Professional Affairs Reference Committee

Purpose: To consider matters relating to osteopathic education, osteopathic colleges, osteopathic hospitals, internship and residency programs, certification, postgraduate training programs, student loans, research, membership and matters related to the practice of osteopathic medicine.

Resolutions: 02, 03, 04, 05, 09, 10, 12 , 14

Location: Magnolia Room

James E. Preston, DO, Chair (District 5)

Nicholas G. Espinoza, DO (District 1)

John C. Biery, DO (District 2)

Jennifer J. Hauler, DO (District 3)

Sean D. Stiltner, DO (District 4)

William J. Burke, DO (District 6)

Sandra L. Cook, DO (District 7)

Douglas W. Harley, DO (District 8)

Sharon George, DO (District 12)

Carol Tatman, Staff

RES. NO.
2012-02

SUBJECT: Reaffirmation of Policy Statements

SUBMITTED BY: OOA Resolutions Committee

REFERRED TO: Professional Affairs Reference Committee

RESOLVED, THAT THE FOLLOWING POLICY STATEMENTS BE REAFFIRMED:

Continuing Medical Education, State- Mandated, Subject Specific

RESOLVED that the OOA continues to oppose any legislation that would mandate subject-specific CME requirements for Ohio physicians, unless there is an extraordinary and/or overwhelming reason to do so, and be it further

RESOLVED that the OOA administrative staff and Committee on State Health Policy work with state legislators to address the concerns and requests by the public sector for subject-specific CME for physicians licensed in Ohio with respect to healthcare issues requiring legislative action; and be it further;

RESOLVED, that the Ohio Osteopathic Association will continue to be sensitive to addressing these concerns in the planning and implementation of its statewide CME programs. *(Original 2002)*

Current Procedural Terminology Code (CPT)
Standardized Usage For Third Party Payers

RESOLVED that the Ohio Osteopathic Association (OOA) continues to seek legislation to require all third party payers doing business in Ohio to solely utilize Current Procedural Terminology (CPT) coding as published by the American Medical Association for the reporting and reimbursement of medical services and procedures performed by physicians; and be it further

RESOLVED that the OOA supports legislation to prohibit third party payers doing business in Ohio from indiscriminately substituting their own internal coding for any published CPT code – and in particular those related to osteopathic manipulative treatment; and be it further

RESOLVED that the OOA continue to work with the Ohio Department of Insurance, the Ohio Association of Health Plans and/or interested provider organizations and coalitions to expedite the universal usage and annual updating of CPT coding in Ohio. *(Original 2002)*

Direct Payment By Insurers

RESOLVED, that the Ohio Osteopathic Association supports legislation requiring all third party payers to reimburse providers directly rather than the policyholder. *(Original 1982)*

Disability Coverage For Physicians Who Are HIV Positive

RESOLVED that the Ohio Osteopathic Association supports language in all disability insurance contracts to define 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. *(Original 1992)*

Driving Under the Influence of Alcohol And Other Mind-Altering Substances

RESOLVED that the Ohio Osteopathic Association continues to support legislation and programs designed to eliminate driving while under the influence of alcohol and other mind-altering substances. *(Original 1982)*

Emergency Department Utilization

RESOLVED that the Ohio Osteopathic Association continues to support policies and regulations which eliminate unnecessary patient utilization of high cost hospital emergency department services. *(Original 1995)*

Immunization Initiatives

RESOLVED that the Ohio Osteopathic Association continues to encourage the active involvement of its members in the promotion and administration of vaccination programs, which target at-risk populations in Ohio. (Original 1992)

Managed Care Plans, Standardized Reporting Formats for

RESOLVED that the Ohio Osteopathic Association (OOA) continues to support legislation to require all third party payers doing business in Ohio to utilize standardized billing, credentialing and reporting forms. *(Original 1997)*

Managed Care Plans, Quality Improvement and Utilization Review

RESOLVED that the Ohio Osteopathic Association continues to seek legislation to require all managed care organizations (MCOs) doing business in Ohio to be certified by the National Committee on Quality Assurance (NCQA). *(Original1997)*

