AMERICAN OSTEOPATHIC ASSOCIATION
POLICY COMPENDIUM
2015

The American Osteopathic Association's House of Delegates is the policy-making body of the osteopathic profession. Each year at its annual meeting, the House considers policy statements submitted by departments, bureaus, committees, divisional societies, affiliated societies, or the AOA Board of Trustees.

The full texts of policy statements adopted by the AOA House of Delegates are noted in the Policy Compendium. The numbering of the AOA policies is noted by the following example:

H200-A/08 ACCUPUNCTURE

H	AOA House of Delegates
200	AOA Resolution Number
A/08	Meeting the Resolution was acted on (2008 Annual Meeting)

A short title for each statement has been adopted for ease of reference. By action of the AOA Board of Trustees in July 1979, the AOA Council on Policy (formerly the Committee on Health Related Policies) will review all AOA policy guidelines relating to healthcare, health planning, and health delivery at least every five years and recommend affirmation, revision, or deletion to the AOA House of Delegates.

Note: Effective June 14, 2001, the Health Care Financing Administration (HCFA) agency was renamed. It is now the Center for Medicare and Medicaid Services (CMS).

H200-A/05 COMMITTEE ON HEALTH RELATED POLICIES MISSION STATEMENT

Policies of the American Osteopathic Association which have not been subject to review within five years from their adoption date or last revision be automatically reviewed; and in any AOA position statement the "Whereas" statements are considered as explanatory and only the "Resolved" statements will be published as official AOA policy. 1990; revised 1995; reaffirmed 2000, revised 2005

H604-A/12 HOUSE OF DELEGATES RESOLUTIONS

All Resolution authors are encouraged to create "Resolved" statements that make clear the intent of the House even when the "Whereas" statements are removed; the American Osteopathic Association House of Delegates authorized the AOA staff to make editorial changes as needed to resolutions passed by the House so that when resolutions are integrated into the Policy Compendium, the intent of the House remains clear; and the AOA will maintain on file a copy of the complete resolution as approved by the AOA House of Delegates. 2012

H-605-A/12 SUNSETTING POLICIES

For all policies due for sunset review, the American Osteopathic Association House of Delegates shall be provided a brief policy summary to include all of the following: the actual policy being reviewed, what action that AOA has taken to implement the policy and the results of that action. 2012

H337-A/14 ABUSE OF PERFORMANCE ENHANCING SUBSTANCE AND PROCEDURES

The American Osteopathic Association: (1) supports efforts to eliminate the abuse of performance enhancing substances, know 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 (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

H414-A/12 ABUSED PERSONS

The American Osteopathic Association continues to encourage its membership to participate in programs designed for the treatment of the abused and the rehabilitation of the abuser and will continue to encourage public health agencies to provide special training in: advocacy for abused persons; effective assessment and intervention techniques to assist those in abuse situations; legal procedures; special needs of young and elderly, building links with local shelters, and related community resources. 1982; revised 1987; reaffirmed 1992, 1997; revised 2002; reaffirmed 2007; 2012

H210-A/11 ACADEMIC OSTEOPATHIC EDUCATORS, RESEARCHERS OR ADMINISTRATORS EDUCATIONAL PROGRAM DEVELOPMENT

The American Osteopathic Association encourages colleges of osteopathic medicine to collaborate and develop with other institutions a master's level medical education program that is available during or after the completion of an osteopathic medical training program that will prepare osteopathic physicians for future academic careers as educators, researchers and administrators. 2011

H203-A/11 ACCESS TO HEALTHCARE – DEVELOPING A NEW MODEL OF ADMINISTERING OSTEOPATHIC PRIMARY CARE RESIDENCIES IN THE UNITED STATES

The American Osteopathic Association will (1) increase access to primary care through expanding innovative programs which incentivize the osteopathic medical students to enter osteopathic primary care residencies by further developing 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 osteopathic primary care residencies. 2011

H200-A/13 ACUPUNCTURE
The American Osteopathic Association recognizes that acupuncture may be a part of the armamentarium of qualified and licensed physicians. 1978; reaffirmed 1983; revised 1988, 1993; reaffirmed 1998, 2003; reaffirmed 2008; reaffirmed 2013

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

H301-A/12 ADMINISTRATIVE RULE-MAKING PROCESS
The American Osteopathic Association supports closer federal and state legislative scrutiny of the administrative rule-making process to more effectively monitor the development of regulations and assure their conformity with expressed legislative intent. 1986; revised 1992; reaffirmed 1997; revised 2002; reaffirmed 2007; reaffirmed as amended 2012

H300-A/13 ADOLESCENTS' BILL OF RIGHTS
The American Osteopathic Association advocates that all medical facilities that provide care for adolescents post an "Adolescents' Bill of Rights" which clearly articulates state and local applicable laws of consent and confidentiality regarding health care for adolescents who have not reached the age of majority. 2003; reaffirmed 2008; reaffirmed 2013

H302-A/12 ADVANCE DIRECTIVES
The American Osteopathic Association supports advance directives and will proactively assist in introducing this concept into federal legislation. 1997, revised 2002; reaffirmed 2007; reaffirmed as amended 2012

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. 1989; revised 1994; reaffirmed 1999; revised 2004; reaffirmed 2009; 2014

H403-A/15 ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS -- SUPPORT FOR THE
The AOA encourages osteopathic physicians consider the vaccination history as an integral part of their patient's health record and should counsel their patients on appropriate vaccinations for their age and health conditions. Osteopathic physicians should take all reasonable steps to ensure their patients of all ages are fully immunized against vaccine preventable illnesses and make vaccine recommendations to their patients according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and

published in the Morbidity and Mortality Weekly Report (MMWR) and should not advocate alternative schedules. 2015

H403-A/13 AIRBAGS IN AUTOMOBILES

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 safety belts, child safety seats and airbags; (2) urges continued corporate development and research into safer airbags; (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 airbags, and (4) urges these organizations continue to examine adult and child fatalities resulting from airbag deployment. 1993; revised 1998, 2003; revised and reaffirmed 2008; reaffirmed 2013

H412-A/15 AIRCRAFT EMERGENCY MEDICAL SUPPLIES

The American Osteopathic Association 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. 1984; revised 1989, 1995; reaffirmed 2000, revised 2005, reaffirmed 2010; reaffirmed as amended 2015

H301-A/13 AIRLINE MEDICAL KITS

The American Osteopathic Association supports the current Federal Aviation Administration (FAA) Final Rules on Airline Emergency Equipment. 1998, revised 2003; revised and reaffirmed 2008; reaffirmed 2013

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

H302-A/13 ALCOHOL AND TOBACCO--ADVERTISING BAN ON

The American Osteopathic Association endorses a ban on all advertising of tobacco and alcohol.1988; revised 1993; reaffirmed 1998; revised 2003; reaffirmed 2008; reaffirmed 2013

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

H442-A/15 ALERT SYSTEM--SILVER
The American Osteopathic Association supports the formation of a "Silver Alert" System on a national level to notify communities of missing persons with mental disabilities, particularly seniors with cognitive or developmental impairments. 2010; reaffirmed 2015

H-202-A/12 AMBULATORY-BASED PRIMARY CARE RESIDENCY PROGRAMS
The American Osteopathic Association supports and advocates for development and implementation of ambulatory-based primary care residency programs; encourages the US Congress to strengthen its graduate medical education reimbursement policies to at least equivalently fund ambulatory-based primary care residency programs; and will lobby Congress to support legislation funding demonstration models of ambulatory-based primary care residency programs. 2012

H413-A/15 ANIMALS IN MEDICAL RESEARCH
The American Osteopathic Association (AOA) supports the use of animals for valid medical research projects and the humane handling and treatment of such animals, and their ready availability from legitimate sources. The AOA supports eventual elimination of the use of animals in medical research as better techniques become available. 1990; reaffirmed 1995; revised 2000, revised 2005; reaffirmed 2010; reaffirmed as amended 2015

H416-A/12 ANTI-BULLYING LAW
The American Osteopathic Association supports anti-bullying policies enabling students to go to school in a peaceful manner without fear of tormenting or intimidating 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. 2002; reaffirmed 2007; 2012

H407-A/15 ANTIBIOTIC STEWARDSHIP
The American Osteopathic Association (AOA), supports the five core actions outlined in the National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic physicians to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which is a commitment to always use antibiotics only when they are necessary to treat, and in some cases prevent, disease; to choose the right antibiotics; and to administer appropriately. 2015

H411-A/15 ANTIFREEZE POISONING
The American Osteopathic Association supports the addition of a bittering agent to antifreeze to lessen the likelihood of accidental ingestion. 2010; revised 2015

H415-A/12 ANTIMICROBIAL—JUDICIOUS USE OF
The American Osteopathic Association supports the education for proper use of antimicrobial agents in order to decrease drug-resistant organisms. 2002; revised 2007; reaffirmed 2012

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

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.

H205-A/14 ASSURE GRADUATE MEDICAL EDUCATION RESIDENCY POSITIONS TO GRADUATES OF U.S. MEDICAL SCHOOL

The American Osteopathic Association will work with COCA, AACOM, AMA, ACGME, AAMC and LCME to advocate for Federal Legislation that will offer GME positions first to DO or MD graduates of U.S. COCA OR LACME accredited medical schools. 2014

H626-A/15 ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT ACTIVITY DISORDER (ADD/ADHD)

The American Osteopathic Association urges insurance carriers to provide coverage for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians. 2005; reaffirmed 2010; 2015

H426-A/14 AUTOMATED EXTERNAL DEFIBRALLATOR (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 an AED for use by the public. 2009; reaffirmed 2014

H401-A/12 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TO TREAT COMMOTIO CORDIS, PROMOTION FOR THE REQUIREMENT OF ALL SPORTING EVENTS TO HAVE ACCESS TO AN

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, training has been provided to responsible individuals. 2012

H217-A/15 AUTOPSIES

The American Osteopathic Association encourages medical schools, private hospital systems and public medical facilities to allow the viewing of autopsies by medical students and residents for teaching purposes. 2010; reaffirmed 2015

H329-A/11 BABY FRIENDLY HOSPITAL INITIATIVE (BFHI)

The American Osteopathic Association will encourage all hospitals and birth centers to provide mothers the information and skills to initiate and continue breastfeeding their babies; and will promote and give special recognition to hospitals and birth centers who receive the Baby Friendly Hospital Initiative (BFHI) designation. 2011

H635-A/14 BEER'S CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS -- USE OF

The American Osteopathic Association recognizes the limitations of the Beer's Criteria as published by the American Geriatrics Society, due to the limitations and intent of the criteria as a measure of physician quality of care. 2014

H437-A/15 BIO-TERRORISM ACTIVITIES, CONTINUED SUPPORT OF COMBATING

The American Osteopathic Association recommends the continued support of any and all constitutionally legal efforts to prevent and respond to future acts of bio-terrorism in the United States. 2010; reaffirmed 2015

H400-A/13 BLOOD DONORS, INCREASING THE NUMBER OF

The American Osteopathic Association (AOA) stand with the American Red Cross, American Blood Centers and American Association of Blood Banks (AABB) in calling to end the indefinite deferment period for Men who have sex with Men (MSM), and supports the American Red Cross, AABB and American Blood Banks request that the FDA modify the exclusion criteria for MSM to be consistent with deferrals for those judged to be at an increased risk of infection. 2013

Behavior-Based Blood Donors Deferrals in the Era of Nucleic Acid Testing (NAT)

Blood Products Advisory Committee, March 9, 2006

Steven Kleinman, MD
Senior Medical Advisor, AABB

AABB, America's Blood Centers (ABC) and American Red Cross (ARC) thank the Food and Drug Administration (FDA) for the opportunity to speak at today's meeting. AABB, ABC, and ARC commend FDA for holding a workshop to review the issues associated with the deferral of prospective blood donors on the basis of an elicited history of behavioral risk. In the context of that workshop, we would like to comment on the deferral criteria for men who have previously had sex with men.

On September 14th, 2000, AABB spoke before the Blood Products Advisory Committee, making the following recommendation:

"Since 1997 AABB has advocated that the deferral period for male to male sex be changed to 12 months. Modifying the deferral time period for male to male sexual contact to 12 months will make that deferral period consistent with the deferral period for other potentially high risk sexual exposures and will improve the clarity and consistency of the donor screening questions. The potential donor will be directed to focus on recent, rather than remote risk behaviors and should have better recall for answers to the screening questions."

The recommendation was not accepted, largely on the grounds that any relaxation in the criteria would increase the number of Human Immunodeficiency virus (HIV) seropositive individuals presenting to give blood and thereby increase risk to recipients because of false negative laboratory screening or inadvertent release of infectious units. We now have evidence to show that the vast majority of donors with prevalent infections will be positive by both antibody tests and nucleic acid amplification testing (NAT), thus assuring redundancy in laboratory testing.

AABB, ABC and ARC believe that the current lifetime deferral for men who have had sex with other men is medically and scientifically unwarranted and recommend that deferral criteria be modified and made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections. Presenting blood donors judged to be at risk of exposure via heterosexual routes are deferred for one year while men who have had sex with another man even once since 1977 are permanently deferred.

Current duplicate testing using NAT and serologic methods allow detection of HIV-infected donors between 10 and 21 days after exposure. Beyond this window period, there is no valid scientific reason to differentiate between individuals infected a few months or many years previously. The FDA-sanctioned Uniform Donor History Questionnaire was developed recognizing the importance of stimulating recall of recent events to maximize the identification of donors at risk for incident, that is, recent, infections. From the perspective of eliciting an appropriate risk history for exposure to HIV and other sexually transmitted infections, the critical period is the three weeks immediately preceding donation since false negative NAT and serology reflect these window-period infections, and the length of these window periods provide the scientific basis for the deferral periods imposed for at risk sexual behaviors.

It does not appear rational to broadly differentiate sexual transmission via male-to-male sexual activity from that via heterosexual activity on scientific grounds. Neither does it seem reasonable to extend this reasoning to other infectious agents. To many, this differentiation is unfair and discriminatory, resulting in negative attitudes to blood donor eligibility criteria, blood collection facilities and, in some cases, to cancellation of blood drives. We think FDA should consider that the continued requirement for a deferral standard seen as scientifically marginal and unfair or discriminatory by individuals with the identified characteristic may motivate them to actively ignore the prohibition and provide blood collection facilities with less accurate information.

AABB, ABC and ARC acknowledge the concern that relaxation of deferral criteria may increase the number of presenting donors who are marker positive. However, this impact has not been measured directly; it has only been modeled using what may be incomplete assumptions. The blood collectors are willing to assist in collecting data regarding the actual impact of changes in the deferral, in order to allow for informed decision-making, and/or for the development of additional, appropriate interventions to ameliorate the impact.

In summary, AABB, ABC and ARC believe that the deferral period for men who have had sex with other men should be modified to be consistent with deferrals for those judged to be at risk of infection via heterosexual routes. We believe that this consideration should also be extended to donors of human cells, tissues and cellular and tissue-based products.

AABB is an international association dedicated to advancing transfusion and cellular therapies worldwide. Our members include 1800 hospital and community blood centers, transfusion and transplantation services and 8000 individuals involved in activities related to transfusion and transplantation medicine. For over 50 years, AABB has established voluntary standards and inspected and accredited institutions. Our members are responsible for virtually all of the blood collected and more than 80 percent of the blood transfused in this country. AABB's highest priority is to maintain and enhance the safety and availability of the nation's blood supply.

Founded in 1962, America's Blood Centers is North America's largest network of community-based blood programs. Seventy-seven blood centers operate more than 600 collection sites in 45 U.S. states and Canada, providing half of the United States, and all of Canada's volunteer donor blood supply. These blood centers serve more than 180 million people and provide blood products and services to more than 4,200 hospitals and health care facilities across North America. ABC's U.S. members are licensed and regulated by the U.S. Food & Drug Administration. Canadian members are regulated by Health Canada.

The American Red Cross, through its 35 Blood Services Regions and five National Testing Laboratories, supplies nearly half of the nation's blood supply. Over six million units of Whole Blood were collected from more than four million Red Cross volunteer donors, separated into 12 million components, and supplied to 3000 hospitals to meet the transfusion needs of patients last year.

H429-A/11 BLOOD DONORS, PROTECTION FROM DEPLETION OF IRON

The American Osteopathic Association encourages blood collection facilities to establish guidelines to identify frequent blood donors, and institute the necessary testing to monitor their iron stores. 2006; reaffirmed 2011

H223-A/15 BLUE RIBBON COMMISSION REPORT

The American Osteopathic Association (AOA) encourages colleges of osteopathic medicine to collaborate with appropriate regulatory authorities, licensing boards, certifying boards, the National Board of Osteopathic Medical Examiners, and other stakeholders in their pursuit of innovative pilot studies to produce primary care, competency-based physician team leaders and the AOA will monitor the outcomes of these pilot programs and the route to board certification. 2015

H428-A/12 BREAST CANCER PREVENTION, DETECTION, DIAGNOSIS AND TREATMENT -- ACCESSIBILITY

The American Osteopathic Association supports development and application of the latest advances in breast cancer prevention, detection, diagnosis and treatment, with dissemination as rapidly as possible to the medical community and the public it serves; and urges adoption of measures and programs to improve access to breast cancer screening for all appropriate patient populations. 2007; reaffirmed as amended 2012

H444-A/15 BREAST CANCER -- SCREENING FOR

The American Osteopathic Association recognizes and promotes the importance of the integrity of the patient-physician relationship and recommends that breast cancer clinical preventive screenings and coverage be individualized to the extent possible for every patient. 2010; reaffirmed as amended 2015

H433-A/12 BREASTFEEDING EXCLUSIVITY

The American Osteopathic Association supports the dissemination of information for the practicing physician about the health benefits associated with the duration and exclusivity of breastfeeding for six months. 2002; reaffirmed 2007; 2012

H417-A/12 BREASTFEEDING, FRIENDLY WORKPLACE

The American Osteopathic Association urges its membership to take a role in providing a breastfeeding friendly workplace in their offices and hospitals. 2002; reaffirmed 2007; 2012

H418-A/12 BREASTFEEDING--PROMOTION, PROTECTION AND SUPPORT OF

The American Osteopathic Association urges its membership to take a role in the protection, promotion and support of breastfeeding. 2002; reaffirmed 2007; 2012

H600-A/13 BREASTFEEDING--PROTECTING
The American Osteopathic Association encourages its members to contact their elected officials in support of legislation protecting the rights of breastfeeding and urges the AOA Bureau on Federal Health Programs to add this issue to their legislative agenda. 2003; amended 2008; reaffirmed 2013

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

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

H414-A/15 CANCER
The American Osteopathic Association 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 and will disseminate to the medical community and the public it serves, information gained from osteopathic and other research activities on the applications of the latest advances in cancer prevention, detection, early diagnosis and treatment. 1974; reaffirmed 1980, 1985; revised 1990, 1995, reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

H401-A/11 CARBONATED SOFT DRINKS IN SCHOOLS
The American Osteopathic Association encourages its physician members through articles in its publications and website and in communications to state societies to educate and caution their patients, school superintendents, and members of school boards across our nation as to the health consequences of carbonated soft drinks and urge them to eliminate these products in our school systems. 2006; revised 2007; reaffirmed 2011

H416-A/15 CARDIOPULMONARY RESUSCITATION--TRAINING
The American Osteopathic Association strongly supports instruction in cardiopulmonary resuscitation (CPR) 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 courses on a voluntary basis. 1980; revised 1985, 1990, 1995, 2000, reaffirmed 2005, 2010; 2015

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 (5) through its website, the AOA will link to organizations whose mission is to educate patients and physicians on CVD; and (6) encourages appropriately designed studies on contributors to CVD in women. 2004; 2009; reaffirmed as amended 2014

H308-A/11 CENTER OF EXCELLENCE FOR STROKE

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. 2011

H313-A/14 CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)--HUMAN IMMUNODEFICIENCY VIRUS (HIV) PROPOSED RULE CHANGE

The American Osteopathic Association voices its concern and opposition to the Centers for Disease Control and Prevention (CDC) proposed rule-making change on42 CFR Part 34 to remove human immunodeficiency virus (HIV) testing as a requirement for immigrants and refugees; and, through its resources encourages members and the public to investigate and comment on the proposed rule-making. 2009; referred 2014

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

The American Osteopathic Association recommends that CMS develop a less burdensome procedure for physicians to provide documentation of medical necessity for diabetic supplies and other covered CMS services that protect patient confidentiality and do not result in duplication of documentation. 2013

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 for the rejection of any Medicare claims be communicated to the physician. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

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

The American Osteopathic Association endorses the Centers for Medicare and Medicaid Services proposal that divides Physician Services into separate categories of Direct Physician Services and Referral Physician Services to provide the true expenditure of health services. 2003; reaffirmed 2008; 2013

H303-A/13 CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)--OPPOSITION TO CMS'S BEHAVIORAL OFFSET DECREASE IN PRACTICE EXPENSE VALUES

The American Osteopathic Association opposes the Centers for Medicare and Medicaid Services' policy to impose behavioral offset to physician services. 1998, revised 2003; reaffirmed 2008; 2013

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

The American Osteopathic Association will continue to inform state associations and their members on policies and rules being considered by the Centers for Medicare and Medicaid Services and/or other federal agencies on major patient/physician issues and encourages the state associations to provide their members with the information and take an active role in responding to CMS on policies and rules pertinent to their members, their practices and patients. 1998; revised 2003; reaffirmed 2008; 2013

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

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

H405-A/13 CERVICAL CANCER, SCREENING FOR
The American Osteopathic Association encourages all osteopathic physicians and students to continue to educate themselves and their patients on current guidelines related to cervical cancer screening using the Pap and HPV testing. 2013

H402-A/11 CHELATION THERAPY
Pending the results of thorough, properly controlled studies, the American Osteopathic Association does not endorse chelation therapy as useful for other than its currently Food and Drug Administration approved and medically accepted uses. 1985; revised and reaffirmed 1990, 1995; revised 2000; referre*d* 2005; revised 2006; reaffirmed 2011

H417-A/15 CHILD ABUSE AND NEGLECT
The American Osteopathic Association urges its members to participate in a continuing national educational program relative to aspects of child abuse and neglect, to cooperate with state and local child protection agencies in reporting suspected child abuse and neglect cases, and to keep a vigilant eye toward recognizing maltreatment of children. 1974; reaffirmed 1980; revised 1985, 1990, 1995, 2000, 2005, reaffirmed 2010; 2015

H411-A/11 CHILDHOOD AND TEENAGE SEXUAL EXPOSURE
The American Osteopathic Association: (1) encourages osteopathic physicians to provide anticipatory guidance to minor children about the risks of sexual exposure and sexually-transmitted diseases, and provide this same guidance to their parents and/or caregivers; (2) encourages osteopathic physicians to support the development of curriculum by local, state and national educational organizations that will lead to the prevention of unwanted pregnancy and transmission of disease, using medically appropriate measures, preferably abstinence and avoidance of high risk sexual behavior; and (3) support public education efforts to prevent unwanted pregnancy and sexually transmitted. 2005, 2006; reaffirmed as amended 2011

H419-A/12 CHILDREN ON AIRPLANES--RESTRAINTS
The American Osteopathic Association encourages the Federal Aviation Administration to develop guidelines on infant and child safety for air travel. 2002; amended and reaffirmed 2007; 2012

H418-A/15 CHILDREN'S SAFETY SEATS
The American Osteopathic Association supports the enforcement of child safety seat statutes in accordance with the National Highway Traffic Safety Administration Guidelines. 1985; revised 1990; reaffirmed 1995; revised 2000, 2005; revised 2010; reaffirmed 2015

H404-A/13 CHOOSING WISELY CAMPAIGN

The American Osteopathic Association endorses the "Choosing Wisely Campaign" to help disseminate information and education to patients and health care providers to make wise decisions and will forward information on the Choosing Wisely Campaign to the osteopathic specialty colleges for review and recommendations. 2013

H209-A/14 CLINICAL ROTATIONS FOR INTERNATIONAL MEDICAL STUDENTS

Policy of 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 continue to monitor, correct and work to prevent any future policies that provide an unfair advantage to international medical students. 2009; reaffirmed 2014

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

The American Osteopathic Association supports colorectal cancer screening reimbursement by all payers according to the current evidence-based guidelines. 1998, revised 2003; amended and reaffirmed 2008; reaffirmed as amended 2013

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.
- 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.

