acofp American College of Osteopathic Family Physicians
Advocacy • Education • Leadership

RES 3
C-3/17

SUBJECT: Revisions to Sunsetting ACOFP Position Statements of the American College of Osteopathic Family Physicians (ACOFP)

SUBMITTED BY: ACOFP Constitution & Bylaws/Policy & Organization Review Committee

REFERRED TO: 2017 ACOFP Congress of Delegates

RESOLUTION NO. 3

RESOLVED, that Congress of Delegates of the American College of Osteopathic Family Physicians adopts and approves the sunsetting ACOFP Position Statements as recommended and submitted by the ACOFP Constitution & Bylaws/Policy & Organization Review Committee. (Old material crossed out, new material capitalized.)

Coverage for Uninsured and Underinsured Minors
ACTION: RECOMMENDS DELETION, AS ACTION ALREADY HAS TAKEN PLACE.
The ACOFP encourages its members to urge the U.S. Congress to vote to fully fund an implement this important health coverage change being proposed for the State Children's Health Insurance Program (SCHIP).

Formularies – Physician Consultation
ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.
The ACOFP supports legislation that requires a physician be available for consultation on pharmaceutical formulary decisions.

HPV Vaccine Coverage
ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.
The ACOFP endorses the recommendation of the Advisory Council on Immunization Practices (ACIP) of the Center for Disease Control (CDC) to provide HPV vaccine to all eligible recipients and/or be made available through the state department of health.

Transportation Costs for Patients
ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.
The ACOFP encourage the CMS and third-party payers to develop a policy that pays for appropriate transportation costs to and from healthcare facilities for those patients at 200 percent of poverty level or below.

Primary Care Incentive Payment

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The ACOFP supports a 10% incentive payment to all primary care physicians and Non-Physician Practitioners (NPPs), who perform Primary Care Services specified in The Affordable Care Act, Section 5501(a).

The ACOFP encourages the United States Congress to instruct the Centers for Medicare & Medicaid Services (CMS) to change the existing qualifications in the Affordable Care Act for the 10% incentive payment by eliminating the Physician's Primary Care Incentive Percentage, thereby including all primary care physicians and non-physician practitioners who perform the specified primary care services.

Texting While Driving

ACTION: RECOMMENDS DELETION. THIS POLICY DUPLICATES EXISTING POLICY, "USE OF ELECTRONIC DEVICES WHILE DRIVING."

The ACOFP opposes texting while operating motorized vehicles.

Certification

ACTION: RECOMMENDS REAFFIRMATION WITH EDITORIAL CHANGES. The ACOFP CONTINUES TO recognize~~s~~ those physicians certified through the clinical pathway as holding board certification equivalent to certification achieved through residency training. When necessary, the ACOFP, working with the AOA, shall educate healthcare institutions and managed care programs on this issue.

Certification – COM Chairs

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The ACOFP requests COCA (Commission on Osteopathic College Accreditation) to amend the accreditation requirements for colleges of osteopathic medicine to state that chairs of the departments of family medicine at colleges of osteopathic medicine be AOA certified and be members in good standing with the ACOFP/AOA.

Soft Drinks in Schools

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

ACOFP members shall educate and caution their adolescent patients, school superintendents, and members of school boards across our nation as to the health consequences of soft drinks, and urge them to restrict sales of non-nutritional drinks. ACOFP supports the efforts of some of the soft drink producers that have already taken the initiative to provide and process more nutritious beverages.

Tissue and Organ Donation Education

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The ACOFP members are encouraged to provide educational materials to families, friends, and patients about tissue and organ donation programs.

Use of Electronic Devices While Driving

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The ACOFP opposes texting while operating motorized vehicles.

Prescription Pain Medication/Long-Acting Opioid Medication

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

It is a basic right of all patients to receive adequate control of acute and chronic pain. It is a primary duty of all physicians, regardless of specialty, to provide medication and modalities that will achieve safe and effective pain control for all their patients.

As patient advocates and physicians, we believe that it is in the best interest of all patients not to confine, or seek to regulate opioid medications by limiting their use to a small number of selected specialties of medicine. This would also extend to newer modalities now developed, or yet to be developed, such as long-acting opioid 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 in all areas of our country.