Medicaid Support of GME Funding

RESOLVED, that the Ohio Osteopathic Association continues to support legislation to require the Ohio Department of Job and Family Services (Medicaid) ~~to continue~~ to support and fund the costs of graduate medical education in Ohio. *(Original 1997)*

Medicare Mandatory Assignment

RESOLVED that the Ohio Osteopathic Association continues to oppose Mandatory Medicare Assignment as a condition for state licensure. *(Original 1987)*

Nursing Facilities, Tiered

RESOLVED that the OOA continues to support multiple levels of licensed nursing facilities and encourages osteopathic physicians in Ohio to promote quality independent living for senior citizens and to direct patients to appropriate tiered care as needed. *(Original 1992)*

OOA Smoking Policy

RESOLVED, that all meetings of the Ohio Osteopathic Association's House of Delegates, board of trustees, executive committee, education conferences and committees continue to be conducted in a smoke-free environment, and be it further;

RESOLVED, that the offices of the Ohio Osteopathic Association be declared a smoke-free environment with such policy to be enforced by the OOA Executive Director. *(Original 1987)*

Osteopathic Practice and Principles/Osteopathic Manipulative Medicine Curricula Standardization

RESOLVED that the Ohio Osteopathic Association (OOA) continues to support the development of a clear and demonstrable osteopathic component for every clinical rotation that a Phase III and Phase IV medical student is assigned to regardless of the location or preceptor that those students are assigned to or elected to rotate with; and be it further

RESOLVED that this process of establishing clear and demonstrable osteopathic components for each clinical rotation should extend into all accredited osteopathic residency programs and incorporated into the curricular standards of the osteopathic postdoctoral training institution (OPTI) programs; and be it further

RESOLVED that the OOA continue to monitor the progress of the American Osteopathic Association in implementing such standards through the Bureau of Professional Education and the OPTI Task Force., as directed by Resolution 306, passed by the American Osteopathic Association House of Delegates in 1997. *(Original 1997, amended and affirmed 2002, reaffirmed 2007)*

Physicians Exclusive Right To Practice Medicine

RESOLVED that the Ohio Osteopathic Association strongly endorses and reaffirms the current Ohio statute which recognizes osteopathic and allopathic physicians as the only primary care providers qualified to practice medicine and surgery as defined by Section 4731 of the Ohio Revised Code; and be it further

RESOLVED that the Ohio Osteopathic Association supports legislation that requires all third party payers of healthcare to recognize fully licensed DOs and MDs as the only primary healthcare providers in Ohio qualified to deliver, coordinate, and/or supervise all aspects of patient care. *(Original 1997)*

Physician-Patient Relationships

RESOLVED that the Ohio Osteopathic Association opposes any governmental or third party regulation which seeks to limit a physician's ability to offer complete, objective, and informed advice to his/her patients. *(Originally passed, 1992 to address counseling on reproductive issues, amended to broaden the intent and affirmed in 1997)*

Pre-Authorized Medical Surgical Services, Denial Of Payment

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to support legislation that would prohibit any healthcare insurer doing business in Ohio from retrospectively denying payment for any medical or surgical service or procedure that has already been pre-authorized by the health insurer; and be it further,

RESOLVED, that the OOA encourages its members to file formal complaints with the Ohio Department of Insurance against any third party payer which retroactively denies payment for any medical or surgical service or procedure that was already preauthorized. *(Original resolution 2002, amended and affirmed 2007)*

Preventive Health Services

RESOLVED that the Ohio Osteopathic Association (OOA) continue to work with all interested parties to develop guidelines for the delivery and reimbursement of preventive medicine services. *(Original 1992)*

Quality Health Care, the role of Medical Staffs and Hospital Governing Bodies

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages hospital medical staffs to remain self-governing and independent through bylaws, rules and regulations; and be it further