H212-A/11 COMLEX-USA LEVEL 2-PE

The American Osteopathic Association will communicate with the National Board of Osteopathic Medical Examiners (NBOME) and continue to consider development of multiple, geographically-dispersed sites for the administration of COMLEX-USA Level 2-PE (Clinical Skills Examination). 2006; reaffirmed 2011

H217-A/14 COMMMUNITY-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

H348-A/14 COMPENSATION TIED TO PATIENT SATISFACTION SURVEYS -- OSTEOPATHIC PHYSICIAN

The American Osteopathic Association opposes the principle that any satisfaction surveys have a significant impact on osteopathic physician's compensation. 2014

H436-A/15 COMPLEMENTARY AND ALTERNATIVE MEDICINE BY NON-PHYSICIANS

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; (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. 2010; reaffirmed as amended 2015

H423-A/15 CONDOM USAGE - HEALTH EDUCATION

The American Osteopathic Association supports full disclosure of the risks and benefits of condom usage and the data on condom failure rates and causes of failure, whenever condom usage is taught. 1995; revised 2000, 2005, reaffirmed 2010; 2015

H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS

The American Osteopathic Association opposes invasion of privacy of the patient record by any unauthorized person or agency; and endorses reasonable programs which seek to protect patient/physician relationships and guarantee confidentiality of patient records. 1980; revised 1985, 1990, 1995; 2000, 2005; reaffirmed 2010; 2015

H427-A/11 COUNTERFEIT MEDICATIONS

The American Osteopathic Association will petition the Food and Drug Administration (FDA) to work with the state boards of pharmacy to investigate the prevalence and potential risk of counterfeit medications in the United States; and encourages the FDA to review and strengthen laws and regulations for tracking prescription medications from factory to pharmacy to ensure the safety of the United States drug supply. 2006; reaffirmed 2011

H606-A/13 CRIMINAL LITIGATION FOR CLINICAL DECISIONS

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

H628-A/11 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES -- BLENDING RATES

The American Osteopathic Association is opposed to blending of payment rates by insurance companies for Evaluation and Management codes. 2006; reaffirmed as amended 2011

H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION

The American Osteopathic Association will continue to review the issue of obtaining prior authorization for prescription procedures as part of ongoing practice expense consideration in addition to the next Medicare five-year review. 2008; reaffirmed 2013

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

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

H439-A/11 CYBERBULLYING THROUGH SOCIAL MEDIA
The American Osteopathic Association supports increasing awareness among parents / guardians, caregivers, educators, counselors and physicians about the danger of cyberbullying through media advocacy efforts and encourages osteopathic physicians to talk to their patients and the parents / guardians of their patients about cyberbullying and the lasting emotional damage that it can cause. 2011

H415-A/11 DAMAGE TO HEARING FROM USE OF HEADPHONES
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) 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) believes that osteopathic physicians should actively educate young people and parents about the safety concerns of using headphones and the necessary safeguards to prevent hearing damage. 2011

H416-A/11 DANGERS OF THE "CHOKING GAME"
The American Osteopathic Association supports increasing awareness among parents, educators, counselors and physicians of the risks and warning signs associated with the choking game and of the resources available for educating teens about the dangers of the choking game; and supports the inclusion of information about the dangers of the "choking game" in classroom education and other school-sponsored discussions about drugs and risky behaviors. 2011

H419-A/15 DEATH: RIGHT TO DIE
The AOA believes that the decision to withhold or withdraw treatment from a patient whose prognosis is terminal, or when death is imminent, shall be based upon the wishes of the patient or his/her family or legal representative if the patient lacks capacity to act on his/her own behalf as mandated by applicable law. 1979; revised 1984, 1989, 1995, 2000, 2005; revised 2010; reaffirmed 2015

H205-A/11 DEPRESSION AWARENESS IN U.S. MEDICAL STUDENTS
The American Osteopathic Association recommends that there be increased awareness of depression amongst US medical students and that treatment options for those affected be provided. 2011

H638-A/15 DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS
The American Osteopathic Association supports the availability of American Diabetes Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA guidelines for all diabetic inmates, who are under the care of a licensed physician, and confined in correctional institutions. 2000, revised 2005; reaffirmed 2010; 2015

H313-A/12 DIETARY SUPPLEMENTS -- GUIDELINES FOR NUTRITIONAL AND

The American Osteopathic Association requests: (1) the Food and Drug Administration (FDA) to be diligent in their monitoring of all products marketed for human consumption, including nutritional supplements, and that there be close attention to reported adverse events directly caused by any of these products; and (2) that the US Congress amend the Dietary Supplement Health and Education Act (DSHEA) so that dietary supplements will undergo pre-market safety and efficacy evaluation by the FDA. 2002; amended 2007; reaffirmed as amended 2011; 2012

H306-A/14 DIRECT-TO-CONSUMER MARKETING OF HEALTH SCREENING AND TESTING

The American Osteopathic Association is against unnecessary exams marketed directly to consumers and encourages its members to educate their patients and follow the US Preventive Services Task Force Guidelines. 2009; reaffirmed 2014

H216-A/15 DIRECTORS OF MEDICAL EDUCATION OVERSEEING OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS

The American Osteopathic Association will continue the present requirement that the Director of Medical Education overseeing osteopathic postdoctoral training programs must be an osteopathic physician. 2010, reaffirmed 2015

H213-A/12 DISABILITY DETERMINATIONS

The American Osteopathic Association supports education, training, and involvement of osteopathic physicians and medical students in the discipline of disability determinations. 2002; reaffirmed 2007; amended and reaffirmed 2012

H420-A/13 DISASTER PREPAREDNESS PLANNING

The American Osteopathic Association supports the Centers for Disease Control and Prevention's (CDC) Centers for Public Health Preparedness programs established to strengthen terrorism and emergency preparedness by linking academic expertise to state and local health agency needs, including programs that focus on vulnerable populations such as pregnant women, new mothers, newborns and infants. 2008; reaffirmed as amended 2013

H430-A/11 DISASTER RELIEF VOLUNTEERS

As part of volunteer service, the American Osteopathic Association recommends: (1) that all osteopathic physicians seek out 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 volunteer to provide medical care during disasters before the next disaster

strikes; (3) encourages all DOs to consider joining the U.S. Surgeon General's Medical Reserve Corps or registering with their state or local Emergency System for Advanced Registration of Volunteer Health Profession Program (ESAR-VHP); (4) encourages osteopathic physicians who wish to volunteer to provide domestic or international emergency medical assistance to contact the humanitarian organizations, for example Heart to Heart and DO CARE International; and (5) encourages the federal government to work with 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. 2006; reaffirmed as amended 2011

H208-A/11 DISASTER RESPONSE COURSES AND TRAINING WITHIN COLLEGES OF OSTEOPATHIC MEDICINE

The American Osteopathic Association supports disaster response didactic courses and training within the curriculum for the colleges of osteopathic medicine. 2011

H306-A/13 DISCRIMINATION AGAINST OSTEOPATHIC PHYSICIANS

The American Osteopathic Association will continue to ensure that legislation and regulatory policy specifies that any reference at the national level in an executive order, an administrative regulation, or in the federal revised statutes to "medical doctor", "MD", "physician", "allopathic physician", an allopathic medical specialty board, or reference to any medical student, or postgraduate, shall include and pertain to a "doctor of osteopathic medicine", "DO", AOA specialty board, and osteopathic medical students and postgraduates. 2013

H639-A/15 DISCRIMINATION BY INSURERS

The American Osteopathic Association will actively pursue all reasonable avenues in support of its members who are discriminated against by insurance companies and excluded from participating in insurance programs; and in those instances where there is no due process to discuss and mediate the exclusions, the AOA will petition organizations to present their credentialing criteria and deselection criteria, and will use those resources at its disposal to help obtain a fair and equitable solution to the problem and to include due process in all cases. 1995; revised 2000, 2005; revised 2010; reaffirmed 2015

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

H612-A/12 DISCRIMINATION -- THE PRACTICE OF OSTEOPATHIC MEDICINE

The American Osteopathic Association: (1) supports the inclusion of osteopathic physicians in all healthcare delivery systems; (2) 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 recognized and prescribed by the AOA; and (3) opposes discrimination against osteopathic physicians. 1987; revised 1992, 1997, 2002; revised 2007; reaffirmed as amended 2012

H630-A/12 DISPENSING OF MEDICATION BY PHYSICIANS

The American Osteopathic Association opposes any attempt by Congress, the federal government or state governments to restrict, prohibit or otherwise impede the prerogative of physicians to prescribe and dispense appropriate medications to their patients. 1987; reaffirmed 1992; revised 1997; reaffirmed 2002; amended 2007; [Editor's note: This policy has been referred to develop a policy that is more reflective of the government's role in protecting public safety – 2012]

H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH

The American Osteopathic Association will widely disseminate publications, research, and evidence based medicine regarding Osteopathic Medicine and Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological basis to the greater public via prominent, designated public information sites, social networking, public information releases, websites, and other media. 2015

H421-A/13 DISTRACTED DRIVER AWARENESS

The American Osteopathic Association will continue to support legislation regarding the banning of activities causing distraction while driving. 2008; reaffirmed 2013

H410-A/13 DISTRIBUTION OF STERILE SYRINGES AND NEEDLES TO IV DRUG ABUSERS -- APPROVAL OF

The American Osteopathic Association supports the controlled distribution of sterile syringes and needles to IV drug abusers to help abate the spread of bloodborne pathogens and to provide an. Opportunity for intervention. 1998; revised 2003; 2008; reaffirmed as amended 2013

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

H440-A/11 DOCARE INTERNATIONAL, RECOGNITION OF 50TH ANNIVERSARY

The American Osteopathic Association recognizes and salutes DOCARE on its 50th anniversary and recognizes the great humanitarian contribution DOCARE and its members make while bringing osteopathic medicine to the less fortunate around the globe. 2011

H208-A/13 DO DEGREE DESIGNATION

The American Osteopathic Association 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. 2008; reaffirmed as amended 2013

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

H413-A/12 DO NOT RESUSCITATE (DNR) ORDERS ON ELDER ADULTS IN LONG TERM OR EXTENDED-CARE FACILITIES

The American Osteopathic Association (1) will work in conjunction with the component state societies and elder care advocacy organizations to encourage legislation which upholds a patient's right to a "Do Not Attempt Resuscitation" (DNAR) and/or Allow Natural Death (AND), designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or durable power of health care attorney (DPOA); (2) supports policies or legislative initiatives to make hospice and palliative care available to allow the patient the dignity of comfort measures when resuscitation is futile; and (3) will work with other key stakeholders to educate physicians in their understanding of the intent of this legislation and to enhance their ability to conduct discussion of this issue with families and facilities where these patients may be treated. 2012

H438-A/12 DRINKING/DRIVING

The American Osteopathic Association pledges its support to law enforcement agencies in their efforts to enforce drinking/driving statutes; encourages agencies in government and in the private sector to promote greater public awareness of the problem; and encourages its members, through discussions with their patients and their communities, to actively assist in the effort by making the problem and its prevention more visible to the public. 1974; revised 1978; reaffirmed 1983; revised 1986, 1991, 1992, 1997; revised 2002; reaffirmed 2007; 2012

H403-A/11 DRIVER INTOXICATION/ IMPAIRED
The American Osteopathic Association: (1) opposes the practice of driving while intoxicated, under the influence or impaired; (2) supports efforts and encourages its membership to educate their patients and the public about the dangers of driving while intoxicated, under the influence or impaired; and (3) will promote and support state society initiatives to lobby their respective legislators for implementation of devices that restrict the use of motor vehicles by intoxicated or impaired persons. 1994; revised 1996, 2001; revised 2006; reaffirmed as amended 2011

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

H627-A/11 DRUG PLAN COVERAGE DENIALS
The American Osteopathic Association will advocate to the appropriate regulatory agencies and other health professional organizations to require drug benefit managers to fully explain any denial of medication coverage, with explanations that must include but not be limited to the following: (1) The medical reason for denial of a prescribed medication; (2) The criteria upon which a reversal of the denial will be considered; (3) A listing within the notification of denial of the approved alternatives to the prescribed medication; and (4) Listing of appeals process for denials. 2006; reaffirmed as amended 2011

H636-A/11 DRUG SAMPLES
The American Osteopathic Association (1) encourages the pharmaceutical industry to continue the distribution of drug samples, and/or vouchers to physicians, including those drugs whose patents have expired, (2) will petition the Food and Drug Administration to not limit the manufacturers' distribution of drug samples and/or vouchers; and (3) will continue to defend and support policies that allow osteopathic physicians to provide drug samples (including stock bottles or vouchers when appropriate) free-of-charge to patients. 1995; reaffirmed 1996; revised 2001; reaffirmed 2006; reaffirmed 2011

H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES
The American Osteopathic Association supports drug therapy surveyor guidelines regarding inappropriate drug use in nursing facilities be developed in collaboration with professional organizations possessing clinical expertise in geriatrics and long-term care medicine. 1999; revised and reaffirmed 2004; reaffirmed 2009; reaffirmed as amended 2014

H430-A/15 DRUGS--CURBING COUNTERFEIT
The American Osteopathic Association supports the Food and Drug Administration's (FDA) efforts to educate osteopathic physicians on how to identify counterfeit drugs. 2005; revised 2010; reaffirmed 2015

H303-A/12 DRUGS -- NON-GENERIC
The American Osteopathic Association urges the development and passage of legislation that would mandate that prescription drug plans provide for name-brand medications when evidence-based treatment protocols recommend their use. 2002, revised 2007; reaffirmed 2012

H314-A/12 DRUGS -- PRESCRIPTION DISCOUNTS—SENIORS
The American Osteopathic Association encourages pharmaceutical companies to continue to provide prescription medicines at reduced or no cost to low-income, uninsured, and under-insured patients through their patient assistance programs. 2002, revised 2007; reaffirmed as amended 2012

H613-A/12 DRUGS -- PRESCRIPTION—USE AMONG THE ELDERLY
The American Osteopathic Association supports having only osteopathic and allopathic physicians prescribe or supervise prescriptions written by non-physician clinicians as another important step in significantly reducing the problems of over-medication, under-medication and / or harmful drug interactions and will work with osteopathic and allopathic physicians, the US Congress, the US Department of Health and Human Services, and other interested parties to assure the appropriate use of therapeutic agents among the elderly. 2002, revised 2007; reaffirmed 2012

H424-A/11 DRUG WITHDRAWAL / RECALL -- PHYSICIAN NOTIFICATION OF PENDING
The American Osteopathic Association will work with the appropriate regulatory agencies and Congress to develop regulations that will permit and encourage companies to communicate to physicians as rapidly as possible pertinent clinical information regarding product(s) withdrawn / recalled from the market. 2006; reaffirmed 2011

H201-A/13 DUAL DEGREES
It is contrary to American Osteopathic Association (AOA) policy for a DO to use another degree to represent themselves as a physician when that degree is unearned or not granted from a college or university that is accredited by either the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education. The AOA will remain vigilant for any false or erroneous information that may undermine the integrity of the profession or osteopathic medicine in the US and will work with the Federation of State Medical Boards (FSMB) and its constituent boards to inform them of attempts to misrepresent the practice of osteopathic medicine in the US or to misrepresent the education leading to the degree Doctor of Osteopathy or Doctor of Osteopathic Medicine. 1969; reaffirmed 1978; revised 1983, 1988; reaffirmed 1993; revised 1998; revised 2003; revised 2008; reaffirmed 2013

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

H321-A/12 DUE PROCESS IN AGENCY DETERMINATIONS
The American Osteopathic Association 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, formal hearing. 1982; revised 1987; reaffirmed 1992, 1997, 2002; 2007; reaffirmed as amended 2012

H304-A/13 DURABLE MEDICAL EQUIPMENT CLAIMS PROCESSING
The American Osteopathic Association remains committed to providing cost effective healthcare and supports a reexamination of federal policy regarding the timely processing of claims for durable medical equipment. 1993; revised 1998, 2003; reaffirmed 2008; reaffirmed as amended 2013

H435-A/14 E-CIGARETTES AND NICOTINE VAPING – REGULATION OF
The American Osteopathic adopts the 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.[1] Accordingly, the use of electronic cigarettes (e-cigarettes) has reached a rapidly expanding consumer base.[2] E-cigarettes are often used or promoted to reduce consumption of tobacco products.[3] 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.[4]

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

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[1]. Jordan Paradise, No Sisyphean Task: How the FDA Can Regulate Electronic Cigarettes, 13 Yale J. Health Pol'y L. & Ethics 326, 329 (2013).
[2] Id. at 330.
[3] Jordan Paradise at 329.
[4] Id.

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.[5] Sales are expected to reach $1.7 billion by the end of 2013, according to the Attorneys General Association.[6] 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.[7] 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.[8] 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.[9] 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.10 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.[11] 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.[12] 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.[13]

The Composition of E-Cigarettes

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[5] 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

[6] Id.

[7] Id. at 331.

[8] 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).

[9] Jordan Paradise at 333.

[10] 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

[11] *Available* at http://publichealthlawcenter.org/sites/default/files/resources/tclc-fs-ftc&tobacco-2012.pdf

[12] 15 U.S.C. § 1335.

[13] 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

The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation.[14] The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients.[15] It is primarily composed of a nicotine cartridge, atomizer, and a battery.[16] The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element.[17] 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.[18] A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[19]

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.[20] 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.[21] The FDA jurisdictional authority covers various products including food, cosmetics, animal and human drugs, medical devices and radiological products.[22] 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. [23] The court held that the FDA lacked authority under the drug/device provisions to regulate tobacco products customarily marketed without claims of therapeutic effect.[24]

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.[25] 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.[26]

State Efforts to Regulate

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[14] Jordan Paradise at 353.
[15] Id. at 353.
[16] Tobacco fact sheet: Electronic Cigarettes (E-Cigarettes), Legacy for Longer Healthier Lives, *available* at http://www.legacyforhealth.org.
[17] Jordan Paradise at 354.
[18] Id.
[19] *Available* at http://www.smokingeverywhere.com/cartridge.php.
[20] Jordan Paradise at 354.
[21] Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).
[22] Food, Drug, and Cosmetic Act (FDCA), Pub. L. No. 75-717, 52 Stat. 1040 (1938).
[23] Troutman Sanders, Federal, State, and Local Lawmakers Take Aim at E-Cigarettes, *available* at www.Tobaccoretailer.com
[24] Sottera, Inc. v. FDA, 627 F.3d 891 (D.C. Cir. 2010).
[25] Jordan Paradise at 329.
[26] Id. at 331.

Attorneys General from 40 states have urged the FDA to regulate e-cigarettes.[27] 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.[28]

Various jurisdictions, both states and municipalities, have enacted laws requiring licenses to sell e-cigarettes and banning sales to minors.[29] 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.[30; 31] Currently, there are 100 local laws restricting e-cigarette use in 100% smoke-free venues.[32] However, there are only 3 state laws restricting e-cigarette use in 100% smoke-free venues and only 9 in other venues.[33]

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.[34; 35] **Minnesota** enacted laws regulating the sale of e-cigarettes and impose criminal penalties for the sale of e-cigarettes to minors.[36] **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.[37] New Hampshire also prohibits the use of such products on the grounds of any public educational facility.[38] 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. [39] 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.[40]

Arguments for E-Cigarettes

Smoking accounts for nearly 5.4 million cancer-related deaths worldwide each year.[41] This includes 443,000 deaths in the United States.[42] Proponents argue that e-cigarettes do not

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[27] Dan Radel *supra.*
[28] Id., The National Association of Attorneys General letter to the FDA.
[29] Jordan Paradise at 374.
[30] 21 U.S.C. § 387g(a)(1)(A).
[31]Jordan Paradise at 373.
[32] American Nonsmokers' Foundation., U.S. State and Local Laws Regulating Use of Electronic Cigarettes. www.no-smoke.org.
[33] Id.
[34] N.J. Stat. Ann. SEC 26:3D-58.
[35] Troutman Sandra *supra.*
[36] Id.
[37] Id.
[38] Id.
[39] Id.
[40] Jordan Paradise at 335.
[41] Tobacco free initiative: tobacco facts, WHO *available* at http://www.www.who.int/tobacco/mpower/tobacco_facts/en/index.html
[42] CDC, Current Cigarette Smoking Among Adults – United States, 2011, 309 JAMA 539, 539-40 (2013).

expose the user, or others close by, to harmful levels of cancer-causing agents and other dangerous chemicals normally associated with traditional tobacco products.[43]

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.[44] 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.[45] According to the American Lung Association there are approximately 600 ingredients in cigarettes.[46] When burned, they create more than 4,000 chemicals.[47] At least 50 of these chemicals are known to cause cancer, and many are poisonous.[48] While e-cigarettes may have less component chemicals, a study found that the usage of e-cigarettes contributes to indoor air pollution.49 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.[50] 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.[51] 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.[52] None said they used them to reduce consumption of tobacco with no intent to quit smoking.[53] 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.[54]

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

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[43] 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.**

[44] Troutman Sanders *supra.*

[45] Dan Radel, *supra* quoting Robert Lahita, Chair of Medicine at New Beth Israel Medical Center.

[46] Dan Radel, *supra* quoting Thomas Kiklas, Co-Founder of The E-Cigarette Association

[47] Id.

[48] Id.

[49] Schober et al, Use of Electronic Cigarettes (E-Cigarettes) Impairs Indoor Air Quality and Increases FeNO Levels of E-Cigarette Consumers, International Journal of Hygiene Environment and Health.

[50] Michael B. Siegal et. al., Electronic Cigarettes as a Smoking-Cessation Tool: Results from an online Study, 40 Am. J. Preventive Med. 472, 474 (2011).

[51] Jonathan Foulds et. al., Electronic Cigarettes (E-Cigs): Views of aficionados and Clinical/public health perspectives, 65 Int'l J. Clinical prac. 1037 (2011)

[52] Id.

[53] Id.

[54] 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

complete smoking cessation.[55] A major concern is that it appeals to youth by being flavorful, trendy and a convenient accessory.[56] 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.[57]

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%.[58] 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.[59] These numbers could also be largely underestimating the percentage of children using e-cigarettes, as many call the devices by other names.60 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.61

Aside from the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine.[62] Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[63] Nicotine addiction is a combination of positive reinforcements, including enhancement of mood and avoidance of withdrawal symptoms.[64] 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.[65]

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.[66] 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.[67]

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[55] Jordan Paradise at 329.
[56] Id.
[57] Bridget M. Kuehn, *supra.*
[58] Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).
[59] Id.
[60] Matt Richtel, E-Cigarettes, By Other Names, Lure Young and Worry Experts, New York Times, March 4, 2014, *available at* http://www.nytimes.com/2014/03/05/business/e-cigarettes-under-aliases-elude-the-authorities.html?nl=todaysheadlines&emc=edit_th_20140305&_r=0
[61] Id.
[62] Neal L. Benowitz, Nicotine Addiction, 362 New. Eng. J. Med. 2295 (2010).
[63] Am. Psychological Ass'n, Disgnostic and Statistical Manual of Mental Disorders: DSM-IV-TR (4th ed. Text rev. 2000).
[64] Neal L. Benowitz, *supra.*
[65] Jordan Paradise at 335.
[66] Neal L. Benowitz, *supra.*
[67] Jordan Paradise at 359.

E-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions.[68] 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.[69]

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.

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[68] Id. at 335.

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

H354-A/13 ELECTRONIC HEALTH RECORDS--INCREASING DRUG INTERACTION SEVERITY WARNINGS IN

The American Osteopathic Association will work to establish a method to further evaluate increasing drug interaction severity warnings in electronic health records and will collaborate with e-prescribing companies to correct inappropriate severity warnings. 2013

H622-A/15 ELECTRONIC HEALTH RECORDS--PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO

The American Osteopathic Association will continue to work with state osteopathic associations to assist solo practice physicians and small-group practices in the adoption of health information technology. 2005; revised 2010; reaffirmed as amended 2015

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

The American Osteopathic Association will request that vendors of electronic health records notify physician clients of reported software errors and provide software updates, in a systematic and timely fashion as is standard in other industries that correct these errors to enhance patient safety. 2014

H631-A/11 ELECTRONIC MEDICAL / HEALTH RECORD EXEMPTION WITHOUT PENALTY

The American Osteopathic Association supports an exemption to financial penalties to solo and small group practices that do not implement electronic medical records. 2011

H345-A/14 ELECTRONIC MEDICAL RECORD (EMR)--STUDENT ACCESS AND USE

The American Osteopathic Association will work with the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Association of Medical Informatics to promote the opportunity for medical students to document and practice order entry in EMRs at facilities where osteopathic medical students are trained. 2014

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

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

H332-A/15 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

The American Osteopathic Association will continue to encourage the US Drug Enforcement Administration to modify rules to reduce any potential administrative barriers to electronic prescribing of controlled substances. Electronic prescribing systems should be interoperable with data collection and tracking systems for the prescribing of controlled substances. 2010; reaffirmed as amended 2015

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.

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.
- **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

H420-A/12 EMERGENCY MEDICAL IDENTIFICATION -- PROTOCOL AND GUIDELINES

The American Osteopathic Association supports the concept of medical identification systems, and urges that osteopathic physicians encourage patients to participate in an emergency medical identification program. 1981; reaffirmed 1985; revised 1991, 1992; reaffirmed 1997; revised 2002; reaffirmed 2007; 2012

H323-A/15 EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

The American Osteopathic Association (AOA) supports the availability of 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. 2005, reaffirmed 2010; revised

H601-A/11 EMERGENCY DEPARTMENT PAYMENT FOR EMERGENCY ON-CALL PHYSICIANS

Due to the unintended consequences that have resulted from the Emergency Treatment and Labor Act (EMTALA), the American Osteopathic Association urges legislators to amend EMTALA legislation to mandate that third party payors reimburse the on call physician for providing care to patients with emergent needs, even if out-of-network, or service area. 2001; reaffirmed 2006; reaffirmed as amended 2011

H602-A/11 EMERGING STATES

The American Osteopathic Association, through its committee and bureau structure will continue to support emerging states (defined as having 300 or fewer AOA physician members) to further strengthen the profession nationwide. 1976; reaffirmed 1981; revised 1986, 1991, 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011

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

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

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. 2004; reaffirmed 2009; 2014

H300-A/11 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

The American Osteopathic Association supports efforts to amend the Employee Retirement Income Security Act (ERISA) to allow states to take necessary steps or actions to require that these plans participate in healthcare reform initiatives and supports legislation to amend the ERISA law to eliminate the ERISA exemption status. 1996; revised 2001; reaffirmed 2006; reaffirmed 2011

H606-A/15 EMPLOYEES IN A HOSPITAL SETTING -- PROPER BADGE IDENTIFICATION OF

The American Osteopathic Association encourages all healthcare providers and hospital employees to wear hospital-issued identification badges with clear delineation of their professional role and that they verbally introduce and identify themselves and their role in the patient's treatment process, with the overall goal of improving patient safety and patient communication. 2015

H218-A/12 END-OF-LIFE CARE FOR CHILDREN

The American Osteopathic Association support the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end-of-life issues relating to children and their families; and the AOA will also be available as a resource to other organizations. 2002; revised and reaffirmed 2007; reaffirmed as amended 2012

H431-A/12 END OF LIFE CARE – CULTURAL SENSITIVITY

The American Osteopathic Association urges that osteopathic physicians 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; 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. 2007; reaffirmed 2012

H411-A/12 END-OF-LIFE CARE FOR THE DEVELOPMENTALLY DISABLED

The American Osteopathic Association will work with component state societies and advocacy groups for the developmentally disabled to develop and implement policies to ensure dignity at the time of death for all individuals, including the developmentally challenged; and will support development and implementation of policies designed to permit the provision of hospice and palliative services to the developmentally disabled. 2012

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] 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] 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]

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] 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]

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, "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], 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 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.

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. 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) 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]

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 Noatske v. Oserhoh, 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]

Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency for Healthcare Research and Quality, the American Pain Society, the Healthcare Facilities Accreditation Program as well as the Joint Commission on Accreditation of Healthcare Organizations 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. [10]

Furthermore, under California's elder abuse statute, a physician was successfully sued by the deceased's family for inadequate pain management at the end of life. [21]

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.[14] 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.[17] 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, 16] 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] 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[5] and potentially precipitate hyperalgesia[18] 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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H431-A/15 END OF LIFE CARE--POLICY STATEMENT ON

The American Osteopathic Association approves the attached white paper on end of life care and (1) 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; (2) encourages all osteopathic physicians to stay current with their individual state statutes on end of life care; and (3) encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions. 2005; revised 2010; reaffirmed as amended 2015

AMERICAN OSTEOPATHIC ASSOCIATION
END OF LIFE CARE

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 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 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.

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 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 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. DO's 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.

Current AOA resolutions related to the Policy on End of Life Care:
H264-A/07 PHYSICIAN ASSISTED SUICIDE--AOA POSITION
H202-A/07 ADVANCE DIRECTIVES
H228-A/08 HOSPICE AND PALLIATIVE CARE, SUPPORT FOR

H428-A/13 ENERGY DRINKS
The American Osteopathic Association supports community awareness and education regarding the effects and potential dangers of consuming energy drinks, and encourages physicians to screen for the use of energy drinks. 2013

H402-A/13 ENVIRONMENTAL HEALTH
The American Osteopathic Association 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. 1970; revised 1978; reaffirmed 1983; revised 1988; reaffirmed 1993; revised 1998, 2003; reaffirmed 2008; reaffirmed 2013

H420-A/15 ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS
The American Osteopathic Association supports the recycling of all recyclables. 1995; revised 2000, revised 2005; revised 2010; reaffirmed 2015

H421-A/12 ENVIRONMENTAL TOXINS AND OUR CHILDREN'S HEALTH

The American Osteopathic Association supports public policy efforts on a national, state and local level, to assure adequate funding and research priority for evidenced based assessment of potential environmental toxins and encourages governmental agencies to adopt a proactive approach to implementing the results of such research in the interest of public health of current and future generations of Americans. 2002; reaffirmed 2007, 2012

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

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

H215-A/15 EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION

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

The AOA opposes any efforts to OCC as a condition for medical licensure, insurance reimbursement or network participation, malpractice insurance coverage or as a requirement for physician employment.