We support the voluntary universal education of all physicians, as well as others involved in the management of pain patients, on the proper diagnosis and appropriate treatment of pain. A well-educated, physician-led team of health care providers, following scientifically-established treatment protocols, will not only deliver quality care, but will be sensitive to the problems of addiction and diversion of prescription pain medication.

Ambulatory-Based Family Medicine Residency Programs

ACTION: RECOMMENDS REAFFIRMATION WITH EDITORIAL CHANGES.

The ACOFP supports and advocates for development and implementation of MORE ambulatory-based family medicine residency programs.

The ACOFP encourages the United States Congress to strengthen its Graduate Medical Education reimbursement policies to at least equivalently fund ambulatory-based family medicine residency programs.

The ACOFP encourages the AOA to CONTINUE TO lobby the United States Congress to support legislation funding ~~demonstration models~~ of ambulatory-based family medicine residency programs.

Human Genome Project

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

Explanatory Statement: The ACOFP agrees with the policy but will work to rewrite a more concise policy accompanied by a whitepaper.

Background

In the late 1980's the U.S. Department of Energy, in cooperation with the National Institutes of Health, initiated a research project that would grow into the Human Genome Project in 1990. The Human Genome Project was sponsored by an agency formed for this purpose, the National Human Genome Research Institute (NHGRI). Despite initial doubts from many sides an optimistic goal was set to decipher the genetic code of Homo sapiens by the year 2005. Today we know that this goal was not too ambitious and an initial map of the human genome was actually achieved in the year

2000 and, in an improved version, was published publicly in February of 2001. The next challenges will lie in interpreting the information and relating it to human health and disease.

The initial goals of the Human Genome Project were: 1. Construction of a high-resolution genetic map of the human genome, 2. Production of a variety of physical maps of all human chromosomes and of the DNA of selected model organisms, with emphasis on maps that make the DNA accessible to investigators for further analysis. This series of maps would be of increasingly fine resolution, and 3. Determination of the complete sequence of human DNA and DNA of selected model organisms. With these goals apparently well in sight there are a multitude of ambitious new objectives springing up in both the scientific and medical/industrial communities such as these listed below (quoted from the U.S. Department of Energy Office of Science, Office of Biological and Environmental Research, Human Genome Program):

Molecular Medicine
Improve diagnosis of disease; detect genetic predispositions to disease; create drugs based on molecular information; use gene therapy and control systems as drugs; and design "custom drugs" based on individual genetic profiles

Microbial Genomics
Rapidly detect and treat pathogens (disease-causing microbes) in clinical practice; develop new energy sources (biofuels); monitor environments to detect pollutants; protect citizenry from biological and chemical warfare; and clean up toxic waste safely and efficiently

Risk Assessment
Evaluate the health risks faced by individuals who may be exposed to radiation (including; low levels in industrial areas) and to cancer-causing chemicals and toxins; bio archaeology, Anthropology, Evolution, and Human Migration; study evolution through germ line mutations in lineages; study migration of different population groups based on maternal genetic inheritance; study mutations on the Y chromo; some to trace lineage and migration of males; and compare breakpoints in the evolution of mutations with ages of populations and historical events

DNA Identification
Identify potential suspects whose DNA may match evidence left at crime scenes; exonerate persons wrongly accused of crimes; identify crime, catastrophe, and other victims; establish paternity and other family relationships; identify endangered and protected species as an aid to wildlife officials (could be used for prosecuting poachers); detect bacteria and other organisms that may pollute air, water, soil, and food; match organ donors with recipients in transplant programs; determine pedigree for seed or livestock breeds; and authenticate consumables such as caviar and wine.

Agriculture, Livestock Breeding, and Bioprocessing
Grow disease-, insect-, and drought-resistant crops; breed healthier, more productive, disease-resistant farm animals; grow more nutritious produce; develop bio pesticides; incorporate edible vaccines into food products; and develop new environmental cleanup uses for plants like tobacco.
In addition, many ethical, legal and social issues (ELSI) have been identified in relation to the Human Genome Project. The involvement of the private sector in the "race" to discover the genome adds another concern as there is considerable opportunity for unforeseen difficulties if proprietary concerns encroach on the project; some groups now working on sequencing are completely commercial and plan to release information only in patent applications. Because of these risks, the

Human Genome Project has dedicated a significant portion of its budget to examining ELSI issues as evidenced by this text from "New Goals for the U.S. Human Genome Project: 1998-2003," Science 282: 682 - 689 (1998) which details some of the goals of the project: Examine issues surrounding the completion of the human DNA sequence and the study of human genetic variation; examine issues raised by the integration of genetic technologies and information into health care and public health activities; examine issues raised by the integration of knowledge about genomics and gene-environment interactions in non-clinical settings; explore how new genetic knowledge may interact with a variety of philosophical, theological, and ethical perspectives; explore how racial, ethnic, and socioeconomic factors affect the use, understanding, and interpretation of genetic information; the use of genetic services; and the development of policy.