RESOLVED, that the OOA encourages hospital medical staffs to maintain independence in exercising medical judgments to control patient care and establish professional standards accountable to the hospital governing body, but not surrendering authority; and be it further

RESOLVED, that the OOA encourages hospital medical staffs and hospital governing bodies to respect the rights and obligations of each body and together be advocates to insure that quality health care is not compromised. *(Originally passed in 1987, amended by substitution in 1992, amended and affirmed in 1997, reaffirmed in 2002)*

Quality of Life Decisions

RESOLVED, that the Ohio Osteopathic Association and its members continue to participate in ongoing debates, decisions and legislative issues concerning quality of life, dignity of death, and individual patient decisions and rights. *(Original 1992)*

Reimbursement Formulas for Government Sponsored Healthcare Programs

RESOLVED, that the Ohio Osteopathic Association continues to seek equitable reimbursement formulas for Medicare, Medicaid and other government- sponsored healthcare programs; and be it further

RESOLVED, if payment for services cannot be at acceptable, usual, customary and reasonable levels, that the Ohio Osteopathic Association continues to seek other economic incentives, such as tax credits and deductions to enhance the willingness of physicians to participate in these programs. *(Original 1992)*

School Bus Safety Devices

RESOLVED, that the Ohio Osteopathic Association supports legislation requiring the use of protective devices and restraints and/or any other measures to improve the safety of children in school buses in the state of Ohio. *(Original 1987)*

Third Party Payers, DO Medical Consultants

RESOLVED that the Ohio Osteopathic Association continues to urge all third party insurers doing business in Ohio to hire osteopathic physicians (DOs) as medical consultants to review services provided by osteopathic physicians (DOs) particularly in cases involving osteopathic manipulative treatment (OMT); and be it further

RESOLVED that third party review of claims from osteopathic physicians which involve OMT should only be performed by a like physician who is licensed to practice osteopathic medicine and surgery pursuant to Section 4731.14 of the Ohio Revised Code and who has a demonstrated proficiency in OMT. *(Original 1992)*

Tobacco Control

RESOLVED, that the Ohio Osteopathic Association:

1. Encourages elimination of federal and state subsidies for the tobacco industry;
2. Supports increased taxation on tobacco products at both the state and federal levels, and urges that any revenue from such taxes be earmarked for smoking reduction programs and research involving tobacco-related diseases;
3. Encourages municipal, state and federal governmental agencies and lawmakers to enact clean indoor acts, a total ban on tobacco product advertising, and elimination of free distribution of cigarettes in the United States:
4. Urges schools to incorporate recognized tobacco use prevention courses in their health education curriculum.
5. Aggressively supports state and national efforts to eliminate smoking from all health care facilities, long-term care facilities and public buildings;
6. Encourages adults to avoid smoking in private homes and vehicles when children are present;
7. Opposes the availability of cigarette vending machines in general and supports state and federal legislation that would further limit access to these machines by minors;

and

8. Supports the position statements of Tobacco Free Ohio and the Ohio Tobacco Control Resource Group.*

**Tobacco Free Ohio is a collaboration of the American Cancer Society, American heart Association, American Lung Association and the Ohio Department of Health. It is supported by a SmokeLess States grant from Robert Wood Johnson Foundation. The Ohio Tobacco Control Resource Group (OTCRG) is a coalition of state and location associations and coalitions concerned with the impact of tobacco on health. OOA Executive Director Jon Wills served as chair of the OTCRG in 2001. Existing policies are on file at the OOA Office.*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2012-03

SUBJECT: Information Technology Adoption and Interchange

SUBMITTED BY: OOA Resolutions Committee

REFERRED TO: Professional Affairs Reference Committee

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AND APPROVED:

~~WHEREAS, the federal government has called for the creation of a national health information network to streamline healthcare transactions, improve the sharing of health information and reduce medical errors; and~~

~~WHEREAS, the Ohio Osteopathic Association has been instrumental in helping the Health Policy Institute of Ohio develop a strategic roadmap and policy options for the effective adoption of health information technology and health information exchange in Ohio; and~~