The AOA through the Bureau of Osteopathic Specialists (BOS) will review the OCC process so as to make it more manageable and economically feasible. 2010; revised 2015

H322-A/12 ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE

The American Osteopathic Association encourages Congress and the Department of Health and Human Services to consult with the osteopathic and allopathic medical professions to determine the necessary, proper and acceptable role of government in ethical and sociological matters regarding medical care. 1985; reaffirmed 1990, 1995, 1997; revised 2002; reaffirmed 2007; 2012

H313-A/13 EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

The American Osteopathic Association:

1. Advocates the use of an independent profession/specialty matched medical peer review process for physicians identified as outliers.

2. Opposes the continuation of random pre-payment audits of claims.

3. Advocates that any auditing of outpatient medical records be conducted on a retrospective post-payment basis and is statistically sound using determinations in effect at the time of claim.

4. Opposes the practice that requires physicians to repay alleged over-payments before all appeal remedies have been exhausted.

5. Advocates immunity from Medicare sanctions for physicians voluntarily participating in the pilot testing of Evaluation and Management guidelines.

6. Advocates that Centers for Medicare and Medicaid Services (CMS) develop educational programs that help physicians identify mistakes or misunderstandings with their coding so as to avoid civil penalties. 2003; revised 2008; reaffirmed as amended 2013

H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES

The American Osteopathic Association deems it an unethical act for any osteopathic physician to deliver or be required to deliver a lethal injection for the purpose of execution in capital crimes. 1995; revised 2000, reaffirmed 2005; 2010; (referred 2015)

H345-A/13 EXPERT WITNESS & PEER REVIEW

The Expert Witness and Peer Review policy of the American Osteopathic Association states (2008; reaffirmed as amended 2013):

Background

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, allopathic physicians 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.

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.[5] In 2004, the American Academy of Orthopedic Surgeons (AAOS) created an expert witness program that involves education and advocacy components.[6]. 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.[7]

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).[12] The ACOOG and ACOG have developed "affirmation" and "qualifications" documents that spell out to members the responsibilities and obligations of expert witnesses.[13] Finally, both the American College of Emergency Physicians 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 a expert witness in a medical liability case.[15]

Licensed in the State

Twenty-two 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.

Active Practice or Teaching

Twenty-two 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 number of years. Arizona, Kansas, Michigan, New Jersey, North Carolina, Ohio and West Virginia require medical experts to have devoted at least half of the 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. Alabama, Alaska, California, Connecticut, Florida, Louisiana, Michigan, Mississippi, Montana, Nevada, North Carolina, Ohio, Texas 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, require the expert to be board certified in the same or similar field as well. South Carolina permits 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 practice implicated by the alleged malpractice. **Rhode Island** only requires "training and education" to qualify as expert witnesses. **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.[11] 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.[12] 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.[13] 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.[14] 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.[15]

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. [16] 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.[17] 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.

Conclusion

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;[30]

The AOA affirms its commitment to promote and facilitate peer review among and through its members;

The AOA supports a policy that peer review of osteopathic physicians should be conducted by other osteopathic physicians, whenever possible, to account for osteopathic physicians' unique training in Osteopathic Principles and Practices and OMT;

The AOA believes that when the standard of care involves a procedure unique to the osteopathic practice of medicine, such as OMT, then only osteopathic physicians should conduct peer review of DOs;

The AOA pledges to pursue any and all legal and legislative recourses to assure that insurance claims reviewed by peers regarding the provision of OMT procedures may only be conducted by qualified osteopathic physicians;

The AOA believes that the voluntary hospital peer review process remains the most natural and appropriate vehicle through which to effect institutional peer review;

The AOA believes that all peer review should remain confidential and undiscoverable except to the physician who is the subject of the peer review;

The AOA believes that all review under the peer review organization program of osteopathic diagnosis and therapeutics be performed by osteopathic physicians.

The AOA believes that an osteopathic physician's failure to provide truthful testimony or peer review constitutes unprofessional conduct subject to peer review consistent with the AOA's policy that expert testimony and peer review by osteopathic physicians constitute the practice of medicine;

The AOA encourages state divisional societies to develop and implement appropriate procedures and measures to monitor and discipline member expert witnesses who provide fraudulent and misleading testimony;

The AOA pledges to support any osteopathic society that wishes to develop its own program to discipline physicians for unprofessional conduct related to expert witness testimony;

The AOA pledges to act as a clearinghouse for advice on the issue of expert witness testimony;

The AOA supports updating state licensing laws to include "providing false or misleading information in the role of expert witness" in the definition of unprofessional conduct;

The AOA's believes that an expert witness should not provide medical testimony that is false, misleading, or without medical foundation;

The AOA's believes that an expert witness should have a current, unrestricted license to practice in the same state as the defendant physician. Preferably, the expert witness should be board certified in the same medical specialty as the defendant and the certifying board should be one that is recognized by the state;

The AOA's believes that an expert witness should be three (3) years removed from residency training, and should be engaged in active medical practice or have teaching experience, or any combination thereof in the same specialty or subspecialty, for a period of no less than three (3) years prior to the date of the testimony. In cases where the physician serving as an expert witness has completed a forensic science, pediatric child abuse, or other approved forensic fellowship and where the expert testimony specifically relates to that training, the requirement of being three (3) years removed from residency training is waived;

The AOA encourages state licensing boards to grant temporary licensure to out-of-state expert witnesses upon a showing of the inability to find an in-state expert witness to make them subject to disciplinary sanctions of the state licensing boards;

The AOA opposes allowing expert witnesses to accept compensation that is contingent on the outcome of the case;

The AOA believes that an expert witness' compensation must be proportionate to the time, level of expertise, and effort given for preparing and attending court appearances; and

The AOA supports a policy that imposes mandatory disclosure to the court and opposing parties of the qualifications of the expert witness, access to copies of all publications authored by the witness in the preceding ten (10) years, and access to transcripts from all cases in which the witness has testified as an expert witness in the preceding four (4) years.

[1] 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.
[2] Editorial Opinion, *Ensuring Accuracy in Medical Testimony, Calling Experts to Account,* American Medical News, September 16, 2002.
[3] Louise B. Andrew, MD, JD, *The Ethical Medical Expert Witness*, Journal of Medical Licensure and Discipline, Vol. 89, No. 3, p. 125 (2003).
[4] Tanya, Albert, *California Court Throws Out "Speculative" Expert Testimony,* American Medical News, August 4, 2003.
[5] AANS, *Professional Conduct – Witness Testimony, (2006), Available At* Http://www.aans.org/aans%20and%20jnspg%20publications/Anns%Neurosurgeon/Aans%20neurosurgeon%20issues/2006/Summer%202006%20-%20issue%202/Professional%20conduct%20-%20witness%20testimony.Aspx?Sc_Database=Web.
[6] AAOS Expert Witness Program, *Available At:* Http://Www3.Aaos.Org/Member/Expwit/Expertwitness.Cfm
[7] ASA, Expert Witness Testimony Review Program, Http://Www.Asahq.Org/For-Members/Office-Of-General-Counsel/Expert-Witness-Testimony-Review-Program.
[8] Mary Ellen Schneider, *Expert Medical Witnesses: medical community targets false testimony. (Practice Trends), OB GYN News, April 15, 2004*.
[9] See, AOA Division Of State Government Affairs, *Expert Witness Chart* (2013).
[10] In Re Lustgarten, 177 N.C.App. 633 (2006)
[11] 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).
[12] Daniel Solomon, *Medical Expert Testimony in Administrative Hearings*, 17 J. NAALJ 285 (1997)
[13] McCormack, *supra* note 23 at 147
[14] *Id.*
[15] *Id* at 187.
[16] 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.
[17] 27 NCAC2.3, rule 3.4, comment 3.

H304–A/12 FAMILY AND MEDICAL LEAVE ACT (FMLA) DOCUMENTATION

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. 2002; revised 2007; reaffirmed 2012

H638-A/11 FAMILY AND MEDICAL LEAVE ACT FORMS -- STANDARDIZATION AND IMPROVING

The American Osteopathic Association will work in collaboration with patient advocacy and other similar groups to assure uniform Family Medical Leave Act (FMLA) and employer documentation requirements which are less burdensome and less time consuming. 2011

H448-A/15 FAMILY CAREGIVERS--SUPPORT FOR

The American Osteopathic Association, recognizing a growing number of family caregivers have unaddressed needs related to personal health and wellbeing, supports caregivers by participating in the developing public debate regarding health care policy to include family caregivers and encourages its members to gain education in caregiver illnesses, resources in their area and treat and/ refer when appropriate. 2010; reaffirmed 2015

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

The American Osteopathic Association supports legislation amending the Family Medical Leave Act (FMLA) Basic Leave Entitlement 'To care for the employee's spouse, son or daughter, or parent, who has a serious health condition' to include responsible designee; and requests the Department of Labor to include these changes at the federal level. 2009; reaffirmed 2014

H619-A/11 FEDERAL GOVERNMENT HEALTH INFORMATION TECHNOLOGY (HIT) INITIATIVE--SUPPORT OF

The American Osteopathic Association will continue to support the goal of a national information infrastructure in order to improve patient care in the United States; urges all osteopathic physicians to integrate health information technology (HIT) into their practices in a meaningful way; and will provide education to its members to assist them in doing their part to effect the transformation of their practices. 2011

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

H408-A/13 FIRE PREVENTION--TEACHING OF

The American Osteopathic Association supports fire prevention education. 1988; revised 1993, 1998, 2003; 2008; reaffirmed 2013

H406-A/14 FIREARM SAFETY

The American Osteopathic Association supports and encourages strategies such as secure storage and the use of safety locks for eliminating the inappropriate access to firearms by children and adolescents and supports and encourages all physicians to educate families in the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014

H603-A/11 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

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, CO_2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]

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

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.

H409-A/11 FITNESS, SPORTS AND NUTRITION

The American Osteopathic Association supports the President's Council on Fitness, Sports and Nutrition. 1991; revised 1996; 2001; reaffirmed 2006; reaffirmed as amended 2011

H315-A/12 FLAME-RETARDANT CLOTHING FOR CHILDREN--SLEEPING OR LOUNGING

The American Osteopathic Association supports legislation to cause manufacturers to produce only flame retardant sleep and lounge clothing for infants and children. 2002; revised 2007; reaffirmed 2012

H305-A/14 FLU PANDEMIC--OSTEOPATHIC TREATMENT OF

The American Osteopathic Association supports the active utilization of osteopathic manipulative treatment, along with other recognized and approved medical interventions, in the treatment of flu pandemics and other infectious outbreaks; and will conduct programs to disseminate appropriately training in osteopathic manipulative treatment. 2009; reaffirmed as amended 2014

H414-A/14 FLUORIDATION

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

H409-A/12 FOOD ALLERGIES AND MANDATES ON SCHOOL LUNCHES
The American Osteopathic Association advocates a holistic approach with respect to childhood nutrition and wellness without mandates that force potentially food allergic children to purchase school lunches. 2012

H632-A/11 FORMULARIES--AVAILABILITY IN ELECTRONIC HEALTH RECORDS
The American Osteopathic Association will work with the Centers for Medicare and Medicaid Services, Congress and other appropriate agencies and organizations to implement a requirement that current patient-specific formularies be available in a format which integrates with all certified electronic health records products. 2011

H626-A/11 FORMULARIES – NOTIFICATION TO PHYSICIANS
The American Osteopathic Association will advocate for legislation requiring all entities maintaining formularies to provide regularly updated plan-specific formulary information to physicians in a timely manner; and urge that this legislation require entities to provide patients with a suitable identification that would provide access to all information needed to identify the specific formulary the patient is required to utilize. 2006; reaffirmed as amended 2011

H614-A/12 FORMULARY CHANGES
The American Osteopathic Association will act to educate healthcare insurers and managed care companies on the potential dangers of formulary substitutions. 2002; 2007; reaffirmed 2012

H401-A/13 GAMBLING DISORDER
The American Osteopathic Association supports research on gambling disorder. 1998; revised 2003; reaffirmed 2008; reaffirmed as amended 2013

H214-A/12 GENDER DISCRIMINATION
The American Osteopathic Association requires all of its recognized training institutions, both osteopathic and allopathic, to provide equally for their male and female physicians and students. 1992; revised 1997, 2002; 2007; reaffirmed 2012

H445-A/15 GENDER IDENTITY NON-DISCRIMINATION
The American Osteopathic Association supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity. 2010; reaffirmed 2015

H305-A/12 GENERIC DRUGS

The American Osteopathic Association (AOA): (1) urges the FDA to strengthen its inspection and approval procedures and equivalency standards to ensure that generic drugs approved by the FDA are therapeutically equivalent to the brand drug for which they are to be substituted; (2) opposes mandatory generic substitution programs that remove control of the treatment program from the physician; and (3) until the FDA has effected such policies, standards and procedures, consistent with its distinguished and longstanding stewardship of drug safety and effectiveness, the AOA opposes the mandatory use of generic drugs. 1990; reaffirmed 1995, 1997; revised 2002; 2007; reaffirmed as amended 2012

H422-A/15 GENETIC MANIPULATION OF FOOD PRODUCTS-- CONSUMERS RIGHT TO KNOW

The American Osteopathic Association supports efforts that require clear identification of any genetically manipulated food products so that consumers may be properly informed as they make food choices. 2000, revised 2005, reaffirmed 2010; 2015

H437-A/12 GENETIC TESTING

The American Osteopathic Association supports the public interest in prohibiting discrimination in employment, insurance coverage, and access to care on the basis of genetic information. 1997; revised 2002; 2007; reaffirmed 2012

H205-A/13 GERIATRIC AND END-OF-LIFE HEALTHCARE

The American Osteopathic Association urges osteopathic medical schools, and appropriate training programs to support innovative approaches to instruction in geriatric medicine and end-of-life care. 1960; reaffirmed 1978, 1983; revised 1988, 1993, 1998, 2003; 2008; reaffirmed as amended 2013

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

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

H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY

The American Osteopathic Association 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 (1991, revised 1994, 1999, 2003; 2008; reaffirmed as amended 2015):

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.

H604-A/11 GOOD SAMARITAN ACTS (HOLD HARMLESS AGREEMENT) PERFORMED ON COMMERCIAL AIRCRAFT

The American Osteopathic Association strongly recommends that all counties and states recognize Good Samaritan (Hold Harmless) laws for medical care rendered on commercial aircraft and urges all airlines to provide liability coverage for such medical care; and will petition the Federal Aviation Administration and appropriate international aviation entities to adopt such standards for all commercial airlines. 2001; reaffirmed 2006; reaffirmed as amended 2011

H304-A/14 GOVERNMENT FUNDING HOSPITALS AND OTHER HEALTH CARE ENTITIES NOT ACCEPTING COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION (COCA) AND LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME) STUDENTS

The American Osteopathic Association will advocate to the United States Congress and individual state legislative bodies to prohibit discrimination and agreements by US hospitals and other health care entities that receive local, state or federal funding in which there is prohibited or limited training, inequitable access, or inequitable fiscal requirements for students of COCA and LCME accredited colleges of medicine. 2014

H310-A/13 GOVERNMENT FUNDING FOR NON-AOA OR NON-LCME MEDICAL SCHOOLS

The American Osteopathic Association will advocate (1) to US Congress and individual state legislative bodies to prohibit agreements between non-COCA (Commission on Osteopathic College Accreditation) and non-LCME (Liaison Committee on Medical Education) certified medical schools and US 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 US citizens and permanent residents; (2) that any US institution that receives local, state or federal funding for the training of medical students be proportional to the percentage of AOA and LCME medical school students that it trains; (3) that local, state and federal funding be prohibited from non-US citizens that attend non-COCA or non-LCME certified medical schools; and (4) that local, state and federal funding for US citizens and permanent residents that attend non-COCA or non-LCME certified medical schools be distributed proportionally to US citizens and permanent residents who attend COCA or LCME certified medical schools. 2013

H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE

The American Osteopathic Association strongly recommends that any intervention by third party payers (Medicare, Medicaid and other third-party insurers), shall not 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

H201-A/14 GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES

The American Osteopathic Association supports the efforts to increase the number of graduate medical education training positions available to United States medical graduates. 2014

H213-A/15 GRADUATE MEDICAL EDUCATION -- TRAINING OF US MEDICAL SCHOOL GRADUATES

The American Osteopathic Association 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. 2009; referred 2014; approved as amended 2015.

H-201-A/12 GRADUATE MEDICAL EDUCATION (GME) PROGRAMS CONTINUE TO SELECT RESIDENTS BASED ON MERIT, ENSURING THAT

The American Osteopathic Association will work with the American Medical Association, the American Association of Colleges of Osteopathic Medicine, the Association of American Medical Colleges and other US stakeholders to ensure that US-based graduate medical education programs maintain their ability to select residents based on merit. 2012

H-207-A/14 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

H319-A/14 HEALTH CARE COSTS 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

H307-A/12 HEALTH CARE DELIVERY SYSTEMS

The American Osteopathic Association will continue to have as a high priority the education of osteopathic physicians and the general public as to the importance of continued availability of osteopathic services in all health care delivery systems. 1987; reaffirmed 1992; revised 1997, 2002; 2007; reaffirmed 2012

H425-A/14 HEALTH CARE FRAUD
The American Osteopathic Association urges the Center for Medicare and Medicaid Services (CMS) to: (1) disclose to the public and the medical community the actual amount of "fraud" in dollars, based on the reasonable definition of "fraud" omitting all denied and resubmitted claims and all honest mistakes by physicians and the Medicare carriers; and (2) strongly opposes the use of law enforcement agencies and auditors to enter physicians' offices without prior request, warning or due process under the law for the purpose of confiscating records. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

H631-A/12 HEALTH CARE INSURANCE OPTIONS
The American Osteopathic Association supports legislation that requires employers who are obligated by law to provide insurance to offer more than one option for health insurance for their employees and that one of the options be a traditional indemnity insurance plan. 1986; revised 1991, 1992, 1997; revised 2002; 2007; reaffirmed as amended 2012

H315-A/13 HEALTH CARE PROVIDERS RIGHT OF CONSCIENCE
It is policy of the American Osteopathic Association that all osteopathic physicians are ethically bound to inform patients of available options with regard to treatment and if an osteopathic physician has an ethical, moral or religious belief that prevents him or her from providing a medically-approved service, they should recuse themselves from the case and refer the patient to another provider. 2003; 2008; reaffirmed 2013

H323-A/12 HEALTH CARE--REGULATION OF
The policy of the American Osteopathic Association with respect to regulation in health care is as follows:

1. The need for any new regulation must demonstrate that access to care, 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. 1981; revised 1986, 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed as amended 2012

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, so that residents can train and stay in these areas and practice osteopathic medicine. 2014

H314-A/13 HEALTH CARE THAT WORKS FOR ALL AMERICANS

The American Osteopathic Association has a priority goal to encourage the US Congress for passage of legislation to further the national health care debate; that this public debate address the major issues that threaten the ability of osteopathic physicians to provide quality, cost-efficient health care to their communities, including the availability of affordable health insurance for all citizens, inclusion of osteopathic physicians, training institutions, and osteopathic manipulative services on insurance company 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. 2003; 2008; reaffirmed/BOFHP 2013

H306-A/12 HEALTH CLINICS--FEDERALLY FUNDED

The American Osteopathic Association supports eliminating the requirement to have a nurse practitioner or physician assistant in federally funded health clinics; supports instead, adequate staffing for the physicians providing medical care in the clinics; and take steps necessary to eliminate the present requirement. 2002; 2007; reaffirmed 2012

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

The American Osteopathic Association (AOA) supports a new risk-based oversight framework for clinical software, developed through a multi-stakeholder consensus-based process. The framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility. Patient safety and appropriate improvements in quality, effectiveness, and efficiency of care delivery should be paramount. This framework should not conflict with or duplicate the medical device regulation framework. The AOA does not support federal regulation of health software because it poses the lowest risk of potential harm and data should not be treated as a medical device regardless of the category of health IT associated with the data. The AOA supports a national network for reporting patient safety events 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

H637-A/11 HEALTH INSURANCE EXCHANGES

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. 2011

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. However, if a state fails to make sufficient progress by January 2013, the federal government is authorized to assume responsibility for the establishment and implementation of an Exchange in that state.

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 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.

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.

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).

H433-A/11 HEALTH LITERACY
The American Osteopathic Association strongly supports the campaign for health literacy and encourages all practitioners and medical facilities to create a shame-free environment where low-literate patients can seek help. 2011

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) 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

H439-A/12 HEALTHY LIFE STYLES
The American Osteopathic Association promotes guidelines for healthy life styles and will continue to work with Congress and related state and federal health care agencies to develop those guidelines. A healthy life style includes healthy eating, regular exercise and maintaining a healthy weight. Healthy eating is based on a diet rich in fruits and vegetables, with limited intake of fat, sugar and salt. A healthy life style eliminates the use of tobacco and illicit drugs, and limits alcohol intake. A healthy life style also includes proper care for mental health and encourages connection with one's community. 1992; revised 1997, 2002; 2007; reaffirmed as amended 2013

H432-A/11 HEALTHY, HUNGER-FREE KIDS ACT
The American Osteopathic Association supports the Healthy, Hunger-Free Kids Act. 2011

H224-A/08 HEALTHY PEOPLE 2010
The American Osteopathic Association supports "Healthy People 2010." 1998, revised 2003; 2008

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

H434-A/14 HEPATITIS C SCREENING
The American Osteopathic Association (AOA) publicly supports universal screening of baby boomers (those born 1945-1965) 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 (1945-1965). The AOA will work with public health entities to educate the public about the need for testing and treatment. 2014

H318-A/14 HOME-BASED CARE FOR FRAIL ELDERLY
The American Osteopathic Association encourages all parties with economic and clinical responsibility to develop programs and systems to assist the frail elderly patient population and provide appropriate access to healthcare services. 1999; revised 2004; reaffirmed 2009; reaffirmed as amended 2014

H621-A/12 HOME HEALTHCARE SERVICE ABUSE
The American Osteopathic Association encourages its members to prevent fraud and abuse of home health care services. 1997; revised 2002; 2007; reaffirmed as amended 2012

H600-A/14 HOSPICE--FEDERAL REIMBURSEMENT FOR REQUIRED FACE-TO-FACE VISITS
The American Osteopathic Association supports reasonable federal reimbursement 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

H435-A/12 HOSPICE CARE PROGRAMS -- AOA SUPPORT FOR
The American Osteopathic Association (1) continues 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; (2) encourages its membership to advocate for participation in and/or utilization of hospice care programs; and (3) urges 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 Medicare / Medicaid and health industry policies. 2007; reaffirmed as amended 2012

H316-A/13 HUMAN CLONING
The American Osteopathic Association will closely monitor debate on the ethics of human cloning; will insure that the state osteopathic associations receive up-to-date information on this issue to share with their members; and will take a leadership role in bringing the osteopathic and allopathic medical communities, researchers, scientists, and ethicists

together to discuss and develop a policy on the issue prior to passage of legislation that may adversely affect patients and/or medical research. 1998; revised 2003; 2008 [Editor's note: This policy has been referred to develop a policy that is more reflective of the emergence of legislation – 2013]

H404-A/11 HUMAN IMMUNODEFICIENCY VIRUS (HIV)

In accordance with the American Osteopathic Association's Code of Ethics: (1) osteopathic physicians should provide care for those at risk and those infected with Human Immunodeficiency Virus (HIV), in an atmosphere of compassion and nondiscrimination; (2) recognize their professional and ethical obligations to care for such patients as they care for all patients; (3) osteopathic physicians in their important role as humanitarian resources to their patients, families, and communities, provide candid, effective nonjudgmental preventive education for those at risk, and serve as effective resources for their patients' families and loved ones; and (4) osteopathic physicians should be educational resources for those at negligible risk in an effort to promote enlightened attitudes in places of work, our schools, and communities in general. 1992; revised 1996, 2001; revised and reaffirmed 2006; reaffirmed 2011

H615-A/12 HUMAN IMMUNODEFICIENCY VIRUS (HIV) -- POSITIVE STATUS AS A DISABILITY FOR PHYSICIANS

The American Osteopathic Association supports efforts to require all disability insurance contracts to recognize HIV positive status as a disability for all physicians, regardless of specialty, provided that the physician can demonstrate that this status has caused a significant loss of patients, income or privileges. 1992; revised 1997; reaffirmed 2002; 2007; 2012

H430-A/13 HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING -- CLINICAL AND PUBLIC HEALTH APPLICATION OF

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

H434-A/12 HUMAN PAPILLOMAVIRUS VACCINATION -- EDUCATION ON

The American Osteopathic Association supports efforts to educate the general public regarding the human papillomavirus (HPV) and its relationship to certain cancers and genital warts; urges osteopathic physicians to educate themselves and their patients regarding the availability and benefits of administering HPV vaccine to patients as recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices; and urges adequate public and private insurance coverage for HPV vaccines in patient populations as recommended by the Advisory Committee on Immunization Practices (ACIP); and supports ongoing research to determine whether HPV vaccine is beneficial to other groups in the general population. 2007; reaffirmed as amended 2012

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

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

It is the policy of the American Osteopathic Association that the use of appropriate single ICD codes should suffice to justify the ordering of laboratory tests, if those tests are ordered as part of the evaluation of a disease process or in the context of an already known disease; and the AOA will communicate this policy to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, health insurance companies, and to the US Congress. 1998, revised 2003; 2008; reaffirmed as amended 2013

H611-A/12 ICD-10, OPPOSITION TO FULL IMPLEMENTATION OF

The American Osteopathic Association opposes full implementation of ICD-10 as currently proposed, lacking sufficient evidence that the improvement in cost-effective patient care outweighs the anticipated burden to physicians, other health care entities (providers) or patients. 2012

H625-A/12 ILLEGAL IMMIGRANTS TO IMMIGRATION AND NATURALIZATION SERVICE--REPORTING OF

The American Osteopathic Association will petition the Centers for Medicare and Medicaid Services, and relevant state agencies, to review and modify their rules and regulations to

ensure that physicians are indemnified and therefore not held responsible to identify the legal resident status of any patient. 2007; reaffirmed as amended 2012