Recognized concerns arising from this project include:
A.) Fairness in the use of genetic information by insurers, employers, courts, schools, adoption agencies, and the military, among others.
Who should have access to personal genetic information, and how will it be used?

B.) Privacy and confidentiality of genetic information.
Who owns and controls genetic information?

C.) Psychological impact and stigmatization due to an individual's genetic differences.
How does personal genetic information affect an individual and society's perceptions of that individual?
How does genomic information affect members of minority communities?

D.) Reproductive issues including adequate informed consent for complex and potentially controversial procedures, use of genetic information in reproductive decision making, and reproductive rights.
Do healthcare personnel properly counsel parents about the risks and limitations of genetic technology?
How reliable and useful is fetal genetic testing?
What are the larger societal issues raised by new reproductive technologies?

E.) Clinical issues including the education of doctors and other health service providers, patients, and the general public in genetic capabilities, scientific limitations, and social risks; and implementation of standards and quality-control measures in testing procedures.

F.) How will genetic tests be evaluated and regulated for accuracy, reliability, and utility? (Currently, there is little regulation at the federal level.)
How do we prepare healthcare professionals for the new genetics?
How do we prepare the public to make informed choices?
How do we as a society balance current scientific limitations and social risk with long-term benefits?

G.) Uncertainties associated with gene tests for susceptibilities and complex conditions (e.g., heart disease) linked to multiple genes and gene-environment interactions.
Should testing be performed when no treatment is available?
Should parents have the right to have their minor children tested for adult-onset diseases?
Are genetic tests reliable and interpretable by the medical community?

H.) Conceptual and philosophical implications regarding human responsibility, free will vs. genetic determinism, and concepts of health and disease.
Do people's genes make them behave in a particular way?
Can people always control their behavior?
What is considered acceptable diversity?
Where is the line between medical treatment and enhancement?

I.) Health and environmental issues concerning genetically modified foods (GM) and microbes.
Are GM foods and other products safe to humans and the environment?
How will these technologies affect developing nations' dependence on the West? J.
Commercialization of products including property rights (patents, copyrights, and trade secrets) and accessibility of data and materials.
Who owns genes and other pieces of DNA?
Will patenting DNA sequences limit their accessibility and development into useful products?

Introduction

The vast potential for good and for harm of the Human Genome Project requires an organization such as ours, which shares the responsibility for health care delivery in this nation, to participate in the vigilance demanded of these possibilities. Monitoring even the few aspects of the project mentioned above would create an enormous task that could easy consume all the resources of the ACOFP, nevertheless we do share an obligation to our members and to the public to carry a realistic burden of watchfulness and caution. It is our duty to promptly incorporate tested and accepted therapies as they are developed. It is our duty to sound the alarm when we see our patients become victims instead of beneficiaries of these technologies.

Recommended Actions

The ACOFP Board of Governors, through its members, committees, and staff shall take appropriate action in each of these areas:

A.) Education

The ACOFP shall support education regarding the Human Genome Project at all levels (practicing physicians, resident physicians and student physicians).

B.) Legislation

The ACOFP shall monitor governmental actions, legislation and intent in regulating the Human Genome Project. The ACOFP shall be proactive in raising the voice of the ACOFP when threats to the implementation or threats from the implementation of the Human Genome Project are identified. The ACOFP should attempt to influence state legislatures and state societies to take stands in their own legislatures.

C.) Ethical, Legal, and Social Issues (ELSI)

As osteopathic family practice physicians we are often among the first to recognize potential for harm to our patients and to our profession. The ACOFP shall take a strong stand whenever it finds evidence of risk to the health or well-being of our patients as a consequence of the ethical, legal, or societal applications of this knowledge and technology.