~~WHEREAS, implementation of a network in Ohio will require the cooperative effort of healthcare providers, payers, consumers, state government, and others; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to participate in efforts to advance health information technology adoption and health information exchange in Ohio with appropriate HIPAA-compliant privacy and security protections; and, be it further

RESOLVED, that the OOA continue to seek funding from public and private sector sources to help underwrite the cost of adopting and maintaining Electronic Health Records (EHR) in physician offices. *(Original 2007)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2012-04

SUBJECT: Ohio Medical Reserve Corps (OMRC)

SUBMITTED BY: OOA Resolutions Committee

REFERRED TO: Professional Affairs Reference Committee

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AND APPROVED:

~~WHEREAS, the mission of the Ohio Medical Reserve Corps (OMRC) is to establish teams of local volunteer medical and public health professionals who can contribute their skills and expertise throughout the year as well as during times of community need; and~~

~~WHEREAS, the Ohio Osteopathic Association was a charter member of the Ohio Medical Reserve Corp Committee and was the first organization in the State of Ohio to sponsor a Advanced Disaster Life Support Course, qualifying participants to become members of the OMRC; and~~

~~WHEREAS, MRC units have been established in 69 Ohio counties and are made of locally based, medical and public health volunteers, who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism; and~~

~~WHEREAS, MRC volunteers also offer education and prevention services to improve the~~

~~public health infrastructure of their neighborhoods; and~~

~~WHEREAS, Ohio Revised Code 121.404 provides liability protection to registered Ohio Citizen Corps (including Ohio Medical Reserve Corps) volunteers during local, state or federally declared emergencies, disasters, drills and trainings; and~~

~~WHEREAS, the statute also exempts a registered volunteer's personal information on the Ohio Citizen Corps Database from public disclosure~~; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages all of its District Academies to establish contact with the local Medical Reserve Corps (MRC) units that have been established in counties within its district; and be it further,

RESOLVED, that the OOA encourages its members to register to become members of the OMRC and obtain necessary training to respond to state, local and national public health emergencies. *(Original 2007)*

EXPLANATORY NOTE: *THE MISSION OF THE OHIO MEDICAL RESERVE CORPS (OMRC) IS TO ESTABLISH TEAMS OF LOCAL VOLUNTEER MEDICAL AND PUBLIC HEALTH PROFESSIONALS WHO CAN CONTRIBUTE THEIR SKILLS AND EXPERTISE THROUGHOUT THE YEAR AS WELL AS DURING TIMES OF COMMUNITY NEED.*

RES. NO.
2012-05

SUBJECT: Physician Fines

SUBMITTED BY: OOA Resolutions Committee

REFERRED TO: Professional Affairs Reference Committee

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AND APPROVED:

~~WHEREAS, some third party carriers strive to control all sources of patient health care utilization; and~~

~~WHEREAS, this includes but is not limited to the use of outpatient laboratory services; and~~

~~WHEREAS, this may require the exclusive use of specific laboratory facilities in a geographic area; and~~

~~WHEREAS, patients may wish to have their orders for laboratory services executed at a facility of their own choosing with full knowledge of economic repercussions and without the authorization of a physician; and~~

~~WHEREAS, for whatever reason some patients may elect to use the services of a competitor laboratory in spite of the request of their insurance carrier; and~~

~~WHEREAS, efforts to control the use of one laboratory over another have included financial fines levied by the carrier upon the panel physician requesting laboratory services; and~~

~~WHEREAS, this punitive fine is arbitrary and capricious it is also misdirected, anticompetitive, and in effect inurnment; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association opposeS all punitive fines levied on physicians for acts committed by patients that are not under the absolute control of the physician~~; and be it further~~

~~RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association for consideration of nationwide support at the 2007 House of Delegates.~~

(Original 2007)