H429-A/15 IMMUNIZATION OF 9 TO 26 YEAR OLD MALE AND FEMALES WITH HUMAN PAPILLOMA VIRUS VACCINE

The American Osteopathic Association recommends Human Papilloma Virus (HPV) immunization for both females and males, 9 – 26 years of age. 2010; reaffirmed 2015

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

H411-A/13 IMMUNIZATIONS

The American Osteopathic Association supports the Centers for Disease Control and Prevention in its efforts to achieve a high compliance rate among infants, children and adults by encouraging osteopathic physicians to immunize patients of all ages when appropriate; supports the HHS National Vaccine Implementation Plan; and encourages third-party payers to reimburse for vaccines and their administration. 1993; revised 1998, 2003; 2008; reaffirmed as amended 2013

H605-A/11 IMMUNIZATIONS--INSURANCE COVERAGE FOR

The American Osteopathic Association endorses a requirement for regulated third-party carriers to provide full coverage for all immunizations as recommended by the Centers for Disease Control and prevention (CDC). 1996; revised 2001; reaffirmed 2006; reaffirmed as amended 2011

H439-A/15 IMMUNIZATIONS--MAINSTAY OF PREVENTIVE MEDICAL PRACTICE

The American Osteopathic Association will create stronger ties with pro-immunization groups within and outside the osteopathic profession; and whenever possible, will assist these pro-immunization groups with appropriate evidence-based information regarding the safety of immunizations and significant positive effects of the proper use of immunizations relative to the overall public safety. 2010; reaffirmed 2015

H322-A/14 IMPORTATION OF MEDICATIONS

The American Osteopathic Association supports the importation of medications that may be imported under the authority of the US Food and Drug Administration and encourages its members to assist patients in utilizing the many programs that are available to provide patients with free or reduced cost medications. 2004; reaffirmed 2009; 2014

H320-A/12 IMPROVEMENT OF THE AMERICAN HEALTH CARE SYSTEM

The American Osteopathic Association, as a physician led effort, will continue to collaborate with other health care associations to improve in developing a health care plan focusing on the medical needs of patients. 2007; reaffirmed as amended 2012

H308-A/15 IMPROVING COMPETITIVE EDGE FOR MEMBERSHIP IN THE AOA

The American Osteopathic Association will review all membership dues, fees, and duration of certification to become more cost competitive with allopathic organizations to help build and maintain membership. 2015

H627-A/14 INDUSTRY TRANSPARENCY STANDARDS

The American Osteopathic Association: (1) acknowledges the contributions made by pharmaceuticals, biologics, and medical devices to the improved health, management of disease, and enhanced life function for millions of patients cared for by osteopathic physicians; (2) acknowledges concerns regarding the perception that pharmaceutical and device companies have undue influence over physicians; (3) affirms its commitment to providing all osteopathic physicians, their patients, and the public timely, accurate, and relevant information on advances in medical science, treatment of disease, prevention, wellness, and other information that advances mental and physical health; (4) continues its commitment to life-long learning for all osteopathic physicians; (5) supports transparency in its industry partnerships by creating a public web site that discloses 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

H434-A/15 INFANT WALKER (MOBILE)--BAN ON THE MANUFACTURE, SALE AND USE OF

The American Osteopathic Association supports the ban on the manufacture, sale and use of mobile infant walkers; and urges osteopathic physicians to educate parents and other caregivers on the risks associated with the use of these devices. 2003; revised 2010; reaffirmed 2015

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

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

H423-A/11 INFLUENZA VACCINE

The American Osteopathic Association will work with the appropriate federal government agencies to assure that physicians receive timely deliveries of flu vaccine in order to assure that high risk patients are provided their vaccinations and thereby protect the most vulnerable patients as a public safety measure; and will encourage its members to actively promote and provide influenza flu and other appropriate vaccinations to their patients. 2005; reaffirmed 2010; reaffirmed 2011

H210-A/14 INHALATION OF VOLATILE SUBSTANCES

The American Osteopathic Association endorses continuing medical education and medical literature to enhance physician awareness of inhalation of volatile substances (huffing) and endorses campaigns to enhance public awareness of this crisis. 2009; reaffirmed 2014

H317-A/13 INSURANCE CARRIERS--PATIENT ACCESSIBILITY OF DIAGNOSTIC SERVICES

The American Osteopathic Association will work with the state health insurance regulators and health insurance companies to allow physicians the option of providing diagnostic services at the same payment level that the insurance carrier has contracted with its other approved providers. 2003; 2008; reaffirmed as amended 2013

H211-A/14 INTEGRITY AND MISSION OF COLLEGES OF OSTEOPATHIC MEDICINE (COM) AND UNIVERSITY HEALTH SCIENCE CENTERS (UHSC) GRANTING THE DOCTOR OF OSTEOPATHIC MEDICINE DEGREE (DO)--MAINTAINING THE

The American Osteopathic Association upholds and supports maintaining the integrity and mission of Colleges of Osteopathic Medicine and University Health Science Centers granting the Doctor of Osteopathic Medicine degree. 2009; reaffirmed 2014

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).

AOA POLICY STATEMENT--INTERFERENCE LAWS

Several 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 as 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. The first prevents physicians from asking their patients about risk factors that may affect their health or the health of their families.[1] An example of this law is a Florida law which limited physicians from asking questions about a patient's gun ownership. The law is 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 medically necessary.[3] Examples of this include 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 not able to use their judgment to determine which 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.[4] 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.

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 providing information about the dangers of chemicals used in the hydraulic fracturing process, also known as "fracking."

Impact on the Osteopathic Medical Profession and Patient-Physician Relationship

Interference laws threaten the osteopathic medical profession, in particular due to the intrusion 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.[6] The patient-physician relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open communication between the physician and patient.[7]

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."[8] Patient-centered care is an essential element in the practice of evidence-based medicine. American Osteopathic Association (AOA) policy supports the use of evidence-based medicine and the implementation of "all methods appropriate to optimize natural healing and to address the primary cause of disease."[9]

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 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 process as a partner."[10] 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 unlocked firearm, they are unable to provide information which may prevent a firearm-related death in the patient's household. "[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."[11] 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.[12]

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. 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. 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. 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."[13] 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."[14]

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]."[15] Conversely, the Fifth Circuit Court of Appeals upheld a similar mandatory ultrasound law in Texas, finding that the law did not violate First Amendment rights of physicians and patients. Significantly, the recent decision by the Fifth Circuit Court of Appeals sets up a possible circuit split with the Fourth Circuit Court of Appeals and 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.[16]

Efforts of Medical Associations

Several medical associations have developed policies or taken action in opposition to interference laws. In 2011, the American Medical Association (AMA) adopted a resolution which opposes any intrusion into patient-physician relationships and supports physician judgment.[17] In October 2012, the American Academy of Family Physicians (AAFP) 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.

In August 2012, the American Bar Association (ABA) also adopted a resolution specifically opposing laws which prevent physicians from asking patients about firearm ownership. The ABA resolution 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.[22]

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.[23]

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 aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner 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 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 undermines physician judgment 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 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 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.

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

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

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

[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] *Obama announces 23 executive actions, asks Congress to pass gun laws.* CNN, January 16, 2013. *Accessed* at http://news.blogs.cnn.com/2013/01/16/obama-to-announce-gun-control-proposals-shortly/.
[3] Id.
[4] Weinberger, *supra.*
[5] Id.
[6] *Osteopathic Medicine and Medical Education in Brief.* AACOM, 2010. http://www.aacom.org/about/osteomed/Pages/default.aspx.
[7] 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.
[8] *Crossing the Quality Chasm: A New Health System for the 21st Century"*, Institute of Medicine, March, 2001. http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.
[9] AOA Policy H330-A/11, *JAOA-The Journal of the American Osteopathic Association – Tenets for Guiding.*
[10] AACOM, *supra.*
[11] *Wollschlaeger v. Farmer* – Florida District Court Opinion. *Accessed at* http://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/Fla%20Gun%20Law%20Summary%20Judgment%20Order.pdf.
[12] AOA Policy H233-A/06, *Patient-Physician Relations.*
[13] Id.
[14]Id.
[15] *Stuart v. Huff* - North Carolina District Court Opinion. *Accessed at* http://www.acluofnc.org/files/Ultrasound%20Opinion%20102511.pdf.
[16] *Nova Health Systems v. Pruitt* - Supreme Court of Oklahoma Opinion. *Accessed at* http://op.bna.com/hl.nsf/id/mapi-92pqnc/$File/nova.html.
[17]*Government Interference in Patient Counseling.* AMA Policy H-373.995. 2011. 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.
[18] *Family Physician Group Decries Legislative Interference in Physician-Patient Relationship.* National Partnership for Women and Families. October 25, 2012. http://www.nationalpartnership.org/site/News2?page=NewsArticle&id=36473.
[19] *Statement of Principles on the Role of Governments in Regulating the Physician-Patient Relationship.* American College of Physicians, July, 2012. http://www.acponline.org/advocacy/where_we_stand/policy/statement_of_principles.pdf.
[20] Weinberger, *supra.*
[21] Id.
[22] *ABA Resolution 111*, August, 2012. http://www.americanbar.org/content/dam/aba/administrative/house_of_delegates/resolutions/2012_hod_annual_meeting_111.authcheckdam.doc
[23] Friedman, Andrea. *Who really cares about Women's health? Ask your doctor.* National Partnership for Women and Families, December 14, 2012. *Accessed at* http://blog.nationalpartnership.org/index.php/2012/12/listen-to-your-doctor/.

H301-A/11 INTERNATIONAL OSTEOPATHIC MEDICINE

The American Osteopathic Association will:

1. Do all things necessary to ensure the continued advancement of osteopathic medicine in the United States through research, education and health care delivery.
2. Actively offer assistance and guidance, upon request, to national or international health care entities wishing to provide for the licensure and practice rights of osteopathic physicians trained in colleges of osteopathic medicine accredited by the AOA Commission on Osteopathic College Accreditation (COCA).
3. Endorse institutions or programs from other countries, which have been accredited by the AOA COCA and designate themselves on diplomas, or similar documents, as

colleges of osteopathy, colleges of osteopathic medicine, or otherwise identify themselves as osteopathic medical institutions.

4. Assist upon request legitimate institutions of other countries in the development of colleges of osteopathic medicine or osteopathic graduate medical education programs when such entities clearly demonstrate the capacity to be accredited by the AOA and COCA.
5. Recognize continuing medical education programs in other countries only when such programs are organized for awarding credit to fully trained physicians (DO/MD), and such programs meet the continuing medical education requirements of the AOA.
6. Encourage members of the AOA, its affiliates, and AOA accredited institutions and programs, to refrain from the hands-on teaching of osteopathic manipulative treatment, injection, diagnostic or therapeutic surgical and / or diagnostic or therapeutic invasive procedures to individuals who do not, or will not upon graduation, have the complete foundation to responsibly master or possess the legitimate scope of practice to apply said skills or procedures.
7. Promote, on request, osteopathic medical education that meets AOA and COCA accreditation standards in those institutions outside of the United States that provide for such instruction, and where feasible, actively promote full medical practice rights for graduates of AOA accredited institutions in that country.
8. Continue to promote awareness, understanding and advancement of osteopathic medicine within other countries, as it has been articulated and developed in the United States, through continued and expanded membership, activity and leadership in international medical organizations, such as the Global Health Council (GHC), Osteopathic International Alliance (OIA), International Association of Medical Regulatory Authorities (IAMRA), and World Health Organization (WHO), among others. 1985; reaffirmed 1990; revised 1996, 2001; reaffirmed 2006; amended and reaffirmed 2011

H607-A/15 INTEROPERABLITY OF HEALTH INFORMATION TECHNOLOGY

The American Osteopathic Association (AOA) supports an open interoperability platform for health care delivery, in order for clinical information systems to capture and share quality, outcome, and cost data for the purposes of defining the "Value" based model of care and is completely committed to health information technologies supporting the long-term goal of a "Learning Health System", which fundamentally depends on interoperable systems to support coordinated health care and data analytics. 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 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, not technology-centered healthcare and policies that include adequate positive incentives for the adoption of health information technology.

The AOA will remain vigilant about mitigating the level of administrative burden posed by existing and new government policies. 2015

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.

Requirement:

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 action (by the state medical board) 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 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 act.

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; reaffirmed 2015

H611-A/14 INVESTMENT TAX

Policy of the American Osteopathic Association notes that it is the responsibility of all osteopathic associations with 501{c}(6) tax status to urge their state legislators, U.S. senators and congressmen, to defeat any proposed expansion of the tax on unrelated business income to include dividends, capital gains and/or interest income on reserves and current operational funds, under the 501{c}(6) tax status. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

H435-A/15 IN-VITRO FERTILIZATION STANDARDS OF CARE--DEVELOP

The American Osteopathic Association supports the appropriate and evidenced based use of in-vitro fertilization in a manner that promotes the health and safety of both the mother and embryo; and supports the ethical guidelines for the practice of in-vitro fertilization set by the American Society of Reproductive medicine that include, but are not limited to, the appropriate number of embryos implanted per patient. 2010; reaffirmed 2015

H212-A/12 JOINING FORCES INITIATIVE

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

partnering with organizations such as Joining Forces and other organizations that help our military members and their families. 2012

H330-A/11 JAOA – *THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION*--TENETS FOR GUIDING

The JAOA-*The Journal of the American Osteopathic Association* adopts the following principles for patient care: Patients are the focus for our treatment, and they bear significant responsibility for their health. Osteopathic physicians use evidence-based medicine and implement all methods appropriate to optimize natural healing and to address the primary cause of disease. The JAOA will realign its sections and departments to highlights these tenets and principles. 2011

H437-A/11 K2 AND BATH SALTS AS DRUGS OF ABUSE, USE OF

The American Osteopathic Association supports the Drug Enforcement Agency and the Department of Human and Health Services current position and classification of K2 and bath salts as a drug or chemical of concern and supports that these substances be withdrawn from the national market permanently. 2011

H623-A/14 LATEX ALLERGY

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

H620-A/15 LAY MIDWIVES

The American Osteopathic Association opposes the licensing of lay midwives and will continue providing support to affiliate societies in opposing state's efforts to license lay midwives. 2010; reaffirmed 2015

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

The American Osteopathic Association (AOA) encourage physicians and public health departments to screen children based upon current recommendations and guidelines established by the US Centers for Disease Control and Prevention and the Advisory Committee on Childhood Lead Poisoning Prevention 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

H617-A15 LIABILITY LAWSUITS--FRIVOLOUS
The American Osteopathic Association 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. 2010; reaffirmed as amended 2015

H318-A/13 LICENSURE OF INTERNS AND RESIDENTS
The American Osteopathic Association recommends that all state licensing boards implement a mechanism to ensure that osteopathic physicians who are eligible for licensure and are in postdoctoral training programs within each board's state have satisfied all necessary credentialing requirements for licensure. 1998; revised 2003; 2008; reaffirmed 2013

H203-A/12 LOAN DEFERMENT DURING RESIDENCY
The American Osteopathic Association supports legislation that would allow resident physicians to defer the repayment of their federal medical school loans interest free until the completion of residency training; and, until such time that interest-free loan deferment is available, the AOA will actively work to reinstate the qualification criterion referred to as the "20/220 pathway" for economic hardship deferment and support mechanisms that address the financial needs of resident physicians with medical school loan debt. 2012

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

H338-A/15 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES
The LBP guidelines policy will post in January 2016.

H615-A/14 MAIL ORDER PHARMACY
The American Osteopathic Association opposes pharmaceutical programs that require all medications be delivered to the patient's residence as failing to act in the best interests of the patient; and that maintenance medication prescriptions may be obtainable at a pharmacy at the patient's discretion. 2004; reaffirmed 2009; 2014

H638-A/14 MAINTENANCE OF LICENSURE
The American Osteopathic Association (1) supports the development of state level maintenance of licensure (MOL) programs to demonstrate that osteopathic physicians are competent and provide quality care over the course of their career. Flexible pathways for achieving MOL should be maintained. The requirements for MOL should balance

transparency with privacy protection and not be overly burdensome or costly to physicians or state licensing boards. (2) The AOA will continue to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels as well as ongoing physician assessment through Osteopathic Continuous Certification (OCC) and the AOA Clinical Assessment Program (CAP) or its equivalent. (3) The AOA will continue to work with State Osteopathic Affiliates, the American Association of Osteopathic Examiners and other stakeholders to establish, implement MOL policies that promote patient safety and the delivery of high quality of care. 2010 [See also H258-A/08]; approved as amended 2014

H642-A/15 MANAGED CARE--ALL PRODUCTS CLAUSES

The American Osteopathic Association and state osteopathic societies oppose the use of all products/all products developed in the future" clauses in physician managed care contracts; actively opposes the use of any other clauses that may limit the ability of the physician to choose the plans in which he or she participates; will educate its members on the potential risks of all products/all products developed in the future" clauses and the importance of identifying such clauses in contracts prior to their signing; 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. 2000, revised 2005; reaffirmed 2010; 2015

H319-A/13 MANAGED CARE ORGANIZATIONS--OSTEOPATHIC DISCRIMINATION BY

The American Osteopathic Association is opposed to discrimination against osteopathic physicians by managed care organizations; and urges that federal and state legislation must clearly state that any and all managed care organizations, and insurance companies must accept as sufficient professional credentials all licenses properly granted by state boards of medicine or osteopathic medicine, and all specialty certifications granted by boards approved by the AOA or American Board of Medical Specialties. 1993; revised 1998, 2003; 2008; reaffirmed as amended 2013

H320-A/13 MANAGED CARE -- PATIENT-PHYSICIAN RELATIONSHIP AND

The American Osteopathic Association believes that it is the responsibility of the osteopathic physician to advocate for the rights of his/her patients, regardless of any contractual relationship and that the patient-physician relationship shall not be altered by any system of healthcare practice, including managed care entities, which may place economic considerations above the interest of patients. 1998, reaffirmed 2003; 2008; reaffirmed as amended 2013

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

H302-A/11 MANAGED CARE REFERRALS
The American Osteopathic Association supports and promotes legislation that enables patient access to medical specialists by direct referral from the primary care physicians without preauthorization by the managed care company. 2001; revised 2006; reaffirmed as amended 2011

H606-A/11 MANAGED HEALTHCARE SYSTEMS--FREEDOM OF CHOICE
The American Osteopathic Association will assist state osteopathic medical associations in drafting of legislation which provides for freedom of choice of providers and will work with managed healthcare entities to: (1) offer high quality healthcare to all patients, which includes osteopathic benefits to all enrollees, and allow osteopathic physicians, if they wish, to be included on the health plans' specialty panels for osteopathic manipulative treatment; (2) permit freedom of choice of hospital and doctors; (3) permit the patient to make economic decisions involving his healthcare; (4) do not exclude certain physicians and hospitals from honest competition for any segment of the marketplace; (5) do not force physicians on a contracting hospital staff to join that hospital's managed care entity and thereby lead to closed hospital staffs; (6) will not exclude DOs on the basis of degree or AOA certification or training; and (7) afford all physicians appropriate hearing and appeal processes. 1988; revised 1993, 1994, 1999; referred for review 2004; reaffirmed 2006 [Editor's note: This policy has been referred to improve the language to address Accountable Care Organizations and other recent changes to the health care landscape-2011]

H610-A/14 MANDATED PATIENT CARE -- ASSIGNMENT OF
The American Osteopathic Association strongly opposes any attempt by a third-party payer, business, institution or government to mandate a patient be seen and managed by any individual, including a hospitalist, or anyone other than the patient's physician in any setting without the concurrence of the patient's physician. 1999; revised 2004; reaffirmed 2009; 2014

H321-A/13 MANDATORY ASSIGNMENT
The American Osteopathic Association supports the right of physicians to accept assignments of payments on a case by case basis. 1988; revised 1993; reaffirmed 1998, revised 2003; 2008; reaffirmed 2013

H214-A/14 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 societies in opposing additional specific CME course requirements. 2004; reaffirmed 2009; 2014

H607-A/11 MANDATORY PARTICIPATION IN INSURANCE PLANS

The American Osteopathic Association opposes any legislation that requires mandatory participation of physicians in any insurance plan, including Medicare or Medicaid and private insurance plans. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011

H219-A/15 MATCHING SERVICE LISTING OF AOA RESIDENCIES WITH ACGME PRE-ACCREDITATION STATUS -- CLARITY

The American Osteopathic Association (AOA) will provide guidance to the osteopathic student body regarding the timelines of residency program transition between the NRMP and NMS matching services. The AOA will openly distribute information regarding the match transition and its implications to osteopathic medical students applying to those residency programs, starting in the period leading up to the pre-accreditation eligibility of AOA residency programs. 2015

H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS

The American Osteopathic Association supports government expenditures for maternal and child healthcare block grants and the efficient use of resources and supports maintaining or increasing funding levels for the maternal and child healthcare block grants. 1988; revised 1993, 1998, 2003, 2004; reaffirmed 2009; 2014

H608-A/11 MEDICAID PHARMACEUTICAL BENEFITS

The American Osteopathic Association take appropriate action including but not limited to informing federal and state government agencies of the need to assure that inequities do not exist in the medical treatment of Medicaid patients. 1996; revised 2001; reaffirmed 2006 [Editor's note: This policy has been referred fur further clairifcation-2011]

H609-A/11 MEDICAID PRIOR AUTHORIZATION PROGRAMS -- EXPANSION OF

The American Osteopathic Association will: (1) promote and encourage state association/specialty societies to pursue sound policies on the composition of an expanded prior authorization program to ensure quality care of Medicaid patients, as well as the protection of physicians, to include but not be limited to: directing the appropriate state regulatory agency to promulgate rules governing the development, implementation, and administration of the expanded program for prior authorization of prescription drugs in the Medicaid program, and requesting that the regulatory agency hold a public hearing on the draft rules and provide a period for written public comment on the rules; and (2) will promote and encourage state association/specialty societies to work with the regulatory

agency to administer the prior authorization program in a way that minimizes the burden on healthcare practitioners and patients in accessing optimal drug therapy. 2001; reaffirmed 2006; reaffirmed as amended 2011

H619-A/15 MEDICAID PAYMENT

The American Osteopathic Association supports the efforts in each state to uphold their obligation to reimbursement physicians and hospitals at a fair and equitable rate for providing quality care to the state's Medicaid recipients. 2010; reaffirmed as amended 2015

H410-A/12 MEDICAL CARE DURING MEDICAL MISSIONS, PROVIDING

DOCARE International will not sponsor medical missions where the mission would be asked to withhold care from individuals based on political or religious beliefs; DOCARE International will not sanction activities or missions where a mission director who is not in a health care related field and does not have patient care as a primary goals; and the American Osteopathic Association supports the idea that medical missions should provide medical treatment without discrimination. 2012

H344-A/14 MEDICAL 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 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 by their insurance so that they are not exposed to medical expenses for which they are not prepared. 2014

H610-A/11 MEDICAL INSURANCE COVERAGE FOR SURGERY IN CASES OF CHRONIC GINGIVITIS

The American Osteopathic Association supports the concept that medical insurance coverage should include medical and surgical treatment of chronic gingivitis for those patients with comorbid conditions. 2001; reaffirmed 2006; reaffirmed 2011

H624-A/11 MEDICAL MALPRACTICE CRISIS

The American Osteopathic Association supports appropriate legislation to ban arbitrarily dropping physician's malpractice coverage, allow meaningful appeals processes and petition malpractice carriers to inform insured physicians at least 90 days prior to a potential termination or rate increase. 2001; 2006; reaffirmed as amended 2011

H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING REIMBURSEMENT OF MEDICARE PAYMENTS

The American Osteopathic Association will seek an immediate reversal of the policy of the Centers of Medicare and Medicaid (CMS) requiring a payback of medical care rendered by a provider who has agreed to a malpractice settlement or received a judgment in a malpractice court. 2010; 2015

H417-A/11 MEDICAL MARIJUANA, RESEARCH ON

The American Osteopathic Association supports well-controlled clinical studies on the use of marijuana and related cannabinoids for patients who have significant medical conditions for which current evidence suggests possible efficacy; and encourages the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of marijuana. 2011

H643-A/15 MEDICAL PROCEDURE PATENTS

The American Osteopathic Association supports measures that restrict medical procedure patents. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

H322-A/13 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 BOFHP 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. 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, 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.