Team Physician Definition

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The team physician must have an unrestricted medical license and be a DO or MD who is responsible for treating and coordinating the medical care of athletic team members. The principal responsibility of the team physician is to provide for the well-being of individual athletes – enabling each to realize his/her full potential. The team physician should possess special proficiency in the care of musculoskeletal injuries and medical conditions encountered in sports. The team physician also must actively integrate medical expertise with other healthcare providers, including medical specialists, athletic trainers, and allied health professionals. The team physician must ultimately assume responsibility within the team structure for making medical decisions that affect the athlete's safe participation.

Qualifications of a Team Physician

The primary concern of the team physician is to provide the best medical care for athletes at all levels of participation. To this end, the following qualifications are necessary for all team physicians: possess a DO or MD degree as a licensed physician in good standing, with an unrestricted license to practice medicine; possess a fundamental knowledge of emergency care regarding sporting events; be trained in CPR; and have a working knowledge of trauma, musculoskeletal injuries, and medical conditions affecting the athlete.

In addition, it is desirable for team physicians to have clinical training/experience and administrative skills in some or all of the following: specialty board certification; continuing medical education in sports medicine; formal training in sports medicine (fellowship training), or board recognized subspecialty in sports medicine (formerly known as a certificate of added qualification in sports medicine); additional training in sports medicine; fifty percent or more of practice involving sports medicine; membership and participating in a sports medicine society; involvement in teaching, research and publications relating to sports medicine; training in advanced cardiac life support; knowledge of medical/legal, disability, and workers' compensation issues; and media skills training.

Duties of a Team Physician

The team physician must be willing to commit the necessary time and effort to provide care to the athlete and team. In addition, the team physician must develop and maintain a current, appropriate knowledge base of the sport(s) for which he/she is accepting responsibility.

The duties for which the team physician has ultimate responsibility include the following: medical management of the athlete; coordinate pre-participating screening, examination, and evaluation; manage injuries on the field; provide for medical management of injury and illness; coordinate rehabilitation and return to participation; provide for proper preparation for safe return to participation after an illness or injury; integrate medical expertise with other health care providers, including medical specialists, athletic trainers and allied health professionals; provide for appropriate education and counseling regarding nutrition, strength and conditioning, substance abuse, and other medical problems that could affect the athlete; and provide for proper documentation and medical record keeping.

Administrative and Logistical Duties

The administrative and logistical duties of the team physician include: establish and define the relationships of all involved parties; educate athletes, parents, administrators, coaches, and other

necessary parties of concerns regarding the athletes; develop a chain of command; plan and train for emergencies during competition and practice; address equipment and supply issues; provide for proper event coverage; and assess environmental concerns and playing conditions.

Education of a Team Physician

Ongoing education pertinent to the team physician is essential. Currently, there are several state, regional and national stand-alone courses for team physician education and there are also many other resources available. Information regarding team physician specific educational opportunities can be obtained from the following sport specific organizations: National Football League Team Physician's Society or level-specific (e.g., United States Olympic Committee meetings; National Governing Bodies' (NGB) meetings; state and/or county medical societies meetings; professional journals; and other relevant electronic media.

Conclusion

The Consensus Statement establishes a definition of the team physician, and outlines a team physician's qualification and responsibilities. It also contains strategies for the continuing education of team physicians. Ultimately, this statement provides guidelines that best serve the health care needs of athletes and teams.

Non-Physician Clinicians

ACTION: RECOMMENDS REAFFIRMATION WITH NO CHANGES.

The AOA Policy Statement on Non-Physician Clinicians shall be adopted as ACOFP Policy on 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.

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.

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.

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.

Educational Standards

DO's/MD's 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.

H228-A/05 NON-PHYSICIAN CLINICIANS: The American Osteopathic Association has adopted the above policy as its position on non-physician clinicians including appropriate onsite supervision. 2000, Revised 2005; Revised 2010.

Receivers of health care should also be advised of the education and training of the PA or NP. At no time should those persons be completely independent of supervision from a fully-licensed physician, in compliance with state law. Any severe or complicated medical or surgical case should be brought to the attention of their supervising physician as soon as possible.

Each PA or NP should carry their own professional liability insurance independent of their employer subject to state law. We realize that many osteopathic/allopathic physicians are employer/supervisors of PAs or NPs. The objective of this position paper is to ensure safe and effective care of the highest quality for their patients.

FINAL ACTION: APPROVED as of MARCH 16, 2017