ACTION TAKEN: _____

DATE: _____

RES. NO.
2012-09

SUBJECT: Telemedicine

SUBMITTED BY: OOA Resolutions Committee

REFERRED TO: Professional Affairs Reference Committee

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AND APPROVED:

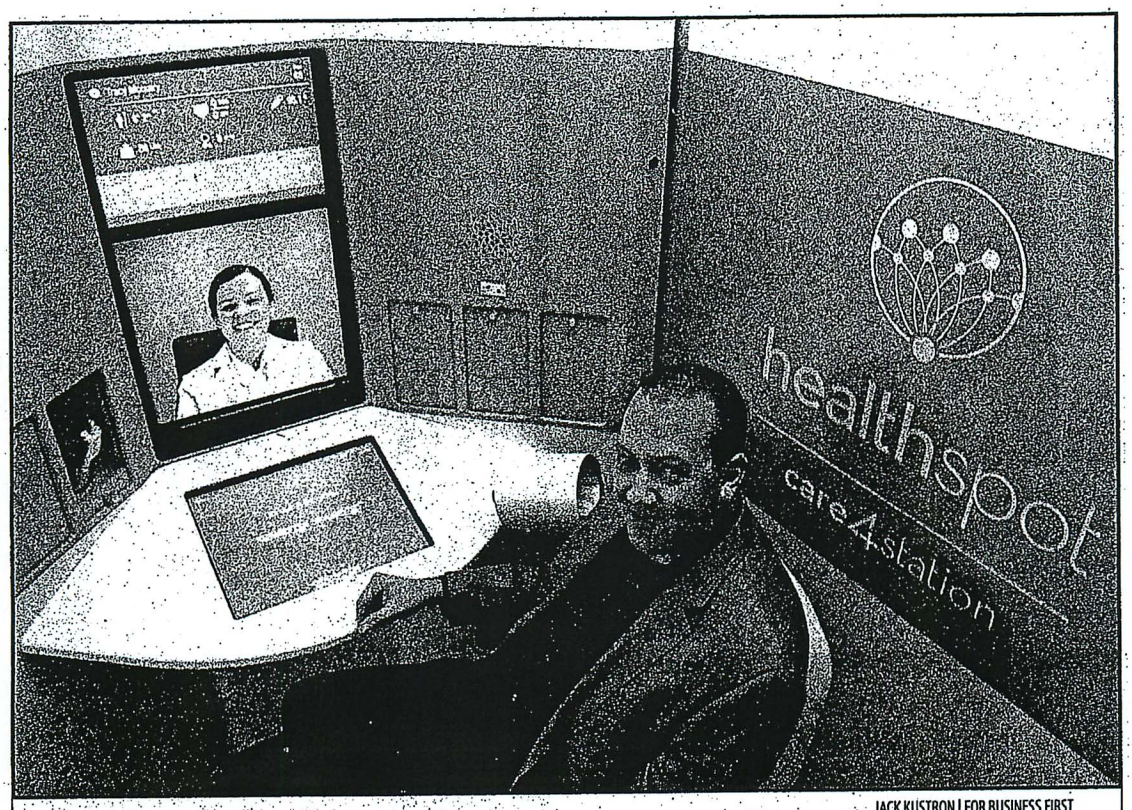
RESOLVED, that the Ohio Osteopathic Association continues to support affordable and uniform medical licensure requirements to enable physicians to practice medicine and surgery by utilizing telemedicine technologies; AND, BE IT FURTHER

RESOLVED, THAT THE OOA WORK WITH THE OHIO STATE MEDICAL BOARD AND OTHE OHIO PHYSICIAN ORGANIZATIONS TO DEVELOP RULES THAT ENCOURAGE INNOVATION AND ACCESS TO OHYSICIAN SERVICES THROUGH TELEMEDICINE WHILE WNSURING QUALUTY AND PROMOTING EFFECTIVE PHYSICIAN-PATIENT RELATIONSHIPS,

EXPLANATORY NOTE: Emerging technology is rapidly changing the traditional practice of medicine. As a result, the Federation of State Medical Boards, the American Osteopathic Association, and other national physician organizations have been examining existing policies on telemedicine. The American Osteopathic Association has drafted a new policy statement on telemedicine, which will be addressed during the 2012 AOA House of Delegates. The Ohio State Medical Board has convened a task force of physician organizations – including the OOA – to develop new regulations as a result of these market forces.