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

H323-A/13 MEDICARE

The American Osteopathic Association declares its continued support of the Medicare program, the continued availability of quality medical care at a reasonable cost and comprehensive Medicare reform to ensure that Medicare beneficiaries receive necessary services. 1966; reaffirmed 1978; revised 1983, 1988, 1993, 1998, 2003; 2008; reaffirmed 2013

H616-A/12 MEDICARE AND MEDICAID ABUSE

The American Osteopathic Association continues to pledge its full cooperation and support of all reasonable and appropriate efforts by the federal government and the states to stop all fraud and abuse of Medicare and Medicaid. 1977; revised and reaffirmed 1982; revised 1987; reaffirmed 1992, 1997, 2002; 2007; 2012

H617-A/12 MEDICARE AND MEDICAID--ETHICAL PHYSICIAN ARRANGEMENTS

The American Osteopathic Association will continue to inform its members regarding the safe harbor rules as put forward by the HHS Inspector General. 1992; revised 1997; reaffirmed 2002; 2007; 2012

H329-A/15 MEDICARE BALANCE BILLING

The American Osteopathic Association encourages federal legislation to support Medicare balance billing and take the necessary steps to initiative federal legislation to achieve balance billing for Medicare patients to support continued participation by physicians. 2010; reaffirmed 2015

H611-A/11 MEDICARE CLAIMS CODING – CENTERS FOR MEDICARE AND MEDICAID SERVICES COMMUNICATIONS WITH PHYSICIANS

The American Osteopathic Association urges the Centers for Medicare and Medicaid Services officials to require its Medicare administrative contractors provide thorough, current, written information on the preparation and coding of Medicare claims to all physicians prior to the implementation of any new policies or programs. 1999; reaffirmed 2006; reaffirmed as amended 2011

H644-A/15 MEDICARE CONTRACTOR DENIAL LETTERS

The American Osteopathic Association calls upon the Centers For Medicare and Medicaid Services (CMS) to continue to involve osteopathic physicians in the development of screening parameters including osteopathic structural diagnoses and manipulative treatments. 1990; revised 1995, 2000, 2005; revised 2010; reaffirmed 2015

H324-A/13 MEDICARE—EQUITABLE PAYMENT

The American Osteopathic Association requests the President of the United States and Congress to take immediate action to revise the current Medicare payment system to ensure fair and equitable access to health care for all Medicare beneficiaries. 2003; 2008; reaffirmed as amended 2013

H629-A/15 MEDICARE LAW AND RULES

The American Osteopathic Association recommends that Medicare regulations that restrict a patient's freedom, as well as assess punitive damages to physicians, be challenged and that administrative burdens placed on both the patient and physician be reduced. 1995; revised 2000, 2005; reaffirmed 2010; reaffirmed as amended 2015

H326-A/13 MEDICARE LIMITING CHARGE/RBRVS SYSTEM
The American Osteopathic Association opposes Medicare's limiting charge ceiling. 1989; revised 1993, 1998, 2003; 2008; reaffirmed 2013

H633-A/11 MEDICARE PART D FORMULARY UNFAIRNESS
The American Osteopathic Association will work to support legislation that would either require Medicare Part D third party payors to continue coverage of medications for entire contract year or allow patients to change their Medicare Part D Plans whenever the plan's formulary is changes. 2011

H617-A/14 MEDICARE PHYSICIAN PAYMENT
The American Osteopathic Association will work with the Centers for Medicare and Medicaid Services (CMS), Congressional Committees of jurisdiction and the Medicare Payment Advisory Commission (MedPAC) to reform the Medicare physician reimbursement formula to protect and enhance the ability of osteopathic physicians to provide quality care and protect Medicare beneficiaries access to physician services; and will identify and aggressively pursue the enactment of long-term remedies to the sustainable growth rate (SGR) formula that protect and maintains quality patient care. 2004; reaffirmed as amended 2009; reaffirmed 2014

H321-A/11 MEDICARE PHYSICIAN PAYMENTS - SGR
The American Osteopathic Association adopts the following five principles on quality reporting, pay-for-performance and physician reimbursements: (1) The AOA continues to seek the elimination of the Sustainable Growth Rate (SGR) methodology and establishment of a new payment methodology for physicians in the Medicare program. The new payment methodology should be equitable, predictable, stable, and accurately reflect the costs associated with providing care. (2) The AOA supports, in concept, new payment methodologies that will reward physicians for providing quality services. (3) The AOA supports, in concept, new payment methodologies that will reward physicians for providing care in rural and other underserved communities. (4) The AOA strongly supports additional short-term payment adjustments that will prevent projected cuts in years 2006 through 2012. (5) The AOA supports the administrative or Congressional removal of physician-administered drugs from any physician payment methodology. 2006; reaffirmed 2011

H326-A/14 MEDICARE – PRESCRIPTION ASSISTANCE FOR MEDICARE PATIENTS
The American Osteopathic Association supports legislation that will allow Medicare Part D recipients, who are in the "donut hole", to utilize prescription discounts and vouchers. 2009; reaffirmed 2014

H636-A/15 MEDICARE PREVENTIVE MEDICAL SCREENING
The American Osteopathic Association supports coverage of Medicare recipients for routine preventive medical services. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

H612-A/11 MEDICARE PHYSICIAN PAYMENT FOR OSTEOPATHIC MANIPULATIVE TREATMENT

The American Osteopathic Association advocate for nationwide consistency in Medicare physician's payment policy, as it relates to osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services, leading to payment for OMT as a separately identifiable procedure from the E/M in all contract regions. 1991; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011

H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS

The American Osteopathic Association will communicate to the Centers for Medicare and Medicaid Services (CMS) its concern about the Medicare Recovery Audit Contractors (RAC) payment methodology. 2005; revised 2010; reaffirmed 2015

H622-A/12 MEDICARE PAYMENT FAIRNESS

The American Osteopathic Association supports the concept of equitable Medicare funding and benefits for all Medicare beneficiaries and will make every effort to convince the Centers for Medicare and Medicaid Services (CMS) to make more equitable payment for medical services provided under Medicare risk contracts. 1997; revised 2002; 2007; reaffirmed as amended 2012

H328-A/11 MEDICARE THREE-DAY QUALIFYING POLICY FOR SKILLED NURSING FACILITY, PROVIDING EXCEPTIONS FOR THE

The American Osteopathic Association will petition the Centers for Medicare & Medicaid Services and insurance agencies with similar rules to develop exception guidelines to the three-day qualifying policy for skilled nursing facility. This will facilitate care to be given to appropriate patients in a most cost effective, less intensive setting, without having to fulfill the three-day rule. 2011

H601-A/14 MEDICARE TRANSITION CARE CODES

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

H325-A/13 MEDICARE USER FEES

The American Osteopathic Association opposes any legislation that would establish Medicare user fees. 1998, revised 2003; 2008; reaffirmed 2013

H405-A/11 MEDICATION FOR INDIGENT PATIENTS

The American Osteopathic Association supports those pharmaceutical companies that donate near-expired maintenance medication to volunteer distribution centers for

distribution to indigent patients on the basis of financial need. 2001; revised 2006; reaffirmed 2011

H407-A/13 MEDICATION TAKE-BACK PROGRAM
The American Osteopathic Association supports the national prescription drug take-back day that aims to provide a safe, convenient and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications; and encourages its state associations and local agencies to sponsor take-back medication days on a frequent basis but at least annually. 2013

H438-A/11 MEDICATIONS -- DISPOSAL OF
The American Osteopathic Association encourages the development of policies appropriate for the safe disposal of over-the-counter (OTC) and prescribed medication, by working with appropriate state agencies in the endeavor and will work with federal regulatory agencies to promote safe disposal and destruction of medications in appropriate medical waste disposal facilities. 2011

H303-A/11 MEDICATIONS -- PRIOR AUTHORIZATION FOR
The American Osteopathic Association will evaluate and recommend alternatives to prior authorizations for medications and will promote legislation that supports these alternatives. 2001; reaffirmed 2006; reaffirmed 2011

H404-A/12 MENINGOCOCCAL VACCINE (MCV4) BOOSTER, RECOMMENDATION FOR UNIVERSAL ADOLESCENT
The American Osteopathic Association supports the administration of a booster dose of the meningococcal vaccine (MCV4) at 16 years of age for those adolescents that receive an initial MCV4 dose at 11 – 12 years of age. 2012

H405-A/12 MENINGOCOCCAL VACCINE (MCV4) PRIMARY SERIES IN PATIENTS WITH SICKLE CELL ANEMIA
The American Osteopathic Association supports the administration of a 2 dose primary series of the meningococcal vaccine (MCV4), given 2 months apart, in patients between 2 and 54 years of age with sickle cell anemia. 2012

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

H646-A/15 MENTAL HEALTH -- OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN

The American Osteopathic Association (AOA) will promote mental health awareness and provide osteopathic medical students, residents, and physicians with educational information on recognizing mental health issues among themselves and their colleagues. The AOA will work with the American Association of Colleges of Osteopathic Medicine, AOA State Divisional Societies, and Advocates for the American Osteopathic Association to reduce the stigma associated with mental illness to eliminate barriers to treatment while advocating for increasing the resources for care. 2015

H618-A/12 MILITARY MEDICAL READINESS

The American Osteopathic Association supports efforts by the Department of Defense which encourage the voluntary participation of osteopathic physicians in the military and improves the military medical readiness of America. 1987; revised 1992; reaffirmed 1997; 2002; 2007; 2012

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 programs implement programs with multi-cultural impact. 2004; reaffirmed 2009; reaffirmed as amended 2014

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

H406-A/11 MINORITY HEALTH AND OSTEOPATHIC MEDICAL EDUCATION

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 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. 1996; 2001; modified and reaffirmed 2006; reaffirmed 2011

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) 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 to increase physician knowledge on racial and ethnic healthcare needs, including disparities in the areas listed above;
2. The elimination of provider stereotypical beliefs 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.

H256-A/06 MODIFYING FTE RESIDENTS CAP

The American Osteopathic Association, in collaboration with the American Association of Colleges of Osteopathic Medicine (AACOM) and other organizations as appropriate, to develop a strategy to expand the number of osteopathic training opportunities and continue to attempt to modify the limits on the number of postdoctoral training positions funded by Medicare. 2006

H406-A/12 NARCO-TERRORISM
The American Osteopathic Association will commit its efforts to address narco-terrorism by emphasizing patient and community addiction education and treatment efforts. 2012

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 osteopathic research among the Research Condition and Disease Categories reported each year to Congress and the American public. 2010; reaffirmed 2015

H327-A/13 NATIONAL PRACTITIONER DATA BANK
The AOA will employ its resources to persuade the National Practitioner Data Bank to 1) limit required reports to significant findings relative to professional matters, 2) establish a maximum time limit of five (5) years for retention of data, 3) record as an action only a settlement that exceeds $50,000, 4) eliminate inclusion of postdoctoral trainees who perform their services properly under the supervision of an attending physician; and urges the US Congress to amend the National Practitioner Data Bank law to mandate that all federal confidentiality protections accorded to the bank supersede state discovery or open-record laws. 1991; revised 1993, 1998, 2003; 2008; reaffirmed as amended 2013

H300-A/12 NATIONAL PRACTITIONER DATA BANK, AOA REPORTING
Adverse membership action based on a physician's loss of license do not need to be reported to the National Practitioner Data Bank (NPDB) by the American Osteopathic Association (AOA) because state licensing boards report separately to the NPDB on their adverse actions. The AOA will not report membership actions based on failure to pay dues or complete AOA requirements for continuing medical education to the NPDB. The AOA shall report adverse membership actions to the NPDB that are related to quality of care issues and will report on adverse membership actions if the action is based on ethical or professional misconduct that affected or could have affected patient care. 2012

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

H204-A/11 NATIONAL RESIDENT MATCHING PROGRAM (NRMP) POLICY CHANGE

The American Osteopathic Association supports the proposed National Resident Matching Program (NRMP) policy change removing the ability of participating NRMP programs to offer pre-Match contracts to independent applicants. 2011

H635-A/15 NEWBORN AND INFANT HEARING SCREENS

The American Osteopathic Association supports adequate funding for universal hearing screening and intervention for newborns and infants. 1995; revised 2000, 2005; reaffirmed 2010; 2015

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

H634-A/15 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

Policy Statement - 2010
NON-PHYSICIAN CLINICIANS

The practice of medicine and the quality of medical care are the responsibility of properly licensed physicians. As the DO/MD medical model has proven its ability to provide professionals with complete medical education and training, their leadership in such an approach is logical and most appropriate. Public policy dictates patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. **Patient Safety**. The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice within the scope of the relevant state statutes. However, it is the AOA's position that new roles for non-physician clinicians may be granted after appropriate processes and programs are established in all of the following four areas: education, training, examination, and regulation. It is further the AOA's stance that non-physician clinicians may be allowed to expand their rights only after it is proven they have the ability to provide healthcare within these new roles safely and effectively.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established protocols and signed

agreements, so physician involvement in patient care is sought when a patient's case dictates. The AOA feels non-physician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted. All non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of expertise.

C. **Liability.** The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians acting autonomously of physicians should be held to the equivalent degree of liability as that of a physician. Within this independent practice framework, the AOA further believes that non-physician clinicians should be required to obtain malpractice insurance in those states that currently require physicians to possess malpractice insurance.

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

H603-A/12 OBESITY ACTION COALITION EFFORTS ON THE TREATMENT OF SEVERE OBESITY

The American Osteopathic Association supports the Obesity Action Coalition efforts to secure coverage for all recognized treatment modalities for the treatment of severe obesity and urges federal and state policymakers and third party payers to cover the treatment of severe obesity including both surgical and non-surgical treatments. 2012

H438-A/15 OBESITY, CHILDHOOD -- WORSENING EPIDEMIC IN THE AMERICAN SOCIETY

The American Osteopathic Association will makes efforts to educate schools and vending machine suppliers of the need of healthy choice snacks; and supports the limited use of vending machines in schools to avoid unnecessary caloric intake. 2010; reaffirmed 2015

H435-A/11 OBESITY EPIDEMIC -- ADDRESSING THE AMERICAN

The American Osteopathic Association, in conjunction with its specialty and divisional affiliates, the American Association of Colleges of Osteopathic Medicine, the National Board of Osteopathic Medical Examiners and the certifying boards, will initiate a profession-wide program to provide leadership in addressing the American obesity epidemic; encourages each osteopathic physician and medical student to measure the body mass index (BMI) and waist circumference in every patient and address with them their obesity-related issues; and encourages each osteopathic physician and student to address any obesity-related issues in their own health as an example to their patients. 2011

H328-A/13 OBESITY -- HEALTH PLANS SHOULD REVIEW BENEFITS FOR TREATMENT OF

American Osteopathic Association policy supports inclusion of nutritional counseling and physical conditioning as a benefit for members of all health plans for the prevention and treatment of obesity. 2003; 2008; reaffirmed as amended 2013

H407-A/11 OBESITY IN CHILDREN

The American Osteopathic Association supports programs which advocate physical fitness and good nutrition for children and families. 2001; modified and reaffirmed 2006; reaffirmed as amended 2011

H440-A/12 OBESITY -- TREATMENT OF

The American Osteopathic Association recognizes obesity as a disease, and that obesity treatment and prevention requires a chronic care model, by encouraging 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 continuing medical education for physicians with established practices; 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 advocate for adequate coverage for obesity treatment and prevention and will develop 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. 2002; 2007; reaffirmed as amended 2012

H304-A/11 OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA) STANDARDS

The American Osteopathic Association requests the US Department of Labor reconsider its penalty structure and conduct a cost benefit analysis of how Occupational Safety and Health Act (OSHA) standards affect the escalating cost of healthcare. 1991; revised 1996, 2001; reaffirmed 2006; reaffirmed 2011

H324-A/12 OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS

The American Osteopathic Association urges that the Occupational Safety and Health Administration (OSHA) emphasize education and training to create a safe work place rather than assessing punitive fines. 1992; revised 1997, 2002; 2007; reaffirmed 2012

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 can now be performed in a physician's office. Of the 80 mission outpatient surgeries performed in the US in 2009, it is estimates 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 cost of an inguinal hernia repair done in an office setting 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]." By 2010, 25 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 ambulatory surgical center persists.

While the media has reported a number of stories of tragic outcomes following office-based surgery, the actual number of morbidity and mortality following office-based surgery is hard to determine because reporting adverse events is only required in slightly more than half of all states.[5] A number of reports that have been published documented adverse events. 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 to avoid adverse events.

Need for Office-Based Surgery Rule Development

States have taken different approaches to the regulation of office-based surgery. A variety of state medical boards have adopted guidelines or rules for physicians to follow regarding 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. 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. 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] 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]

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] Furthermore, two Florida ophthalmologists and one anesthesiologist have placed advertisements for breast augmentation surgery, and several dentists have been identified as performing hair transplants and liposuction procedures.[11] 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 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, dire, 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 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);

The AOA believes that surgery performed in a physician's office must be done by a physician or health care provider qualified by education and training to perform that specific procedure;

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 physician administering the anesthesia or 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 all patients 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 who perform surgery in an office setting must have a written protocol in place for transfer to an accredited hospital within proximity to the office when extended or emergency 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.

[1] Connie Midey, *Doctor's Offices Doing More Surgeries*, The Arizona Republic, Nov. 7, 2010, *Available At* Http://Www.Azcentral.Com/Arizonarepublic/News/Articles/20101107doctors-Office-Surgery.Html.
[2] Robert K. Stoelting, MD, *Special Issue: OBA Safety, Office Based Anesthesia Growth Provokes Safety Fears,* APSF NEWSLETTER, Spring 2000, *citing* Lazarov SJ, *Office-based Surgery and Anesthesia: Where are We Now?*, 15 WORLD J UROL, 384-385 (1998); Schulz, Cost Analysis of Office Surgery Clinic With Comparison to Hospital Outpatient Facilities for Laparoscopic Procedures, 79 INT. SURG. 273-277 (1994).
[3] Midey, *Supra*; Michelle Andrews, *In-Office Surgery: Fewer Rules Apply*, N.Y. Times, Aug. 18, 2002, *Available At* Http://Www.Nytimes.Com/2002/08/18/Business/Money-Medicine-In-Office-Surgery-Fewer-Rules-Apply.Html.
[4] Midey, Supra.
[5] *See,* National Academy For State Health Policy, *2007 Guide To State Adverse Event Reporting Systems*, Dec. 2007.
[6] Stoelting, *Supra, citing* Grazer FM, deJong RH. *Deaths from Liposuction: census survey of cosmetic surgeons.* PLAST RECONSTR SURG 1999; in press.
[7] Stoelting, *Supra.*
[8](www.facs.org/ahp/pubs/sutton0201.pfd and "Office-Based Surgery Regulation: Improving Patient Safety and Quality Care" – Vol 56. Num 2; Bulletin of the American College of Surgeons)
[9] Rebecca Twersky and Scott Springman, *American Society of Anesthesiologists, Task Force on Office – Based Anesthesia Setting Precedents for a Growing Field*, May 2000 at http://www.asahp.org/NEWSLETTERS/2000/05_00/taskforce0500.html.
[10] Shari Roan, *Study Blasts Lack Of Training In Cosmetic Surgery Marketplace*, L.A. Times, April 2, 2010, *Available At* Http://Latimesblogs.Latimes.Com/Booster_Shots/2010/04/Cosmetic-Surgery-Liposuction.Html.
[11] Stoelting, *Supra.*

H240-A/04 ONSITE LAB WORK NO. 1

The American Osteopathic Association supports the adoption of national legislation that enables the physician to perform and be compensated for CLIA certified in-office laboratory tests and supports the adoption of national legislation which enables the physician to perform and be appropriately compensated for medically indicated on-site diagnostic procedures. 1999; reaffirmed 2004

H305-A/11 ONSITE LAB WORK NO. 2

The American Osteopathic Association will work with federal and state governments to enact legislation that requires healthcare plans to pay for appropriate on-site testing at a rate equal to the highest rate paid for the same service to off site providers. 2001; amended and reaffirmed 2006; reaffirmed 2011

H429-A/13 "OPIOID OVERDOSE" DEATHS IN AMERICA, EPIDEMIC

The American Osteopathic Association recommends systematic evaluation of all available interventions to prevent opioid overdose deaths including patient education and the normalization of take home Naloxone. 2013

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

The American Osteopathic Association (1) believes that third party payors (health insurers) should assist physicians by publishing their guidelines and rationales for exceptions to expedite care; (2) opposes policies and any practice of third party payors (health insurers) that replace physician clinical judgment with a fixed protocol or potentially less effective medications for required trial of treatment; (3) opposes policies and any practice of third party payors (health insurers) that replace physician clinical judgment with a fixed protocol of prerequisite of diagnostic procedures; and (4) will work with national physician organizations, state and osteopathic specialty societies to preserve the physician patient relationship and physician clinical judgment as the basis for formulating an individual plan of care. 2013

H312-A/11 ORAL AND/OR DENTAL CARE BY OSTEOPATHIC PHYSICIANS

The American Osteopathic Association will meet with the American Dental Association as necessary regarding the issue of oral and/or dental health care provided by osteopathic physicians; and will work with dental and medical third party payors to gain payment for services related to injuries and diseases of the mouth, gums and teeth when these conditions are treated by osteopathic physicians. 2006; reaffirmed as amended 2011

H408-A/11 ORGAN DONATION AND TRANSPLANTATION INITIATIVES -- COMMITMENT TO

The American Osteopathic Association affirms its support for organ 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 donation and transplantation; urges the Osteopathic Family to volunteer personally as organ donors, and in turn, actively encourage their patients to do the same; and encourages osteopathic divisional and specialty organizations, osteopathic medical colleges, and other members of the osteopathic family to develop organ donation programs in their states and organizations. 2001; reaffirmed 2006; reaffirmed 2011

H422-A/12 ORGAN DONATION -- OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS

The American Osteopathic Association states its opposition to direct payment or other financial reimbursement in exchange for donation of human organs and tissue and urges the osteopathic medical profession investigate other, more ethical alternatives to raising organ donor identification rates while preserving its first duty to protecting patient interests. 2002; 2007, 2012

H423-A/12 ORGAN DONOR IDENTIFICATION

The American Osteopathic Association encourages osteopathic physicians to discuss organ donation options with their outpatients as well as their inpatients and asks that all physicians honor the policies of their designated Organ Procurement Organization in achieving optimal organ donor identification goals. 2002; 2007, 2012

H315-A/15 OSTEOPATH AND OSTEOPATHY - USE OF THE TERM

The American Osteopathic Association policy both officially in our publications and individually on a conversational basis, is to preferentially use the term "osteopathic physician" in place of the word "osteopath" and the term "osteopathic medicine" in place of the word "osteopathy;" and that the words "osteopath" and "osteopathy" be reserved in the United States for the following purposes: (1) previously named entities within the osteopathic medical profession; (2) historical, sentimental an informal discussions; and (3) osteopaths with a limited scope of practice. 1994; reaffirmed 2000; revised 2005; revised 2010; revised 2015

H328-A/12 OSTEOPATHIC CERTIFICATIONS, RIGHTS OF MEMBERS TO PROTECT THEIR

The American Osteopathic Association shall not withdraw an osteopathic physician's certification, due to restrictions placed upon their medical licenses, unless all appeals have been exhausted. 2012

H202-A/13 OSTEOPATHIC CONTINUOUS CERTIFICATION

The American Osteopathic Association encourages input from osteopathic physicians on maintenance of licensure rules. 2013

H213-A/13 OSTEOPATHIC CONTINUOUS CERTIFICATION, AFFORDABILITY OF

The American Osteopathic Association will undertake every effort to make transparent the cost structure of osteopathic continuous certification (OCC) and, wherever possible, to make the costs of OCC affordable to its members and its affiliate organizations. 2013

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

H614-A/13 OSTEOPATHIC GRADUATE MEDICAL EDUCATION

The American Osteopathic Association urges its member physicians to support hospitals that provide osteopathic postdoctoral training programs which are an integral part of osteopathic medical education. 1998 revised 2003; 2008; reaffirmed 2013

H242-A/04 OSTEOPATHIC GRADUATE MEDICAL EDUCATION FUNDING

The American Osteopathic Association will continue efforts that encourage support and awareness of osteopathic GME programs within governmental entities.
1994; revised 1999, reaffirmed as amended 2004

H219-A/12 OSTEOPATHIC GRADUATE MEDICAL EDUCATION (OGME) PROGRAMS

The American Osteopathic Association opposes any federal or state law or regulation that would prevent the development of additional osteopathic graduate medical education programs or training positions and will continue to take all measures possible to prevent the termination of distinctive osteopathic training programs. 1997; revised 2002; 2007; reaffirmed as amended 2012

H215-A/12 OSTEOPATHIC LICENSING

The American Osteopathic Association reaffirms its position that the only examinations able to fully evaluate the ability and competency of osteopathic physicians for licensure are the examinations developed by the National Board of Osteopathic Medical Examiners, Inc.
1982; revised 1987, 1992, 1997, 2002; 2007; reaffirmed 2012

H307-A/11 OSTEOPATHIC MANIPULATIVE MEDICINE (OMM) AND OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) – AFFIRMING THE SCIENTIFIC AND MEDICAL FOUNDATION OF

The American Osteopathic Association continues to affirm its position that the scientific and medical foundation of osteopathic manipulative medicine (OMM) and osteopathic manipulative treatment (OMT) is integral to this distinctive practice; and advocates for proper recognition of the scientific and medical foundation of osteopathic manipulative medicine (OMM) and osteopathic manipulative treatment (OMT) to all political bodies, research groups, third party payers, and any other entity that formulates policy on OMM and OMT. 2011

H613-A/14 OMT -- OSTEOPATHIC MANIPULATIVE TREATMENT

The American Osteopathic Association urges that in all forms of communication the term OMT shall always be "Osteopathic Manipulative Treatment." 1999; revised 2004; reaffirmed 2009; 2014

H203-A/13 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) BY OSTEOPATHIC MEDICAL STUDENTS DURING MEDICAL SCHOOL ROTATIONS, PROMOTING USE OF

The American Osteopathic Association supports and encourages osteopathic medical schools to assign osteopathic physicians to offer hands-on osteopathic manipulative treatment (OMT) practice sessions to physicians teaching osteopathic medical students in order to increase their understanding about osteopathic manipulative treatment. 2013

H647-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

The American Osteopathic Association (AOA) approves the attached policy as the standard guidelines for OMT coverage and encourages all public and private payers to refer to the AOA's policy when developing new policy or revising existing guidance for OMT coverage. 2015

American Osteopathic Association (AOA) Policy on Osteopathic Manipulative Treatment (OMT)

Introduction to OMT

Osteopathic manipulative treatment (OMT) is a distinct medical procedure used by physicians (DOs/MDs) to treat somatic dysfunction or other conditions. The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as the therapeutic application of manually guided forces by a physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions. The AACOM Glossary of Osteopathic Terminology defines somatic dysfunction as:

> Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: 1). The position of a body part as determined by palpation and referenced to its adjacent defined structure, 2). The directions in which motion is freer, and 3). The directions in which motion is restricted.[70]

Osteopathic manipulative treatment can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial and myofascial tissues. (Example: tight right shoulder muscles in a patient with gallbladder disease). Normalizing musculoskeletal activity (relaxing tense muscles, etc.) can normalize outflows through sympathetic or parasympathetic autonomic nervous systems to visceral systems, resulting in more normal visceral and any organ system function. Somatic dysfunction is identified on the physical exam by one or more elements of TART (**T**issue texture changes, positional **A**symmetry, **R**ange of motion alterations, or changes in palpatory sensitivity, e.g., **T**enderness).

Provider Types Qualified to Perform OMT

To perform OMT a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine or a medical doctor must have completed a board-approved postgraduate osteopathic training program that encompasses osteopathic principles and practices, including hands-on demonstration and competency testing in OMT.

OMT Payment:

The decision to utilize osteopathic manipulative treatment (OMT) as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical to perform a history and physical examination on initial and subsequent encounters. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall care of the patient. OMT is a paid service when somatic dysfunction is documented in the history and/or the physical examination. OMT is not paid when somatic dysfunction is absent from the patient's history or physical examination documentation. The method of OMT employed by the physician is determined by the patient's condition, age and the effectiveness of previous methods of treatment.

OMT Documentation

The medical record documentation should include a history and physical. If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the services that constitute the E/M service and the OMT service. The documentation should clearly identify the body regions affected and treated with OMT in order to support the procedure code(s) reported.

The selection of body region(s) to which OMT is applied should reflect the region(s)of documented somatic dysfunction. There may be instances when multiple regions are treated due to the occurrence of compensatory changes. When this occurs, the documentation should describe the compensatory changes and the rationale for treating this area, especially

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[70] The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology, November 2011.

if the patient has no complaints related to this area. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at areas unrelated to the diagnosis. The type, frequency and duration of OMT should be consistent with current standards of medical practice.

Factors that may affect frequency and duration of treatment are: severity of illness, duration or chronicity of the patient's condition and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician's treatment approach.

The American Osteopathic Association strongly recommends that documentation include a procedure note to detail the regions manipulated, the techniques utilized, and a description of how the patient tolerated the treatment.

OMT Vignettes and Coding Examples

In April 2010, the American Medical Association (AMA) Relative Value Update Committee (RUC) requested that the AOA survey the existing OMT codes to develop accurate and unbiased information for the relative value of the physician work involved in performing OMT as part of the Centers for Medicaid and Medicare Services (CMS) forth fifth year review of RBRVS.

The survey process required the creation of vignettes to describe the typical patient for OMT CPT® Codes 98925-98929. Additionally, the description of the preservice, intraservice, and postservice work for OMT was included. As of January 2012, the vignettes for the typical patient and the preservice, intraservice and postservice descriptors are contained within the RUC database.

