will not need to be addressed by the Rules & Order of Business Reference Committee as a late entry.******

SUBJECT: APPROVAL OF THE AOA BUDGET, FISCAL YEAR 2020

SUBMITTED BY: Finance Committee

REFERRED TO: Joint Board House Budget Review Committee

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1 RESOLVED, that the Fiscal Year 2020 Proposed Budget of the American Osteopathic
2 Association be approved as submitted.

ACTION TAKEN **APPROVED**

DATE **July 28, 2019**

AMERICAN
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ASSOCIATION