ACTION TAKEN: _____

DATE: _____



JACK KUSTRON | FOR BUSINESS FIRST

HealthSpot founder Steve Cashman developed a kiosk that allows patients to consult with off-site medical professionals via videoconference. He's shown demonstrating how it works with HealthSpot's Angie Homan.

Ohio's next billion-dollar business?

INVESTORS IN DUBLIN-BASED HealthSpot believe its kiosk combining videoconferencing with digital medical instruments will spur a revolution among doctors and patients.

BY CARRIE GHOSE | BUSINESS FIRST

Sleek blue pods will be sprouting in clinics and pharmacies across Ohio by summer, giving patients convenient access to a medical appointment but requiring a do-it-yourself element as they operate stethoscopes and thermometers while talking to doctors on videoconference.

A 20-minute visit to a HealthSpot Inc. kiosk will cost about $60 and can net patients a diagnosis and a pre-

SEE **HEALTHSPOT**, PAGE 35

HEALTHSPOT: *Cardinal Health has minority stake*

FROM PAGE 1

scription right away.

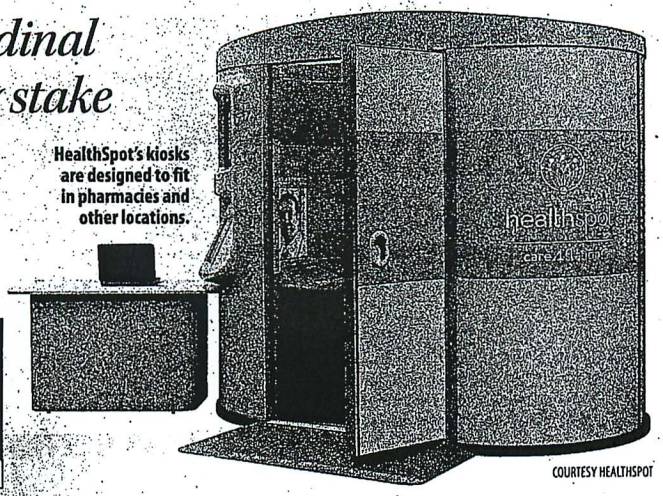
CEO Steve Cashman says HealthSpot can provide the long-sought pathway to easily accessed, lower-cost, more-effective health care.

The Dublin business he conceived at poolside can become Ohio's next billion-dollar company, he said. He raised $6 million in 18 months from backers, many from billion-dollar enterprises, and landed a giant distribution partner in Cardinal Health Inc.

H. Cathey: Early investor

One investor and adviser is venture capitalist Hugh Cathey, who propelled the former Nextlink Communications Inc. to one of Central Ohio's top telephone providers, then built up the Columbus office of Qwest Communications International Inc.

"I've looked for the next thing I think could be that big," Cathey said. "This is that big."



HealthSpot's kiosks are designed to fit in pharmacies and other locations.

COURTESY HEALTHSPOT

BRINGING THE A-TEAM

The 9- by 5-foot kiosks are an opportunity for independent and regional chain pharmacies to finally compete with the in-store clinics of national chains, Cashman said, giving up less precious floor selling space and paying one medical assistant rather than two or more nurse-practitioners.

Other host sites could include nursing homes, which would save on transport to doctors, he said, and large self-insured employers as an alternative to an on-site clinic.

For doctors, it means seeing more patients but less overhead on scheduling, billing and generating records. For patients, it means less waiting and easier access.

The last component is insurers. State Medicaid rules vary on whether telemedicine is covered – Ohio in nearly all cases does not. Cashman said he's meeting with private insurers.

"If we provide more efficient health care, it's more profitable for them," he said.