There are five OMT Service Current Procedural Terminology (CPT©) Codes (98925-98929). Below find the vignettes, description for the preservice, intraservice and postservice work and coding examples for the OMT codes 98925-98929.

Note: The OMT service codes do not include any elements of the history, examination and medical decision making.

OMT service code 98925: Osteopathic manipulative treatment (OMT); to one to two body regions defined**.**

Vignette:

A 25-year-old female presents with right lower neck pain of two weeks duration. Somatic dysfunction of cervical and thoracic regions are identified on exam.

Description of Preservice Work:

The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intraservice Work:

Patient is initially in the supine position on the treatment table. Motion restrictions of C6 and C7 are isolated through palpation and treated using muscle energy technique. Dysfunctions of T1 and T2 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual

somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
OMT Service code 98926: Osteopathic manipulative treatment (OMT); 3-4 body regions involved
Vignette:
A 39-year-old female presents with right lower back pain of two weeks duration after a lifting injury. Somatic dysfunction of lumbar, pelvis and sacral regions are identified on exam.
Description of Pre-Service Work:
The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc., for a complete list of techniques see the American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic Terminology) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intra-Service Work:
The patient is initially in the prone position on the treatment table. Motion restrictions of sacrum and pelvis are isolated through palpation and treated using muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Post-Service Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
OMT service code 98927: Osteopathic manipulative treatment (OMT); five to six body regions defined.
Vignette:
A 17-year-old male presents with pain in the neck, upper and lower back, right shoulder, and right chest following an injury in a high school football game two days ago. Somatic dysfunctions of the right glenohumeral and acromioclavicular joints, as well as the lower cervical, upper thoracic, right upper costal and lumbar areas are identified on exam.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the

appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
The patient is initially in a side-lying position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: acromioclavicular joint is treated with articulatory technique; glenohumeral and costal dysfunctions are treated with muscle energy technique; cervical spine is treated with counterstrain technique; thoracic and lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
OMT service code 98928: Osteopathic manipulative treatment (OMT); seven to eight body regions defined.
Vignette:
A 64-year-old female, in rehabilitation following a left total knee replacement, presents with swelling in the left lower leg, pain in her low back, hips and pelvis with muscle spasms and numbness and bilateral wrist pain with use of a walker. She has a history of widespread degenerative joint disease with stiffness and pain making it difficult for her to actively participate in her rehabilitation program. Somatic dysfunctions of the lumbar, thoracic and cervical spine, sacrum, pelvis, right leg, and bilateral wrist joints are identified on exam.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
The patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: radiocarpal joints are treated using articulatory and myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated using balanced ligamentous tension technique; dysfunction of C5 through T3, the pelvis and lower extremity are treated with muscle energy technique. Lower extremity edema is treated with lymphatic drainage techniques. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT service code 98929: Osteopathic manipulative treatment (OMT); nine to ten body regions defined.
Vignette:
A 40-year-old male presents with sub-occipital headache, and pain in the neck, upper and lower back, left shoulder and chest, and right ankle. He was involved in a rear-end MVA two weeks ago. X-rays in the ED were negative. He has been taking prescribed analgesic and muscle relaxant medications with minimal improvement. On examination, somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the cervical, thoracic, costal, lumbar, sacral and pelvic regions.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
Patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: occiptoatlantal joint and sacrum are treated using muscle energy and counterstrain techniques; right glenohumeral joint and pelvis are treated with articulatory technique; lumbar, thoracic, cervical and right ankle are treated with passive thrust (HVLA) technique; costal dysfunctions are treated using muscle energy technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide selection of further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

Documenting the Patient Visit: S.O.A.P. Note Example[71]:

Below is an example of a new and established patient encounter and a subjective, objective, assessment and plan (S.O.A.P) note for each to illustrate how to document the patient's visit in the medical record. Other styles and preferences exist for medical record documentation.

Soap Note – New Patient Example

S. A 20-year-old African-American male complains of low back pain that began three days ago after he lifted a heavy object. Cannot straighten up when walking, pain with change of position. The patient denies radiation of pain and areas of numbness, the pain stays along the back and waist. He is comfortable when lying down, aspirin

71 American Osteopathic Association Osteopathic Manipulative Treatment Coding Instructional Manual Second Edition, August 2012.

helps some, has used heat with some help. No prior history of back pain or injury. Denies allergies, medical/surgical history is unremarkable.

O. Tenderness noted over lumbar and sacral regions Inability to extend lumbar spine when standing Flexion posture when standing Muscle spasms noted in paraspinals of the lumbar region Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing Neurologic exam normal.

A. 1. Lumbosacral sprain/strain 846.0/533.8XXA
2. Somatic dysfunction lumbar, sacral 739.3/M00.03 739.4/M99.04

P. 1. OMT (appropriate techniques used) applied to the lumbar and sacral regions
2. Continue aspirin
3. No lifting, bending or twisting
4. Follow up in two days to reevaluate patient progress

CODING FOR THIS CASE

Evaluation and Management: new patient 99203
OMT two body regions: lumbar/sacral 98925

Soap Note-Established Patient Example

S: Patient presents to the office for a reevaluation of lower back pain. He states that the pain has decreased in his low back and that he can get around better. He states that he has no radiation of pain in his legs. He does state that he feels stiff and achy if he tries to do his normal daily activities. He is s till taking aspirin with some relief. Denies GI symptoms from aspirin use.

O. Tenderness with palpation and stretch of the erector spinae muscles
Pain with extension and rotation left of L5
Pain along right SI joint with sacral extension
Motion restrictions of lower lumbar vertebrae and sacrum identified
No muscle spasms noted with active or passive range of motion
Negative neurological exam of lower extremities

A. 1. Lumbosacral sprain/strain
846.0/533.8XXA
2. Somatic dysfunction lumbar, sacral 739.3/M99.03
739.4/M99.04

P. 1. OMT (appropriate techniques used) applied to the lumbar and sacral regions
2. Instructed on proper posture when lifting
3. Increased home activities gradually and to tolerance
4. Follow up if improvement does not continue

CODING FOR THIS CASE

Evaluation and Management: established 99213
OMT two body regions: lumbar/sacral 98925

Reporting E/M Services:

Patients present to the office on the initial or a subsequent encounter to address complaints of pain, strains or other signs or symptoms or to address unresolved issues. As such, an E/M service is provided on the initial and subsequent encounter. Patients do not present to the office for OMT.

The E/M service is a separate service from the OMT service, both are separately reportable and payable. Make sure to document the three key components (history, examination and medical decision making). If utilizing an electronic health record (EHR), ensure that it is capable of capturing all of the history, physical examination and medical decision making and any other service(s) provided on each patient visit.

Per CPT © guidance Evaluation and Management services may be reported separately using Modifier- 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the (OMT) procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for reporting of the OMT and E/M service on the same date.

Below find the description for the preservice, intraservice and postservice work for the E/M Service Code most frequently reported to CMS in CY 2013. The descriptions illustrate the work of the E/M service is significantly, separately, identifiable and above and beyond the usual preservice and postservice work of the OMT service.

E/M service code 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

Description of Pre-Service Work:

Review the medical history form completed by the patient and vital signs obtained by clinical staff.

Description of Intra-Service Work:

- Obtain an expended problem focused history (including response to treatment at last visit and reviewing interval correspondence or medical records received)*
- Perform an expended problem focused examination*
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making)*
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s) o Write prescription(s) o Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:

- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence

- Revise treatment plan(s) and communicate with patient, as necessary

OMT Coding Information:

CPT/HCPCS Codes

98925 Osteopathic Manipulative Treatment (OMT); 1-2 Body Regions Involved
98926 Osteopathic Manipulative Treatment (OMT); 3-4 Body Regions Involved
98927 Osteopathic Manipulative Treatment (OMT); 5-6 Body Regions Involved
98928 Osteopathic Manipulative Treatment (OMT); 7-8 Body Regions Involved
98929 Osteopathic Manipulative Treatment (OMT); 9-10 Body Regions Involved

ICD-9/ICD-10 Diagnosis Codes

ICD-9 Codes:

739.0 Head region
739.1 Cervical region
739.2 Thoracic region
739.3 Lumbar region
739.4 Sacral region
739.5 Pelvic region
739.6 Lower extremities
739.7 Upper extremities
739.8 Rib cage region
739.9 Abdomen and viscera region

ICD-10 Codes:

M99.00 Segmental and somatic dysfunction of head region
M99.01 Segmental and somatic dysfunction of cervical region
M99.02 Segmental and somatic dysfunction of thoracic region
M99.03 Segmental and somatic dysfunction of lumbar region
M99.04 Segmental and somatic dysfunction of sacral region
M99.05 Segmental and somatic dysfunction of pelvic region
M99.06 Segmental and somatic dysfunction of lower extremity
M99.07 Segmental and somatic dysfunction of upper extremity
M99.08 Segmental and somatic dysfunction of rib cage
M99.09 Segmental and somatic dysfunction of abdomen and other regions

OMT Techniques are listed below (Please refer to the AACOM Glossary of OMT Terminology for more information)
Active method
Articulatory method
Articulatory treatment
Articulatory (ART)

Balanced ligamentous tension (BLT)
Chapman reflex
Combined method
Combined treatment
Compression of the forth ventricle (CV-4)
Counterstrain (CS)
Cranial Treatment (CR)
CV-4
Dalrymple treatment
Direct method
Exaggeration method
Exaggeration technique
Facilitated oscillatory release technique (FOR)
Facilitated positional release (FPR)
Fascial release treatment
Fascial unwinding
Functional method
Galbreath treatment
Hepatic pump
High velocity/low amplitude technique
Hoover technique
Indirect method (I/IND)
Inhibitory pressure technique
Integrated neuromusculoskeletal release
Jones technique
Ligamentous articular strain technique (LAS)
Liver pump
Lymphatic pump
Mandibular drainage technique
Mesenteric release technique
Muscle energy
Myofascial release (MFR) direct and indirect
Myofascial technique
Myotension
Osteopathic in the Cranial Field (OCF)
Passive method
Pedal pump
Percussion vibrator technique
Positional technique
Progressive inhibition of neuromuscular structure (PINS)
Range of motion technique
Soft tissue technique
Spencer technique
Splenic pump technique
Spontaneous release by positioning
Springing technique
Still technique
Strain-Counterstrain ®

Thoracic pump
Thrust technique (HVLA)
Toggle technique
Traction technique
V-spread
Ventral techniques

Sources of Information

American Osteopathic Association Osteopathic Manipulative Treatment Coding Instructional Manual Second Edition (2012)
American Osteopathic Association (2014). Position paper on Evaluation and Management services (E/M) with Osteopathic Manipulative Treatment (OMT).
American Osteopathic Association (1998). Protocols for Osteopathic Manipulative Treatment (OMT).
American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic Glossary of OMT Terminology.
American Medical Association (AMA) Current Procedural Terminology (CPT©) 2015 Manual
American Medical Association (AMA) Relative Value Update Committee (RUC) Database

H632-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT--REIMBURSEMENT POLICIES FOR

The American Osteopathic Association will work to ensure that: (1) osteopathic manipulative treatment in any prepaid compensation model be recognized as a separate procedure; (2) osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and surgeons be considered unique; and (3) osteopathic manipulative treatment in any prepaid compensation model be compensated as a special separate procedure, either by payment of additional capitation or on a fee-for-service basis without the need for prior authorization. 1995; revised 2000, 2005, 2010; reaffirmed as amended 2015

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.

H632-A/12 OSTEOPATHIC MANIPULATIVE TREATMENT -- PAYMENT FOR

The American Osteopathic Association will pursue any and all legal and legislative recourse to protect the rights of its member physicians to deliver approved and beneficial modalities of healthcare; objects to any attempt by third party payors to deny or restrict payment for osteopathic manipulative treatment when appropriately rendered by an osteopathic physician; and will continue to oppose any attempt by third-party payers to interchange and/or combine osteopathic manipulative treatment codes with codes used to describe other forms of manual therapy. 1986; revised 1991, 1992, 1997, revised 2002; 2007; reaffirmed as amended 2012

H329-A/13 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) AND EVALUATION AND MANAGEMENT (E&M) ON THE SAME DAY OF SERVICE-- PAYMENT FOR

The American Osteopathic Association supports remuneration for osteopathic manipulative treatment (OMT) and evaluation and management services separately when performed on the same day of service. 1998, revised 2003; 2008; reaffirmed as amended 2013

H216-A/12 OSTEOPATHIC MANIPULATIVE TREATMENT -- SUPERVISION FOR

The American Osteopathic Association strongly encourages all qualified supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them. 1997; reaffirmed 2002; 2007; 2012

H426-A/13 OSTEOPATHIC MANIPULATIVE TREATMENT OF SOMATIC DYSFUNCTION OF THE HEAD, SAFETY IN

The American Osteopathic Association (1) promotes public awareness of the complexity and vulnerability of the human central nervous system; (2) promotes public awareness for the safe intervention of physical forces to the head by the educated hands of a trained osteopathic physician; (3) advocates 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; (4) promotes health care laws which supports the teaching of medical interventions to fully qualified professionals; (5) hold the position 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 osteopathy in the cranial field; and believes that the practice of OMT of somatic dysfunction of the head and osteopathy in the cranial field requires a professional clinical diagnosis, complete medical treatment plan, professional ethics and appropriate follow-up care. 2013

H203-A/14 OSTEOPATHIC MEDICAL EDUCATION

The American Osteopathic Association will establish a mechanism by which input can be contributed from interested stakeholders if a plan is formulated to pilot or implement concepts identified within the blue ribbon commission report. 2014

H201-A/11 OSTEOPATHIC MEDICINE -- AUTONOMY OF

Policy of the American Osteopathic Association states that the osteopathic profession, in the interest of providing the best possible healthcare to the public, shall maintain its status as a complete and distinct philosophy of medicine. 1959; reaffirmed 1965, 1974, 1980, 1985; revised 1990, 1996, 2001; amended and reaffirmed 2006; reaffirmed 2011

H330-A/13 OSTEOPATHIC MEDICINE DEFINITION

The American Osteopathic Association holds as policy the definition of 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. 1991; revised 1992, 1997, 1998, reaffirmed 2003; 2008; reaffirmed as amended 2013

H633-A/12 OSTEOPATHIC MUSCULOSKELETAL EVALUATION
The American Osteopathic Association policy urges the osteopathic physician 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. 1982; reaffirmed 1987; revised 1992, 1997, 2002; 2007; reaffirmed as amended 2012

H401-A/15 OSTEOPATHIC NAME AND IDENTITY
The American Osteopathic Association will advise the Accreditation Council for Graduate Medical Education that MDs who complete osteopathic-recognized residencies should describe themselves as "MDs who have been trained in Osteopathic Manipulative Medicine" and not as Osteopathic Physicians or DOs. 2015

H600-A/10 OSTEOPATHIC NEUROLOGIC AND PSYCHIATRIC STANDARD OF CARE
The American Osteopathic Association acknowledges the role osteopathic manipulative treatment (OMT) has in the specialty of Osteopathic Neurology and Psychiatry and agrees that when OMT is chosen to be utilized with appropriately selected patients, therapeutic boundaries will be maintained and respected. 2010

H206-A/13 OSTEOPATHIC POSTDOCTORAL TRAINING IN ALL SPECIALTY AREAS
The American Osteopathic Association urges the osteopathic profession to reaffirm itself as a complete profession of medicine and surgery and reaffirms its commitment to quality osteopathic postdoctoral training in all specialty areas. 1993; revised 1998, revised 2003; 2008; reaffirmed 2013

H425-A/11 OSTEOPATHIC QUALITY AND OUTCOMES MEASURES
The American Osteopathic Association will assume a leadership role in developing and providing benchmarks that represent the uniqueness of osteopathic care in chronic disease management; specifically in the use of osteopathic manipulative treatment. 2006; reaffirmed as amended 2011

H319-A/11 OSTEOPATHIC TERM PROTECTION
The American Osteopathic Association's policy regarding the preferential terms to be used in reference to the osteopathic profession has been updated over the years. However, we are mindful that there are osteopathic physicians practicing medicine who were granted degrees in "osteopathy." Therefore, the AOA will continue to advocate for the protection of the terms "osteopathic", "osteopathy" and "osteopath" as referenced in state and federal laws and rules. 2006; reaffirmed as amended 2011

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

H601-A/15 OSTEOPATHIC TRAINING POSITIONS IN POST-GRADUATE MEDICAL EDUCATION -- REDUCTION OF

The American Osteopathic Association will work to create parity in reimbursement from the Centers for Medicare and Medicaid Services (CMS) for all osteopathic training to be equivalent to allopathic programs. 2015

H623-A/12 OVERWEIGHT AND OBESITY-- RECOGNITION AS BILLABLE DIAGNOSES

The American Osteopathic Association will work with insurers, the CMS and other third-party payers to recognize obesity as a growing threat to the health and security of our nation; and work so that physicians may be appropriately paid for the treatment and prevention of both overweight and obesity as a primary or secondary diagnoses. 2007; reaffirmed as amended 2012

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

The American Osteopathic Association supports federal funding for chaplain, social work and home health aide provider services for palliative care patients. 2014

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. 1995; revised 2000, 2005, 2010; revised 2015

H313-A/11 PATIENT CARE AT EXTENDED LONG TERM CARE FACILITIES

The American Osteopathic Association encourages the Centers for Medicare and Medicaid Services (CMS) and any other regulatory and non-regulatory entity to: (1) re-evaluate their payment policy to encourage appropriate and adequate care to occur at extended long term care facilities; (2) improve payment to physicians for patient care in extended long term care facilities and to reimburse time spent on phone calls and care plan oversight from extended long term care facilities to physicians; (3) encourage caring physicians to participate in

treatment of their patients at their respective extended long term care facilities; and (4) encourages appropriate tort reform to eliminate less than meritorious claims of elder abuse and malpractice in extended long term care facilities. 2006; reaffirmed as amended 2011

H331-A/13 PATIENT CONFIDENTIALITY

It is policy of the American Osteopathic Association that in such cases where the physician is bound by law to protect patient confidentiality, the physician shall only be required to provide information that can be disclosed under law and where possible, the physician shall be allowed to submit narrative reports or only copies of the part of a medical record that is pertinent in lieu of a complete record. 1993; reaffirmed 1998; revised 2003; 2008; reaffirmed 2013

H413-A/13 PATIENT EDUCATION

The American Osteopathic Association reaffirms its commitment to the advancement of patient education to promote a better understanding of personal health and wellness. 1983; revised 1988, 1993, 1998, 2003; 2008; reaffirmed 2013

H613-A/11 PATIENT INTERPRETERS

The American Osteopathic Association supports efforts to remove an unfunded mandate on physicians by revising the current federal policy that requires interpreters for Limited English Proficiency (LEP) patients and requests the Centers for Medicare and Medicaid Services (CMS) to implement reasonable reimbursement for interpretive services. 2001; amended 2006; reaffirmed as amended 2011

H616-A/15 PATIENT PARTICIPATION IN THEIR HEALTH CARE, ENCOURAGING

The American Osteopathic Association recommends that all insurance companies consider the establishment of a system for rewarding those patients who are trying to stay health as a means of decreasing the amount of money spent on health care. 2010; reaffirmed 2015

H306-A/11 PATIENT-PHYSICIAN RELATIONS

The American Osteopathic Association rejects any claim of a right to censorship of professional communication, in any regard, and for any reason; will work to secure enactment of legislation protecting these necessary rights of patients and physicians; and will continue to oppose any and all attempts to impede the nature of the patient-physician relationship. 1991; revised 1996, 2001; reaffirmed 2006, reaffirmed as amended 2011

H326-A/12 PATIENT SAFETY

The American Osteopathic Association endorses the policy of patient safety in health care that encourages payers to provide adequate reimbursement so that hospitals can provide the best quality care in the safest of environments. 2002; 2007; reaffirmed as amended 2012

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

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

H642-A/12 PAYMENT FOR PSYCHIATRIC DIAGNOSES AND TREATMENT BY PRIMARY CARE PHYSICIANS

The American Osteopathic Association: (1) strongly objects to any insurance plan refusal to pay primary care physicians for treating patients with psychiatric diagnoses without a referral from the behavioral medicine agency or provider; (2) will make every effort to influence these insurers to reverse this policy and allow primary care physicians to provide care for these patients and be paid for these services; and (3) will communicate with the Department of Health and respective third-party payers to eliminate the mandatory referral in order to be paid when proper documentation is provided. 2007; reaffirmed as amended 2012

H629-A/11 PAYOR ADHERENCE TO CURRENT PROCEDURAL TERMINOLOGY (CPT) AND INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODING DEFINITIONS

The American Osteopathic Association will assume a leadership role in working with other health professions and Congress to mandate that all payors adhere to all CPT coding conventions in developing payment policies; and will continue support for action to prevent payors from deviating from CPT definitions and promote autonomous, fair, and uniform interpretation of CPT and ICD codes to allow for non-prejudicial treatment by payors in the reimbursement arena. 2006; reaffirmed as amended 2011

H414-A/13 PEDIATRIC DRUG TESTING

The American Osteopathic Association supports legislation requiring all pharmaceutical companies to ensure all medications with potential therapeutic benefits for children are tested for their use and that all new appropriate medications to be studied in children at the same time, or soon after, the drug is approved for use in adults. 2003; 2008; reaffirmed 2013

H417-A/13 PEDIATRIC MEDICAL IMAGING

The American Osteopathic Association supports the reduction of excess ionizing radiation exposure of the pediatric population and urges its members involved in medical imaging of pediatric patients to review the latest research and educational materials from the National Cancer Institute and other organizations and pledge to do their part to "child-size" the radiation dose used in children's imaging. 2008; reaffirmed as amended 2013

H423-A/13 PEDIATRIC OBESITY

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 (2008; reaffirmed as amended 2013):

(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 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.

H625-A/15 PEDIATRIC PSYCHIATRIC CARE

The American Osteopathic Association supports the development of educational programs to assist primary care physicians to identify and initiate appropriate support of pediatric psychiatric care and encourages insurance providers to adequately reimburse counseling and psychiatric care deemed necessary by the patient's primary care physician. 2005; reaffirmed 2010; 2015

H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY

The American Osteopathic Association supports environmentally responsible packaging of samples. 1991, reaffirmed 1994, 1999; revised 2004; reaffirmed 2009; 2014

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

The American Osteopathic Association will work with the appropriate regulatory / environmental and public health agencies to encourage the development of educational materials for the public on the dangers of keeping unused and expired pharmaceuticals in their possession; and will insure that such materials also include education on the proper disposal of unused and expired pharmaceuticals. 2004; reaffirmed 2009; 2014

H436-A/12 PHYSICAL EDUCATION FOR GRADES K-12 - DAILY

The American Osteopathic Association supports daily physical education for all US students in grades K-12. 1981; reaffirmed 1986; revised 1991, 1992; reaffirmed 1997, revised 2002; revised 2007; reaffirmed as amended 2012

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

H247-A/04 PHYSICIAN ADMINISTERED OMT

The American Osteopathic Association actively opposes the use of Osteopathic Manipulative Treatment (OMT) / Current Procedural Terminology (CPT) codes by groups other than fully-licensed osteopathic and allopathic physicians and will work diligently to reverse such policies, wherever they exist, that allow non-physicians to utilize OMT/CPT codes for reimbursement. 1994; revised 1999, 2004

H441-A/12 PHYSICIAN ASSISTED DEATH

The American Osteopathic Association: (1) will provide information on the care of the seriously ill to physicians and the public; (2) will provide osteopathic physicians with continuing medical education on palliative therapies utilized to provide patients with an improved quality of life; (3) recommends that osteopathic medical colleges and osteopathic post-graduate medical education programs include specific courses of study on pain management and palliative care of the seriously ill, specifically addressing the goals, objectives and value of hospice and palliative medicine; (4) urges that continuing medical education programs include information and resources for physicians on supportive care valuable to their patients, including, but not limited to hospice and palliative care; (5) urges that the osteopathic profession take a leadership role in providing the public with information on the alternatives to physician assisted death; (6) recognizes that physician assisted death ("death with dignity") is a complex biomedical and ethical issue that merits serious discussion within our profession; and (7) opposes legislation that mandates or legalizes individual physician participation in physician assisted death. 1997; reaffirmed 2002; 2007; reaffirmed as amended 2012

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

The American Osteopathic Association's policy on co-management of a patient, requires the patient to have an examination by the physician who will be performing the procedure; the physician providing the procedure be available for the follow-up care of the patient; and if for any reason the physician providing the procedure cannot provide the pre- and post-procedural care to the patient, that he/she arrange for an osteopathic or allopathic physician to provide for the pre-procedural and post-procedural care. In cases where only physician extenders are available, appropriate physician supervision should continue as defined by state law. 2002, revised 2003; reaffirmed 2008; reaffirmed as amended 2013

The American Osteopathic Association (AOA) adopts the following principles on physician comparative utilization and physician profiling (2006; reaffirmed as amended 2011).

1. Comparative utilization or physician profiling should only be used to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should only be disclosed to the physician involved. If comparative utilization or physician profiling data were to be made public, assurances should be in place that ensures rigorous evaluation of the measures to be used by practicing physicians and that only measures that are deemed sensitive and specific to the care being delivered are used.
3. Physicians should be compared to other physicians with similar practice mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide OMT to their patients.
4. Matrixes within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, measure sets and/or data points should be evidenced-based and vetted by relevant physician specialty or professional societies.
5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program(s) should not adversely impact the physician-patient relationship or unduly intrude upon physicians' medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system (i.e., defensive medicine).
6. Practicing physicians must be involved in the development of measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. That all physicians shall have full access to their report cards to verify the accuracy of the data prior to the dissemination of information to patients and the public.
9. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.
10. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
11. The osteopathic profession should have representation on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program.

H614-A/15 PHYSICIAN COMPETENCY RETESTING

The American Osteopathic Association: (1) supports the mission of physician competency, the quality movement and patient safety through self-regulation mechanisms rather than through government mandated retesting for purposes of obtaining relicensure or for receiving payment under a health benefits program. (2) continue its voluntary efforts to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels, physician assessment through osteopathic continuous certification and its AOA Clinical Assessment Program (CAP). 1988; reaffirmed 1993; revised 1998, 2003; revised 2008; revised 2010; reaffirmed as amended 2015

H312-A/12 PHYSICIAN CONSULTATION FOR FORMULARIES

The American Osteopathic Association supports legislation that requires a physician be available for consultation in a timely manner on pharmaceutical formulary and drug substitution decisions. 2007; reaffirmed 2012

H606-A/12 PHYSICIAN DEPOSITIONS

The American Osteopathic Association believes that physician s being deposed should have the right to review and amend the deposition prior to submission and be provided a complete, final copy of the deposition. 2012

H333-A/13 PHYSICIAN FEES AND CHARGES

The American Osteopathic Association upholds the following policy on Physician Fees and Charges (1998, reaffirmed 2003; 2008; reaffirmed as amended 2013):

PHYSICIAN FEES AND CHARGES

1. *Physician's Fees*

   A physician's fees should be based on the medical services provided to the patient, with due respect for:

   a. The difficulty and/or uniqueness of the services;
   b. The time, skill, and experience required;
   c. Customary fees charged for the same service in the same community;
   d. Overhead and professional liability costs.