W. Wulf: Central Ohio Primary Care Physicians

HealthSpot would break even leasing out the $49,000 units, but based on taking just a slice of the patient tele-visit fee, Cashman projects surpassing $1 billion in revenue within five years. He expects to double the 30-employee company's staff this year as it adds sales and operations expertise.

HealthSpot has compiled a deep roster of Ohio partners. Cardinal Health, Ohio's largest public company, confirmed it owns a minority stake and is marketing the kiosk to independent and regional pharmacy customers.

Scott Summers, marketing director for Dublin-based Cardinal's retail pharmacy business, said in an email to *Columbus Business First* that the "kiosks allow retail pharmacies to offer their patients all the benefits of an in-store clinic, at a fraction of the cost."

Central Ohio Primary Care Physicians Inc. of Westerville, the region's largest independent practice, has lined up eight of its 225 doctors to see patients from a unit that was to be installed Feb. 3 at its same-day appointment center on Olentangy River Road in Columbus. After a test run, it could add doctors and deploy kiosks at other sites starting with Reynoldsburg and Westerville, said Medical Director Dr. William Wulf.

"You could probably see several more patients an hour, and you could work with fewer staff," he said.

New Albany-based truck components maker Commercial Vehicle Group Inc. will manufacture the kiosk, called a Care4Station, with final assembly in North Carolina. Paul Bennett, vice president of engineering, research and development, said via email that CVG expects it to be "a successful, market-leading concept."

Central Ohio's largest military contractor, Mission Essential Personnel LLC of Columbus, is marketing the kiosk to the U.S. government and aid groups, and planning to use it for its employees in 16 countries.

"About 30 percent of the Pentagon's budget is consumed by health-care expenses, so there's a clear need for solutions," CEO Chris Taylor said via email.

Cleveland industrial design firm Nottingham Spirk was an early investor, designed the kiosk and refined it after feedback from patients and doctors.

"We look at what we call 'sleepy' categories where we see an opportunity to change the game," Nottingham Spirk Co-President John Nottingham said. "When you have a situation where everybody wins, the market forces will drive this thing."

HEALTHSPOT INC.

Business: Seeks to improve convenience and cost of health care through technology.
Based: Dublin
CEO: Steve Cashman
Employees: 30
Website: healthspot.net
Board members and top advisers:
Manuel Fernandez: Co-founder, managing director, SI Ventures; formerly CEO of Gartner Inc.
Chuck Hallberg: Founder, MemberHealth LLC, a pharmacy benefits management provider acquired by Universal American Corp.
Mervin Dunn: CEO, Commercial Vehicle Group Inc.
John Spirk: Co-president, Nottingham Spirk.
Andy Alderman: Senior vice president of strategy and business development, Cardinal Health Inc.
Hugh Cathey: Principal, Columbus-Partners LLC; former president, broadband division, Qwest Communications International Inc.
Bruce Roberts: Former CEO, National Community Pharmacists Association.

UNTESTED MARKET

Not that there aren't skeptics. Even though the former CEO of the National Community Pharmacists Association is advising the company, the trade group's spokesman John Norton asked why pharmacies bear most of the financial risk of the units.

"While the product is intriguing, it would seem more prudent for our members who operate off of 3 percent profit margins to lease space as opposed to paying for the service," he said in an email.

Cashman's revenue projections are based on capturing 15 percent of 60,000 pharmacies nationwide, or 9,000. In a soon-to-be-released report on telemedicine for BCC Research in Wellesley, Mass., analyst Andrew McWilliams projected a U.S. market for just 1,000 Web-enabled kiosks by 2016. Adoption of kiosks that use just videoconferencing has been slow, he said via email, but those with integrated medical instruments might do better. Other companies have designed enclosed, instrument-equipped kiosks, but HealthSpot would be the first to get one to consumers, said Jonathan Linkous, CEO of the American Telemedicine Association.

"It's an untested market," he said, but there are clear signs consumers are ready.