2. *Excessive Fees*

   A physician should not collect excessive fees.

3. *Reduced Fees*

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

4. *Specialty Designation*

   A fee should not be dependent upon a physician's specialty designation but upon the services provided. Any physician who provides a service for

which he/she is properly trained has the right to charge the prevailing rate for such service, whether the service is performed by a family physician, a surgeon, an internist, or any other specialist.

5. Contingency Fees

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

6. Division of Fees

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

7. Fee Splitting

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

8. Referrals to Suppliers

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

9. Form Completion Charges

A physician may charge for completion of forms.

10. Copying Charges

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

11. Missed Appointments

A physician may ethically charge for missed appointments, or appointments cancelled less than 24 hours in advance, provided:

a. The patient has been previously notified in writing of the policy;
b. Utmost consideration is given to the patient, including the circumstances involved;
c. The practice is resorted to infrequently;
d. The physician's patient load is considered.

12. Delinquent Accounts

Harsh or grossly commercialized collection practices are discouraged. If a physician has experienced problems dealing with patients who have delinquent accounts, he/she may properly request payment for service at

the time of treatment, or may add interest or other late-payment charges in accordance with state and federal laws. The patient must be notified of such a policy in advance by one or more of the following:

a. Posting a notice in the waiting room;
b. Distribution of patient handbooks containing the policy;
c. Notification by special letter;
d. Notation of the policy on the billing statement before the charge is incurred.

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

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

13. Legal Restrictions

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

H629-A/12 PHYSICIAN FINES IMPOSED BY THIRD PARTY PAYORS

The American Osteopathic Association opposes all punitive fines levied on physicians for acts committed by patients that are not under the absolute control of the physician. 2007; reaffirmed 2012

H334-A/13 PHYSICIAN HEALTH ASSISTANCE

The American Osteopathic Association supports continued assistance in the rehabilitation of the impaired osteopathic physicians through its Bureau of Membership. 1973; reaffirmed 1978; revised 1983, 1988, 1993, 1998, 2003; revised 2008; reaffirmed as amended 2013

H324-A/15 PHYSICIAN INCENTIVES--TO UNDERSERVED AREAS

The American Osteopathic Association will focus attention on potential legislation to increase physician loan repayment programs and tax deductions or tax credits when initiating a practice in underserved areas to assist and assure an adequate supply of physicians in the future. 2005; reaffirmed 2010; 2015

H614-A/11 PHYSICIAN NEGOTIATION RIGHTS

The American Osteopathic Association will pursue legislation to allow physicians to jointly negotiate with third-party payers thereby creating an equitable basis for negotiations between these parties. 2001; amended and reaffirmed 2006; reaffirmed as amended 2011

H318-A/15 PHYSICIAN OFFICE LABORATORIES

The American Osteopathic Association supports the development and expansion of Waived Physician Office Laboratory testing and will work to ensure that physician office laboratory certification be as non-intrusive into the practice of medicine as possible; and will seek assurances that access to any laboratory tests deemed medically necessary by the physician, not be limited by unnecessary regulations. 1990; revised 1995, 2000, 2005, 2010; revised 2015

H620-A/12 PHYSICIAN / PATIENT EDUCATIONAL MATERIALS RECEIVED FROM PHARMACEUTICAL COMPANIES THAT PRODUCE AND/OR MARKET GENERIC MEDICATIONS

The American Osteopathic encourages pharmaceutical companies that produce and/or market generic medications to provide educational materials about their products to both physicians and patients. 2007; reaffirmed 2012

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. 2013

H400-A/15 PHYSICIAN-PATIENT RELATIONSHIP -- BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGENTS

The American Osteopathic Association opposes any interference in the physician-patient relationship by persons with financial and business interests regarding a personal injury incident. 2015

H634-A/12 PHYSICIAN PAYMENT IN FEDERAL PROGRAMS

The American Osteopathic Association recommends that educational programs for osteopathic medical students, interns, residents and practicing physicians should include utilization management and cost-effectiveness in the curricula; 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 managed care for capitated 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 as established by the osteopathic profession. 1986; revised 1991, 1992, 1997; reaffirmed 2002**;** 2007; reaffirmed as amended 2012

H621-A/11 PHYSICIAN PRESCRIPTION FOR OVER-THE-COUNTER MEDICATION TAX-PREFERRED ACCOUNT REIMBURSEMENT, OPPOSITION OF REQUIREMENT OF

To reduce needless cost and liability, the American Osteopathic Association actively supports legislative efforts to repeal the provision of the Patient Protection and Affordable Care Act (PPACA) which requires over the counter medication purchases to have a physician prescription in order to qualify for reimbursement through flexible spending accounts, health savings accounts and other tax-preferred accounts. 2011

H615-A/11 PHYSICIAN PROFILES

It is the American Osteopathic Association's position that state medical or osteopathic boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to collect, maintain, and disseminate physician profile information to the public; supports the position that any legislation or regulations which mandate the release of physician profile information provide funding for the creation and maintenance of the profiling system without added expense to the physician; supports the position that only physician profiles that incorporate all of the following five principles (fairness, relevancy, timeliness, accuracy, and reliability) should be released to the public; opposes the inclusion of medical malpractice histories within physician profiles due to their susceptibility to misinterpretation and inherently prejudicial effect; supports the position that before physician profiles are released to the public, every physician has the opportunity to verify the accuracy of the information and to contest any incorrect information before it is disseminated to the public; and believes that the state licensing boards must include an appeal mechanism in their regulations that a physician may pursue if any information in his or her profile is inaccurate, and institute appropriate corrections. 2001; reaffirmed 2006 [Editor's note: This policy has been referred to develop an updated policy in light of all organizations profiling physicians – 2011]

H604-A/15 PHYSICIAN QUALITY REPORTING AND PAY FOR PERFORMANCE

In an effort to support the establishment of an 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 reimbursements, 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.
11. The AOA believes that patient satisfaction measures should be limited to easily definable measures.

H347-A/13 PHYSICIAN PAYMENT FOR ELECTRONIC ADVICE, COUNSELING AND TREATMENT PLANS

The American Osteopathic Association will continue to implement strategies for payers to include as a benefit for physicians to receive payment for professional advice, consultation and development of patient treatment plans provided to patients, family members or designee through telephone or other electronic interactions. 2008; reaffirmed as amended 2013

H311-A/12 PHYSICIAN ROLE IN GOVERNANCE OF FEDERALLY CONTRACTED QUALITY IMPROVEMENT ORGANIZATIONS (QIOS) - REDUCED

The American Osteopathic Association supports the concept of improving diversity of representation on the governing bodies of Quality Improvement Organizations (QIOs) via the inclusion of non-physician professionals and consumers; and expresses deep concern and will forcefully advocate against any guidelines that would seek to link federal contracting with QIOs when the governing bodies of these organizations are comprised of a majority of non-physicians, since this is antithetical to the fundamental principles of physician peer review and evidence based quality improvement. 2007; reaffirmed 2012

H421-A/11 PHYSICIAN SUPPLY IN RURAL UNITED STATES-- RECOMMENDATIONS FOR IMPROVING

The American Osteopathic Association will work toward improving rural physician supply and monitor the potential for nationwide implementation of the following recommendations (2011):

RECOMMENDATIONS FOR IMPROVING PHYSICIAN SUPPLY IN RURAL AMERICA, 2011

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, the Texas Medical Association, and the Texas Osteopathic Medical Association, 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, 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 and should seek professional advice before signing hospital employment contracts, including resources provided by the Texas Medical Association and the Texas Osteopathic Medical Association.

2. Support Promotion of Rural Practice

- Information on rural physician shortage areas should be readily available through coordinated websites of state agencies such as the Texas Department of State Health Services, the Texas Medical Board, area health education centers, and the Texas Department of Rural Affairs, to practicing physicians, medical students, and residents seeking rural practice opportunities, as well as to underserved communities. To assist physicians in selecting practice opportunities, comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics {percentage child-bearing (for obstetric al 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, 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.
- Physicians should be informed by state authorities, including the Texas Medical Board, of the unique peer review services offered by the Knowledge, Skills, Training, Assessment, and Research (KSTAR) Program at Texas A&M University Health Science Center 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 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, the Texas Medical

Association, and the Texas Osteopathic Medical Association. Further, when licensed physicians allow their Texas medical license to lapse, they should be informed by the Texas Medical Board 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 by the Texas Department of Rural Affairs for their potential impact on the viability of rural practices. The Texas Medical Association and the Texas Osteopathic Medical Association should continue to advocate for reimbursement parity between Medicaid and Medicare beyond the two-year period authorized by the Affordable Care Act. In addition, reimbursement 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 the Texas Medical Board, the Texas Medical Association, the Texas Osteopathic Medical Association, and other 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 screening criteria should be used by 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 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 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.

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

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

H410-A/11 PLASTIC BEVERAGE AND FOOD CONTAINER RECYCLING ACT

The American Osteopathic Association supports conservational recycling and encourages that materials are made from recycled products. 1990, revised 1995; reaffirmed 2000; reaffirmed 2006; reaffirmed as amended 2011

H209-A/12 POSTDOCTORAL FELLOWSHIPS -- INCREASING

The American Osteopathic Association will collect fellowship data including type, certification, location and AOA resident eligibility; will propose methods to initiate or increase AOA fellowships in those areas of shortage; and will provide that information to osteopathic medical students and to the AOA specialty colleges for dissemination to its directors of medical education, program directors and residents. 2012

H319-A/15 POSTGRADUATE COMPENSATION

The American Osteopathic Association affirms its support for maintaining and enhancing the quality of teaching programs, and urges Congress to provide more equitable graduate medical education funding so hospitals and other healthcare delivery systems can provide competitive compensation for postgraduate training. 1990; revised 1995; reaffirmed 2000, revised 2005, reaffirmed 2010; 2015

H615-A/13 POSTPARTUM DEPRESSION

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

H313-A/15 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

The American Osteopathic Association and its component societies be encouraged to promote 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) Educate physicians as to the importance of compliance, risk management, at risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues. (2). Identify supportive agencies, liability companies, and physicians with expertise in these issues. (3) Encourage government and insurance agencies 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) Develop and advise the leadership and state societies of the needs, trends, and issues of concern which will encourage unity, and enhance the practice rights of our fellow 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

H619-A/12 PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES - DENIAL OF PAYMENT OF

The American Osteopathic Association supports legislation that would prohibit any healthcare insurer from retrospectively denying payment for any medical or surgical service or procedure that has already been pre-authorized by such health insurer; and, furthermore, any such letters by health insurers to physicians and patients indicating that the medical services/procedures that have been pre-authorized may not necessarily be compensated for should cease and desist. 1997; revised 2002; 2007; reaffirmed 2012

H348-A/13 PRE-FILLED MEDICAL NECESSITY FORM

The American Osteopathic Association encourages physicians to verify directly with patients that the patient is in need of supplies and supports disclosure regarding medical necessity and making it inappropriate for supply companies to provide physicians with medical necessity certification forms on which the quantity or indication of a need for a product is pre-filled. 2008; reaffirmed 2013

H429-A/12 PRENATAL AND PEDIATRIC HOSPICE AND PALLIATIVE CARE – SUPPORT FOR

The American Osteopathic Association endorses the practice of hospice and palliative medicine in prenatal and pediatric patient populations; urges that osteopathic physicians providing prenatal care or consultation be knowledgeable about the existence and availability of prenatal hospice and palliative care, and offer it as an option to parents of a baby with a

fatal fetal anomaly; and supports organizations dedicated to the promotion, education and provision of prenatal and pediatric hospice and palliative care. 2007; reaffirmed 2012

H327-A/12 PRESCRIPTION DRUG SAMPLES

The American Osteopathic Association supports the enactment of appropriate criminal penalties for those who illegally divert such samples; opposes any legislation which intends to restrict drug sampling; and encourages pharmaceutical manufacturing companies to continue the effective practice of drug sampling. 1994; revised 1997, 2002; 2007; reaffirmed as amended 2012

H325-A/15 PRESCRIPTION DRUGS -- DIRECT CONSUMER ADVERTISING

The American Osteopathic Association encourages pharmaceutical companies to develop disease-specific public health education as the focus of direct to consumer advertising of prescription medicines. These ads should refer patients to their physician should they need additional information. 2001; revised 2003, 2005; revised 2010; reaffirmed 2015

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.

The AOA opposes the imposition of administrative or financial deterrents that decrease access to and coverage of prescription drugs with abuse-deterrent properties. 2015

H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES

The American Osteopathic Association believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice. 1995; reaffirmed 2000, 2005, 2010; 2015

H624-A/15 PRESCRIPTION MEDICATIONS--OVERRIDES FOR

The American Osteopathic Association support legislative efforts to: (1) decrease the hold time for physicians and staff for requesting approval from insurance pharmacy plans, (2) require insurance pharmacy plans to allow patients to continue receiving the medications for which they are prescribed and are in good control; and (3) make it easier for a physician to request an approval. 2005; reaffirmed 2010; 2015

H235-A/13 PRESCRIPTION PLANS--RESTRICTIVE

The American Osteopathic Association urges state legislatures to pass laws that would: (1) Mandate that insurance companies and managed care organizations use the term limited prescription plan, limited paid prescription plan, or similar terminology, in their marketing of such products to their customers, unless such plans pay for all prescription pharmaceuticals currently recognized by the FDA as safe and effective; (2) Require truth in advertising and prohibit insurance companies and managed care organizations marketing such plans from restricting their reimbursement for pharmaceuticals to formularies or other devices intended to limit patient and physician choice to a narrow list of approved medications; and (3) Prohibit these companies from mandating the use of generic drugs to the exclusion of proprietary pharmaceuticals. 1998, revised 2003; 2008; reaffirmed 2013

H310-A/12 PRESERVATION OF ANTIBIOTICS FOR MEDICAL TREATMENT

The American Osteopathic Association supports legislation that would ban feed additive uses of antibiotics for non-therapeutic uses in animals such as for growth promotion, feed efficiency, weight gain, routine disease prevention or other routine purposes. 2007; reaffirmed 2012

H602-A/12 PRIMARY CARE INCENTIVE PROGRAM -- ADJUSTMENT TO

The American Osteopathic Association is supportive of a 10% incentive payment to primary care physicians and non-physician providers (NPPs), 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. 2012

H311-A/13 PRIMARY CARE PHYSICIANS IN HEALTH PROFESSIONAL SHORTAGE AREAS -- MODEL FUNDING TO INCREASE

The American Osteopathic Association encourages state and federal US medical student funding agencies to provide loans to US citizens and permanent residents from federally designated Health Professional Shortage Areas (HPSA) when they commit to practice in the same HPSA; and encourages state and federal US medical student funding agencies to provide medical school loan forgiveness for US citizens and permanent residents from federally designated HPSA for each year they practice in the same HPSA. 2013

H309-A/13 PRIMARY CARE PHYSICIANS MENTORING PROGRAMS IN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA) -- FUNDING TO INCREASE

The American Osteopathic Association encourages state and federal agencies to provide funds to US osteopathic and allopathic medical schools to develop and maintain informational curricula programs, and mentoring of US citizens and permanent residents from federally designated Health Professional Shortage Areas (HPSA), for high school through the first year in primary care which encourage long-term primary care medical practice in HPSA; and encourages state and federal agencies to provide medical school loan forgiveness for osteopathic and allopathic medical schools for the aforementioned loans for each year they deliver high school through the first year in primary care practice informational curriculum and mentoring of US citizens and permanent residents from federally designed HPSA that encourage long-term primary care practice in federal designated HPSA. 2013

H217-A/12 PRIMARY CARE PHYSICIANS -- TRAINING REAFFIRMATION

The American Osteopathic Association reaffirms its commitment to train competent and compassionate primary care physicians. 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed as amended 2012

H625-A/11 PRIOR AUTHORIZATION FOR PAYMENT OF MEDICAL SERVICES

The AOA approves the attached statement of principles for prior authorization; and will communicate these principles to payors implementing or using prior authorization procedures (2006; reaffirmed as amended 2011).

STATEMENT OF PRINCIPLES ON THE IMPLEMENTATION AND USE OF PRIOR AUTHORIZATION PROGRAMS

- Prior authorization should be implemented only after a payor has evidence that the majority of physicians in their panel are not following recognized diagnostic and/or treatment guidelines and efforts to educate physicians have failed to impact utilization.
- When implemented, prior authorization requirements should be imposed only on those physicians identified as having risk-adjusted utilization outside of recognized guidelines.
- Prior authorization procedures should be as minimally intrusive on the physician and medical staff as possible.
- Prior authorization procedures should be evaluated following implementation for their impact on access to care, cost of care, cost of administration of the program (including physician costs), and whether the program has had a positive effect on moving utilization of the procedures covered by the program into alignment with recognized diagnostic and therapeutic guidelines.
- Prior authorization programs not showing positive impact on the quality of care should be discontinued.

H219-A/14 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.

H336-A/13 PROFESSIONAL LIABILITY INSURANCE REFORM

The American Osteopathic Association continues support of professional liability insurance reform that includes the following six 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) periodic payment of future expenses or losses; (3) offsets for collateral sources; (4) joint and several liability reform; (5) limitations on attorney contingency fees; (6) establishment of uniform statutes of limitations; and (7) 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. 1985; revised 1990, 1993, 1998, 2003; revised 2008; reaffirmed 2013

H334-A/15 PROFESSIONAL ORGANIZATION--PHYSICIANS CHOOSING TO WHICH THEY BELONG

The American Osteopathic Association supports all physicians having the right to choose which medical associations they join, even when the employer is paying the membership fees; and will provide the physician with a letter template stating their desire to have dues paid to an osteopathic medical association. 2005; reaffirmed 2010; 2015

H336-A/14 PROMOTING DIVERSITY IN AOA MEMBERSHIP AND LEADERSHIP

The American Osteopathic Association reaffirms its commitment to promote 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 enrollment of these groups at colleges of osteopathic medicine; and will work to identify and encourage 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

H207-A/11 PROMOTION OF OSTEOPATHIC MEDICINE TO DISADVANTAGED HIGH SCHOOL STUDENTS

The American Osteopathic Association encourages colleges of osteopathic medicine to identify and support outreach programs for disadvantaged high school students in their communities for successful health careers in osteopathic medicine. 2011

H407-A/12 PROSTATE CANCER, PSA-BASED SCREENING FOR

The American Osteopathic Association recognizes and promotes the importance of the integrity of the patient-physician relationship and recommends that prostate cancer clinical preventive screenings be individualized. 2012

H304-A/15 PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN FOREIGN MEDICAL SCHOOLS

The American Osteopathic Association will officially adopt and advocate for the position that federal student loans shall be restricted from medical schools not subject to the accreditation standards of the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education. 2015

H405-A/15 PROTECTION OF SAFE WATER SUPPLY

The American Osteopathic Association (AOA) will encourage the oil industry and the Environmental Protection Agency (EPA) to seek out new technologies for safer disposal of waste well water and the protection of our water supply. 2015

H618-A/15 PROVIDER TAX
The American Osteopathic Association opposes any effort by a state or the federal government to impose a provider tax of any type. 2010; reaffirmed 2015

H212-A/14 PSYCHIATRY CURRICULUM AND STAFFING
The American Osteopathic Association supports the use of members of the American College of Osteopathic Neurology and Psychiatry and their commitment to serve as a resource for developing core competencies and learning objectives for osteopathic psychiatry both in undergraduate and graduate medical education. 2009; reaffirmed 2014

H424-A/12 PUBLIC HEALTH SERVICE -- AOA SUPPORT
The American Osteopathic Association recognizes the contribution of the US Public Health Service (PHS) Commissioned Corps to the healthcare of the United States and supports the continued existence of the United States Public Health Service Commissioned Corps. 1981; revised 1986; reaffirmed 1991, 1992, 1997, 2002; 2007, 2012

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 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

H317-A/11 QUALITY IMPROVEMENT ORGANIZATIONS (QIO)
The American Osteopathic Association will work with the Centers for Medicare and Medicaid Services to require that the care guidelines used by Quality Improvement Organizations be made available to physicians and hospitals free of charge. 2006; reaffirmed 2011

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 osteopathic physicians may educate their patients of both the safety concerns and the health risks of consuming raw milk. 2009; reaffirmed 2014

H622-A/11 READMISSION RATES BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS A CRITERION FOR RANKING -- OPPOSITION TO USE OF

The American Osteopathic Association is opposed to the use of readmission rates as a criterion for deciding payment for physicians and the use of readmission rates as a criterion for ranking the quality of care provided by physicians. 2011

H316-A/12 RECOUPMENT LAWS

The American Osteopathic Association calls upon the U.S. Congress to pass federal legislation which subjects all parties to the same terms and time frame for billing, payment and appeal. 2002; 2007; reaffirmed as amended 2012

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

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

H349-A/13 REFERRALS AND CONSULTS -- NON-PHYSICIAN DISCLOSURES

The American Osteopathic Association recommends that a patient referred to a physician specialist should be seen and evaluated by a physician specialist and that any care by anon-physician in a specialist's office / clinic be disclosed to the patient and referring physician before the care is provided. 2008; reaffirmed 2013

H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

The American Osteopathic Association will include in its work plan investigation and recommendations for a framework for diagnostic and procedure coding, along with associated payment policies, for physician time spent obtaining required Medicare pre-certifications or pre-authorizations for those designated services or prescriptions and provide a template for use by state affiliates for third party payers within the jurisdiction of their state. 2015

H318-A/11 REIMBURSEMENT OF STATE AND FEDERAL DISEASE PREVENTION AND CONTROL RECOMMENDATIONS

The American Osteopathic Association will meet with the Centers for Medicare and Medicaid Services (CMS) and major healthcare payors to discuss and work to find solutions which allow payors to rapidly adjust their payment policies to coincide with state and federal disease prevention and control recommendations. 2006; reaffirmed 2011

H305-A/15 REMOVAL OF FDA BAN ON ANONYMOUS SPERM DONATION FROM MEN WHO HAVE SEX WITH MEN

The American Osteopathic Association (AOA) will call for an end to the five-year deferment period for anonymous sperm donation for men who have sex with men, and modify the exclusion criteria for men who have sex with men to be consistent with deferrals for those to be judged at an increased risk of infection. The AOA supports lobbying measures with the intention of amending this policy. 2015

H425-A/12 REPRODUCTIVE ISSUES -- COUNSELING FEMALE PATIENTS ON

The American Osteopathic Association will take whatever actions are necessary to ensure that osteopathic physicians can continue to offer their patients complete, objective, informed advice in a confidential, culturally sensitive manner on all aspects of reproductive issues. 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed as amended 2012

H208-A/12 RESIDENCY FUNDING -- ADDITIONAL METHODS OF

The American Osteopathic Association will study, develop and promote additional funding methods for osteopathic graduate medical education (OGME). 2012

H252-A/04 RESIDENCY TRAINING SLOTS

The American Osteopathic Association will work toward (1) Health Maintenance Organizations (HMOs) being encouraged by the appropriate state agency to provide funding for graduate medical education (GME) training programs and (2) encouraging state societies to introduce and support the enactment of the Physician Education Advancing Community Health (PEACH) program model legislation developed by the Bureau of State Government Affairs to effect changes in funding GME training programs. 1999; revised 2004; 2009

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 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 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.

H314-A/15 RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS

The American Osteopathic Association discourages the placement of medical practices in retail settings and limited service health clinics that promote and sell tobacco because it is contrary to the efforts and standards of the health care community at large. 2010; revised 2015

H341-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 seeks changes in statutes and regulations that will allow physicians individually and as defined groups be allowed to negotiate fair contracts with private sector and public sector health plans. 2009; reaffirmed 2014

H337-A/13 RURAL HEALTH CARE PAYMENT EQUITY

The American Osteopathic Association endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality healthcare in rural areas. 1988; revised 1993; reaffirmed 1998, 2003; 2008; reaffirmed 2013

H253-A/04 RURAL HEALTH CLINICS--LOCATION AND QUALITY OF CARE

The American Osteopathic Association supports the concept that federal and state tax dollars should not be used to support rural health clinics that choose to locate within the vicinity of an established, private physician's healthcare facility rather than other sites within medically underserved areas. 1999; revised 2004; 2009

H202-A/11 RURAL SITES AND UNDERSERVED/INNER CITY AREAS -- OSTEOPATHIC EDUCATION

The American Osteopathic Association, working with the American Association of Colleges of Osteopathic Medicine (AACOM), will encourage clinical rotations in underserved areas, including rural office/hospital settings as well as inner city office/hospital settings, by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs. 2001; modified and reaffirmed 2006; reaffirmed 2011

H309-A/12 RURAL AND URBAN PRACTICES, DISPARITIES BETWEEN

The American Osteopathic Association supports federal legislation that would sustain a minimum geographic cost-of-practice index value for physicians' services at or above 1.000. 2002; revised 2007; reaffirmed 2012

214-A/15 RURAL SITES--OSTEOPATHIC EDUCATION IN

The American Osteopathic Association encourages clinical rotations in rural settings by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs.1990; revised 1995, 2000, 2005, 2010; 2015

H254-A/04 SALE OF HEALTH-RELATED PRODUCTS AND DEVICES

The American Osteopathic Association believes that it is (1) appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data and, in the opinion of the physician, are medically necessary or will provide a significant health benefit provided that such action is permitted by the state licensing board(s) of the state(s) in which the physician practices; and (2) inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to distribute health related products or devices in which distribution results in a profit for the physician. 1999; revised 2004; reaffirmed as amended 2009

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

H350-A/13 SCOPE OF PRACTICE STATEMENT BY THE AMERICAN OSTEOPATHIC ASSOCIATION FOR OSTEOPATHIC MANIPULATIVE MEDICINE
The AOA has available an official statement that can be presented to all third parties outlining the use of osteopathic manipulative treatment as an integral facet of osteopathic medicine. 2008; reaffirmed as amended 2013

H426-A/12 SCHOOL BASED HEALTH EDUCATION--PROMOTION
The American Osteopathic Association will continue to urge the state legislatures to enact measures establishing programs that meet with the Centers for Disease Control and Prevention definition of comprehensive school health education. 1992; reaffirmed 1997, revised 2002; 2007; reaffirmed 2012

H409-A/15 SEAT BELT LAWS -- PRIMARY ENFORCEMENT
The American Osteopathic Association endorses the passage of primary enforcement seat belt laws in every state. 2005; reaffirmed 2010; 2015

H320-A/15 SECOND OPINION -- SURGICAL CASES
The American Osteopathic Association believes that AOA members who are board certified, or board eligible and qualified by their training and experience to render a second surgical opinion in any given case, be recognized and utilized as qualified and reimbursed by entities underwriting such opinions and that this policy statement in no way advocates the institution of any mandatory second surgical opinion programs, by any entity. 1980; revised 1985, 1990; reaffirmed 1995; revised 2000, 2005, revised 2010; revised 2015

H318-A/12 SEXUAL HARASSMENT
The American Osteopathic Association urges the enactment of appropriate legislation to eliminate all sexual harassment. 1992; reaffirmed 1997, revised 2002; 2007; reaffirmed as amended 2012

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, 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

H432-A/12 SINGLE USE DEVICE (SUD) -- REPROCESSED

The American Osteopathic Association recommends that more studies are needed to investigate the safety of reprocessed single use devices (SUDs) and that physicians be given the option of using the original device from the original equipment manufacturer. 2007; reaffirmed 2012

H309-A/15 SITE NEUTRAL REIMBURSEMENT

The American Osteopathic Association (AOA) believes 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 and 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 efforts 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, and 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, and that Medicare patients should be provided access to data regarding differences in copayment requirements among various sites of service. 2015

H432-A/15 SLEEP DISORDERS--PROMOTING THE UNDERSTANDING AND PREVENTION OF

The American Osteopathic Association supports programs that promote education and understanding of sleep and its impact on health and encourages osteopathic physicians to educate their patients about sleep disorders and the importance of sleep and its impact on health. 2005; reaffirmed 2010; 2015

H442-A/12 SMOKING -- USE OF TOBACCO PRODUCTS

The American Osteopathic Association: (1) supports education on the hazards of smoking beginning at the elementary school level; (2) encourages physicians to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health supervision visit; (3) 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; (4) encourages its members to discuss the hazards of tobacco use with their patients; (5) 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; 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 federal legislation to limit access to cigarette machines to minors, and the elimination of free distribution of cigarettes 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; and, (6) urges the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation. 1990; revised 1995, 1997; revised 2002; 2007; reaffirmed as amended 2012

H352-A/13 SOCIAL MEDIA GUIDELINES -- IMPLEMENTATION OF

The American Osteopathic Association supports the use of appropriate social media by osteopathic physicians as a method to promote our profession and practices and will work to develop "professionalism in social media" guidelines for our osteopathic physicians to use. 2013

H321-A/15 SPECIALTY CERTIFICATION -- OSTEOPATHIC MEMBERSHIP OF DOs

The American Osteopathic Association will continue to condition AOA specialty board certification upon AOA membership and encourages membership in its practice affiliates as well as state and local osteopathic associations. 1979; reaffirmed 1984; revised 1990; reaffirmed 1995, 2000, revised 2005; reaffirmed 2010; 2015

H255-A/04 SPINAL MANIPULATION LEGISLATION OR REGULATION

The American Osteopathic Association opposes all legislation or regulatory changes that could be interpreted to exclude osteopathic physicians from the right to practice spinal manipulation and all other forms of osteopathic manipulative treatment; and will works with legislators and state licensing boards to preserve the osteopathic profession's right to establish and maintain standards of practice of osteopathic manipulative treatment. 1999; revised 2004; 2009

H419-A/11 SPORTS AND PREVENTION OF TRAUMATIC BRAIN INJURY

The American Osteopathic Association supports the development of official sports rules that consider education and traumatic brain injury prevention for school sports, sports clubs and professional leagues. 2011

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 specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues.[1] However, the current single largest funder of GME is the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS).[2] The federal government contributes approximately $9.5 billion in Medicare funds and approximately $2 billion in Medicaid dollars to help pay for GME.[3] 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, GME is potentially faced with a significant reduction in funding. The Obama Administration and several members of Congress have spoken out in favor of reducing GME funding as part of a comprehensive approach to reducing overall federal spending.[5] Additionally, several bills have been introduced at the federal level that attempt to address GME funding shortages. 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 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.[6] IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest hurdles in 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 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). 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.[8,9] 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.[10]

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.[11] 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 being under no obligation to do so, Medicaid is the second largest contributor to GME programs. Several 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 $3.87 billion to GME programs in 2012, up from $3.78 in 2009.[12, 13] From that, at least half came from matching federal payments.[14] 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.[15] By 2012, only 42 states and the District of Columbia (DC) supported GME through their Medicaid program.[16] Arizona, Massachusetts, Montana, Rhode Island, Vermont and Wyoming have since ended GME funding, citing budget shortfalls.[17, 18] 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.[21] Twelve states and DC fund DME and/or IME programs using a calculation method similar to Medicare's GME funding formula. The remaining states calculate payments by "some other method," which usually includes a variation of a per-resident or lump-sum amount. The per-resident or lump-sum amount is based on the "hospital's share of total Medicaid revenues, costs or patient volumes."

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-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 states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments. This is a decline in the number of states who have made direct payments under managed care. States who make direct Medicaid payments

indicate 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 states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations. Five of these states – Kansas, Kentucky, Michigan, Oregon and Washington – require MCOs to distribute the negotiated payments to teaching hospitals. The other four 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.

Kansas and Florida

In an effort to promote accountability in the use of GME funds, Kansas and Florida link Medicaid GME payments to stated state policy goals. Kansas applied to both fee-for-service and managed care Medicaid programs, while Florida GME payments focus on fee-for-service payments.[26] Like most states, Kansas and Florida have focused on encouraging training in primary care specialties, rural and medically underserved areas.

Kansas also uses GME payments to promote an increased supply of physicians serving the Medicaid population, and increase the geographic distribution and fund teaching hospitals that have experienced GME funding cuts through the Medicare program. In addition to Medicare and Medicaid GME funding, Florida also uses alternative sources to fund residency programs 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.[27]

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 2007, the Texas legislature 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.

Texas also provides supplemental funding for approved medical residency training programs. In the Texas Administrative Code, the Texas Health and Human Services Commission reimburses approved state-owned or state-operated teaching hospitals, the hospital'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]

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.[32]

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.[33] 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 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 waiver ultimately ended on June 30, 2010.[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 all-payor system has proven to work in several states. 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.[38] The extents to which private insurers help fund portions of residency training and costs are nearly incalculable. 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 currently has an all-payor system where the Health Services Cost Review Commission sets hospital rates for all payers. Maryland has built costs associated with GME funding into its rate-setting system.[40] 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 in which the federal government pays more in Maryland than anywhere else. In return, Maryland has to keep its Medicare costs below national growth.[42] Maryland is currently in jeopardy of losing its waiver due to federal sequester concerns.

New York's all-payor system 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. 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.[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."[45] 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 compliment AOA Policy, H252-A/04 RESIDENCY TRAINING SLOTS. The PEACH program 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 their efforts to provide adequate GME funding.

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[2] *Health Policy Brief: Graduate Medical Education.* Health Affairs, August 16, 2012.
[3] Id.
[4] *Physician Education Advancing Community Health Brief*, AOA Division of State Government Affairs, January 2013.
[5] *Health Policy Brief*, *supra*.
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[9] Certain non-hospital settings may be counted when applicable.
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[17] Metzler, *supra.*
[18] Henderson 2010, *supra.*
[19] Henderson 2013, *supra*
[20] Metzler, *supra.*
[21] *Insurance Glossary*, U.S. Office of Personnel Management. http://www.opm.gov/healthcare-insurance/insurance-glossary/#f
[22] Id.
[23] Henderson 2013, *supra.*
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[34] Id.
[35] *Utah Graduate Medical Education Demonstration Project*, Utah Medical Education Council.
http://www.utahmec.org/uploads/files/23/AACOM%20Utah%20GME%20Demonstration%20Poster.pdf
[36] Squire, *supra*.
[37] Id.
[38] AOA Policy, H252-A/04.
[39] Rye, Brian, CFA. *Assessing the Impact of Potential Cuts in Medicare Doctor-Training Subsidies."* Bloomberg Government, February 28, 2012.
[40] *Hospital Graduate Medical Education Reporting Changes to Schedules P4A to P4I (Direct Medical Education) and Schedule IRS (Indirect Medical Education),* Health Services Cost Review Commission, December 8 , 2011.
http://hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/ApprovedPolicyPapersStaffRecommendations/2011/12/GME_ScheduleRevisions_Draft2011-12-08.pdf
[41] Id.
[42] Gantz, Sarah. *Sequester Could Impact Maryland Hospital Rates, Medicare Waiver*, Baltimore Business Journal, March 5, 2013. http://www.bizjournals.com/baltimore/news/2013/03/05/sequester-maryland-hospital-rates.html?page=all
[43] NY Pub Health L § 2807-M (2012).
http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=$$PBH2807-M$$@TXPBH02807-M+&LIST=SEA2+&BROWSER=+&TOKEN=08985037+&TARGET=VIEW
[54] Id.
[55] AOA Policy H-232-A/05.

H257-A/04 STATE LICENSURE OF MANAGED CARE ORGANIZATIONS (MCO) MEDICAL DIRECTORS

The American Osteopathic Association supports legislation or regulations that would require all managed care organization (MCO) medical directors to be fully-licensed physicians of the state where the care is being provided; and supports state medical boards' rights to oversee and discipline any medical director of an MCO licensed as a physician in their state. 1999; reaffirmed 2004; 2009

H430-A/12 STEM CELL RESEARCH

The American Osteopathic Association supports biomedical research on stem cells and will continue to monitor developments in stem cell research and sources of stem cell funding. 2007; reaffirmed 2012

H410-A/15 INTRAUTERINE FETAL DEMISE AWARENESS

The American Osteopathic Association supports increasing public awareness of the risk for intrauterine fetal demise and encourages the director of the National Institutes of Health to allocate more resources to intrauterine fetal demise research. 2010; reaffirmed as amended 2015

H258-A/04 STUDENT LOAN INTEREST DEDUCTIONS
The American Osteopathic Association will pursue changes in the tax code that increase the eligible income thresholds for qualification of allowable student loan interest deductions for both single and joint filers and with the appropriate affiliated organizations will communicate pertinent tax deduction laws to its members. 1989; revised 1994, 1999; reaffirmed 2004; reaffirmed as amended 2009

H415-A/13 SUBSTANCE ABUSE
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 and law enforcement agencies in their efforts to eliminate substance abuse, and urges all members of the osteopathic profession to participate in the prevention and rehabilitation of persons suffering from substance abuse and the disease of addiction. 1978; revised 1983, 1988, 1993, 1998, 2003; 2008; reaffirmed as amended 2013

H207-/13 SUBSTANCE USE DISORDERS EDUCATION
The American Osteopathic Association recommends the inclusion of substance use disorders education in all osteopathic education. 2008; reaffirmed 2013

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 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

H424-A/15 SUPPORT OF LITERACY PROGRAMS
The American Osteopathic Association supports programs that promote literacy in the United States. 1990; revised 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

H311-A/11 SUPPORT OF STATE SOCIETIES
The American Osteopathic Association recommends that membership in an individual's state or divisional society, if available and where prohibited by law, be given strong consideration when determining qualification for all osteopathic Directors of Medical Education (DMEs) and residency directors. 2006; reaffirmed 2011

H311-A/15 SUPPORTING THE USE OF OMM IN THE VA

The American Osteopathic Association (AOA) will work with the Veterans Administration (VA) to: 1) establish the position of National Osteopathic Manipulative Medicine (OMM) Director within the Veterans Administration System; 2) create National VA Regulation promoting the use of Osteopathic Manipulative Medicine; 3) create Manual Medicine Clinics; 4) to hire physicians trained in Osteopathic Manipulative Medicine, to staff manual medicine clinics within the department of PMR; 5) assist the National OMM Director in coordinating support for manual medicine clinics by encouraging Osteopathic Schools to sign Memorandum Of Understandings that allow osteopathic students and residents to rotate through the manual medicine clinics and eventually apply for jobs in these clinics on an equal opportunity basis; 6) and the AOA will work with Congress to pass any legislation required to put forth the promotion of OMM in the VA (see policy background in VHA Directive 2009-059 supporting Chiropractic Care.

The AOA will continue to educate the VA on the benefit of OMM to patient care. 2015

H425-A/15 TANNING DEVICES

The American Osteopathic Association endorses appropriate governmental action to impose those safety precautions and educational materials which are needed regarding the use of tanning devices. 1990; revised 1995, 2000, reaffirmed 2005; revised 2010; reaffirmed as amended 2015

H618-A/13 TASER SAFETY

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

H631-A/15 TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

The American Osteopathic Association supports the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas and urges that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities. 2005; reaffirmed 2010; 2015

H312-A/15 TAX CREDIT FOR PRECEPTING

The American Osteopathic Association (AOA) will develop a template for model legislation and a toolkit with strategies to implement precepting tax credit legislation. The AOA will advocate for the development of novel solutions to promote the evolving culture of undergraduate and graduate inter-professional education. 2015

H213-A/14 TEENAGE ALCOHOL ABUSE
The American Osteopathic Association endorses continuing medical education for health care professionals to aid them in educating lower and middle school students of the dangers of alcohol and endorses outreach programs to elementary "lower" and middle schools to create awareness of the dangers of alcohol. 2009; reaffirmed 2014

H-600-A/12 TELEMEDICINE -- AOA POLICY ON
The American Osteopathic Association adopts the following policy white paper on Telemedicine. (2012)

AOA POLICY STATEMENT--TELEMEDICINE

With the rapid pace of advancement in technology, telemedicine is an evolving practice – both in the scope of practice that is covered, and in the overall meaning of the term "telemedicine." Telemedicine 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 argue that it provides improved access to medical care and services to patients in rural or distant 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.

Despite its advantages, opponents raise concerns over the lack of regulation and oversight to control this practice. The primary issues involving telemedicine are: (1) licensure of out-of-state practitioners who use technology to treat patients in a state where they are not licensed to practice; (2) technological problems and barriers; (3) reimbursement issues regarding payment for services rendered; and (4) 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 and Quality
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. 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 across state lines. Additionally, standard of care must be established and may vary between face-to-face encounters and telemedicine encounters; although, many providers argue against this variation.

Liability Concerns

One issue that arises under the discussion of advancing online medicine is the question of jurisdiction for liability cases. In 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 that the accident occurred, if there is a reasonable expectation for that harm to have occurred there. So long as the patient can provide evidence confirming that location, ex: location of the IP address, 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, 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 is a broad area and is not regulated by one specific board or oversight body. There is no standard for telemedicine education and no certification in the provision of telemedicine. 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 vary 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 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.

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 recommendations to address telemedicine 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 believes 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 believes 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 and advocates that public and private payers adopt payment systems that are inclusive of telemedicine.

The AOA believes 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 believes 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.

The AOA believes that the scope of care being delivered by the physician and other health care providers through telemedicine should not exceed education, training and applicable state and federal law.

The AOA believes that state-based licensure and the ability of states to govern activities within their borders is paramount and would oppose any national licensure or efforts to pre-empt state statutes.

The AOA believes that malpractice claims that arise from care provided through technological means, when the physician and patient are located 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 believes 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 believes that as physicians provide care in a variety of new ways, including telemedicine, advanced technology can be used to improve patient care. The AOA further believes that online medicine policies directly tie into the Patient-Centered Medical Home (PCMH) model for care, and recognizes that we must simultaneously implement advancements in telemedicine in order to be successful in that new model.

The AOA will monitor developments in telemedicine 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

H622-A/13 TENETS OF OSTEOPATHIC MEDICINE

The American Osteopathic Association approves as policy the following consensus statement on the tenets of osteopathic medicine: (1) The body is a unit; the person is a unity of body, mind and spirit. (2) The body is capable of self-regulation, self-healing and health maintenance. (3) Structure and function are reciprocally interrelated. (4) Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation and the interrelationship of structure and function. 2008; reaffirmed 2013

H353-A/13 TERMINOLOGY -- VOLUNTEER OSTEOPATHIC MEDICAL HEALTH CARE DELIVERY

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

H346-A/14 TESTOSTERONE THERAPY: LONG TERM EFFECT ON HEALTH

The American Osteopathic Association requests that the National Institutes of Health fund independent research of the long term risk/benefits of testosterone therapy. 2014

H440-A/15 TEXTING WHILE DRIVING

The American Osteopathic Association supports efforts to educate all drivers concerning the dangers of texting and driving and supports efforts to ban the use of texting while driving. 2010; reaffirmed 2015

H316-A/11 THIRD PARTY PAYORS CHANGING CLASSES OF MEDICATIONS

The American Osteopathic Association supports all efforts to end the practice of requiring a change in class of medication, thereby decreasing the administrative burden and improving access to care. 2006; reaffirmed 2011

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

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

H616-A/11 TIMELY ACCESS TO ANCILLARY FACILITIES

The American Osteopathic Association will exert its influence to insure that third party payers will provide payments for a full range of medical services, if available, within the service area of its subscribers. 2001; revised 2006 [Editor's note: This policy has been referred for clarification – 2011]

H615-A/15 TOBACCO CESSATION TREATMENT--HEALTH PLAN COVERAGE OF

The American Osteopathic Association encourages all health plans to follow tobacco cessation recommendations of the Centers for Disease Control and Prevention (CDC) and encourages all health care plans to accept CPT, ICD-9 and ICD-10 codes for tobacco use as legitimate codes for payment for services provided for these codes. 2010; reaffirmed as amended 2015

H412-A/11 TOBACCO CONTROL--THE FRAMEWORK CONVENTION ON
The American Osteopathic Association support the efforts of international health agencies in eliminating the use of tobacco products from their societies, and encourage the United States to use its experience in tobacco control to help developing countries with this health issue and support the public health initiatives of the World Health Organization for tobacco control by promoting the Framework Convention on Tobacco Control (FCTC) and urge the President of the United States to submit the framework convention on tobacco control to the United States Senate for ratification. 2001; revised 2006; reaffirmed as amended 2011

H434-A/11 TOBACCO FREE COLLEGES / SCHOOLS OF OSTEOPATHIC MEDICINE
The American Osteopathic Association commits to the goal of establishing and supporting tobacco-free colleges of osteopathic medicine at every Commission on Osteopathic College Accreditation (COCA)-accredited colleges of osteopathic medicine. 2011

H426-A/15 TOBACCO SETTLEMENT FUNDS
The American Osteopathic Association supports the use of the tobacco settlement fund for health-related items to include health care services, education and research only. 2000, revised 2005; reaffirmed 2010; 2015

H338-A/13 TOBACCO USE
The American Osteopathic Association supports third-party coverage of evidence-based approaches for the treatment of tobacco use and nicotine withdrawal. 1998; revised 2003; revised 2008; reaffirmed 2013

H616-A/13 TOBACCO USE IN ENTERTAINMENT MEDIA
The American Osteopathic Association encourages the media producers to measure, monitor and reduce the use of tobacco products in entertainment media. 2003; 2008; reaffirmed as amended 2013

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) 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

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

H626-A/12 TRANSLATOR SERVICES -- PAYMENT FOR

The American Osteopathic Association will work with third party payers and government insurers to develop a system wherein physicians will be offered additional payment when the use of translators is necessary for the care of the patient. 2007; reaffirmed as amended 2012

H446-A/15 TRAUMATIC BRAIN INJURY AWARENESS

The American Osteopathic Association 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. 2010; reaffirmed 2015

H416-A/13 TUBERCULOSIS MEDICAL TRAINING

The American Osteopathic Association supports tuberculosis prevention programs carried out by the Centers for Disease Control and Prevention (CDC), The National Institutes of Health (NIH) and other organizations and encourages the use of the CDC's core curriculum on tuberculosis by osteopathic physicians who treat patients diagnosed with tuberculosis or who are at high risk for tuberculosis disease or infection. 1993; revised 1998; reaffirmed 2003; 2008; reaffirmed as amended 2013

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. 2013

H339-A/13 UNIFORM BILLING

The American Osteopathic Association opposes charging a fee or other penalty to physicians for the reimbursement claims that they submit for care provided to Medicare and Medicaid patients. 1993; revised 1998, 2003; 2008; reaffirmed 2013

H351-A/13 UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT (UEHVPA)

The American Osteopathic Association supports enactment of the following Uniformed Emergency Volunteer Health Practitioners Act (UEVHPA) as written by the National Conference of Commissioners on Uniform State Laws and amended by the AOA. 2008; reaffirmed 2013

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.

H340-A/13 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 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. 1991; revised 1993, 1998, 2003; 2008; reaffirmed as amended 2013

H324-A/11 UNIFORM TITLE FOR OSTEOPATHIC MEDICAL STUDENTS

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.). 2006; reaffirmed as amended 2011

H322-A/15 UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES

The American Osteopathic Association will continue to assist the Surgeons General of the uniformed services and the American public in maintaining and assuring the highest quality of healthcare by its representatives in the uniformed services and recognizes the 45th anniversary of osteopathic physicians being commissioned in the military. 1985; revised 1990, 1995; 2000, 2005; revised 2010; revised 2015

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

H325-A/11 UNIFORMITY IN COMMERCIAL PHYSICIAN EVAULATION PROGRAMS -- DEVELOPMENT OF PAYER COALITIONS

The American Osteopathic Association, in markets where multiple payers compete, will work in concert with other physician organizations to encourage those insurance plans to form a payer coalition for consolidated data reporting; request that the coalition should offer a single chart review in the physician and / or group practice office that includes aggregated clinical chart review data into a single consolidated performance report; and work with commercial insurance plans and their national organizations to develop a single national standard of data collection and reporting applicable to all physician performance evaluation programs. 2006; reaffirmed 2011

H341-A/13 UNINSURED -- ACCESS TO HEALTH CARE

The American Osteopathic Association 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. 2003; 2008; reaffirmed 2013

H609-A/12 UNIVERSAL EXCHANGE LANGUAGE FOR HEALTH CARE INFORMATION -- NEED FOR

The American Osteopathic Association endorses the development, acceptance and implementation of an operational, universal, national protected health information technology infrastructure; and that this infrastructure has as its core function a universal exchange language or interchange portal for healthcare information that will allow electronic medical records systems (EMR) throughout the nation to access important health data anywhere in the country, with a requirement for rigorously protecting privacy and security. 2012

H617-A/11 URGING STANDARD POLICIES FOR CERTIFYING UNINSURED / UNDERINSURED PATIENTS FOR FREE PHARMACEUTICALS

The American Osteopathic Association urges the Pharmaceutical Research and Manufacturers of America (PHrMA) to continue to work with the federal government to find acceptable solutions, to address the problem of varying criteria and paperwork within its Patient Assistance Program (PAP). 1996; revised 2001; revised 2006; reaffirmed as amended 2011

H324-A/14 USE OF THE TERM "DOCTOR"

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; (2) supports the appropriate use of credentials and professional degrees in advertisements; (3) 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 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" to persons other than US-trained DOs, and MDs; (6) supports a policy that physicians and non-physician clinicians identify themselves to their patients noting their degree in both a verbal description as well as a 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

H404-A/15 VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS

The American Osteopathic Association (AOA) supports legislation at the state level that requires daycare facilities to notify parents (in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations and state regulations where applicable) that their facility has in its care unvaccinated children who may pose a health risk to high risk populations. 2015

H402-A/15 VACCINES FOR INFANTS, CHILDREN, AND ADULTS-- PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF

The American Osteopathic Association supports the widespread use and high compliance rate of the Health and Human Services National Vaccine Implementation Plan for infants, children, and adults through education of the public using media and marketing tools available to its organization. 2015

H413-A/11 VACCINE SUPPLY AND DISTRIBUTION

The American Osteopathic Association will monitor the supply of vaccines and contact the manufacturers of vaccines to encourage adequate vaccine supply and distribution of these vaccines preferentially to physicians, healthcare facilities and healthcare agencies before they are made available to retail outlets. 2001; amended 2006; reaffirmed as amended 2011

H326-A/15 VACCINE SHORTAGES

The American Osteopathic Association (AOA) will outreach federal legislators and the Centers for Disease Control & Prevention on the critical issue of vaccine shortage. The AOA will also communicate that steps be taken to give manufacturers of vaccine immunity from lawsuits because of complications which are not due to negligence; that additional US companies will be urged to manufacture vaccines for the US citizens; and that the public be provided information on potential side effects and complications of vaccines so they are fully informed and responsible for their decision to be immunized. 2005; revised 2010; reaffirmed as amended 2015

H419-A/14 VACCINES

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

H408-A/15 VACCINES FOR CHILDREN PROGRAM

The American Osteopathic Association supports the expansion of the Vaccines for Children (VFC) Program to include all Advisory Committee on Immunizations Practices (ACIP) age appropriate vaccines for all underinsured children, in keeping with the original goals of the program. 2005; revised 2010; reaffirmed 2015

H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS

The American Osteopathic Association supports the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system and supports the establishment of a consistent requirement for the privileging of non-physician providers in the VA system. 2005; reaffirmed 2010; 2015

H617-A/13 VETERANS—HEALTH CARE FOR US

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

H342-A/13 VETERANS HOSPITALS AND CLINICS-OMT IN

The American Osteopathic Association will work with the Department of Veterans Affairs to provide information to appropriate administrative and managerial personnel on osteopathic manipulative treatment (OMT) that will allow osteopathic physicians to provide OMT in all departments of Veterans Affairs healthcare facilities. 2003; 2008; reaffirmed 2013

H337-A/15 VIOLENCE AGAINST HEALTHCARE STAFF

The American Osteopathic Association supports legislative change that would hold patients and their associates (that includes friends, family, and anyone that affiliates with them) accountable for their actions by supporting uniformity in laws in every state that would upgrade physical assault and verbal threat laws from misdemeanor to felony charges where applicable. 2015

H200-A/11 VIOLENCE AND ABUSE PREVENTION AND EDUCATION

The American Osteopathic Association urges its members as well as government agencies to continue to develop and expand educational and preventative programs to reduce violence and abuse of all kinds; supports the promotion, distribution and implementation of curricula and other educational resources focused on medical students, residents and practicing physicians to improve their knowledge, attitudes and skills in addressing violence and abuse; this effort will include, but not be limited to, pre and postdoctoral education, continuing medical education, community education, demonstration projects and efforts for dissemination of "best practices" in preventing and addressing violence and abuse across the lifespan. 2001; revised 2006; reaffirmed and amended 2011

H427-A/12 VIOLENCE IN THE ENTERTAINMENT MEDIA
The American Osteopathic Association opposes the presentation of gratuitous violence in the entertainment media. 1977; revised 1982, 1987, 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed 2012

H309-A/11 VOTING DAY—AOA SUPPORTS VOTING DAY POLICY
The American Osteopathic Association encourages all osteopathic physicians to adopt voting policies in their workplaces that would allow their employees time off during working hours, if necessary, to participate in voting for local, state, and national elections.1991; revised 1996, 2001; 2006; reaffirmed as amended 2011

H431-A/11 5-2-1-0 WELLNESS CAMPAIGN FOR AMERICA'S CHILDREN
The American Osteopathic Association recommends the continued wellness campaign for America's children. 2011

H265-A/04 WOMEN'S CONTRACEPTIVE COVERAGE LEGISLATION
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. 1999; revised 2004; reaffirmed 2009