"I've seen hundreds of studies on patient acceptance," he said. "Every one of them has said patients really like telemedicine, even if they have to hold their own stethoscope."

Cashman likened the consumer-led adoption he expects to the way ATMs introduced people to online banking.

BET THE JOCKEY, NOT THE HORSE

A self-described "Kansas farm boy" who went to college for electrical engineering, Cashman started and sold an IT company in Colorado before moving to Ohio as strategy chief for a Westerville software company. In early 2010, he got the itch to start a company again – "something with more meaning," although he didn't yet know what. He was reading health-care market research while spending time at the pool with his kids when the idea for a digitally enhanced private kiosk came to him "in about 30 seconds," he said.

Cathey said Cashman's driven personality and ability to get things done fast stands out.

"All investors are betting on the jockey," Cathey said.

614-220-5458 | cghose@bizjournals.com

DRAFT POLICY RECOMMENDATIONS
BSGA TELEMEDICINE WORKGROUP

WHEREAS, the American Osteopathic Association's House of Delegates adopted H250-A/08 Policy on Online Medicine as a policy paper governing the organization's position on technology and medicine and reaffirmed this policy, as amended, in 2009; and

WHEREAS, this policy charges the AOA with monitoring updates in online medicine on an ongoing basis; and

WHEREAS, a recent review demonstrated that advancements in technology and its use in patient care have surpassed the scope of H250-A/08 in its current form; now, therefore be it

RESOLVED, that the following policy paper and the recommendations provided within substitute H250-A/08 as AOA Policy on Online Medicine:

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 of this practice. The primary issues telemedicine issues include: (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.[1] Additionally, eighteen states grant expedited telemedicine licenses and forty states have specific statutes addressing the practice of medicine over technologic networks.[2]

Access and Quality

Many observers believe telemedicine can solve the problem of limited access to care currently faced by patients 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

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[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*

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 most people are generally 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. Some feel that confusion over jurisdiction exists in instances where a physician, who is licensed in two or more states, practices across state lines through electronic means with an adverse outcome.

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 incident 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. States' licensure requirements also diverge in areas such as testing, postgraduate education and continuing medical education requirements. Additionally, scopes of practice vary by state with no overall standard in regards to prescriptive authority or practice rights. Finally, there is no consensus regarding what constitutes a visit and establishes the "physician-patient relationship". Some states require a face-to-face visit before a telemedicine relationship can be established, but others do not. 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 recently been expressed regarding the assumption of 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 for 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 establish a national licensure system, which he believes would allow physicians to more freely provide care to remote areas across state lines.

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[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

Conclusion

WHEREAS, the AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who would not normally have access to medical care. The AOA also acknowledges the special challenge for osteopathic physicians whose philosophy of a hands-on approach is hindered by the use of information technology to deliver health care services; now, therefore be it further

RESOLVED, 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; and, be it further

RESOLVED, 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 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 reimbursement systems that are inclusive of telemedicine; and, be it further

RESOLVED, that 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; and, be it further

RESOLVED, that the technological network being used to deliver patient care must have protocols in place that ensure the stability of that network, and that the scope of care being provided does not supersede applicable state and federal law; and be it further

RESOLVED, that the AOA supports state-based licensure and the ability of states to govern activities within their borders is paramount. Physicians should be allowed to obtain licensure in one jurisdiction with states working together to establish reciprocity in licensure for the delivery of patient care through telemedicine; and, be it further

RESOLVED, that 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 heard, within the constraints of that system; and be it further

RESOLVED, that 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; and, be it further

RESOLVED, that as physicians provide care in a variety of new ways, including telemedicine, advanced technology can be used to improve patient care. The AOA 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; and, be if further

RESOLVED, that the AOA will monitor developments in online medicine on an ongoing basis and update this policy as needed.

RES. NO.
2012-10

SUBJECT: CME Accreditation

SUBMITTED BY: Cleveland (VII) Academy of Osteopathic Medicine

REFERRED TO: Professional Affairs Reference Committee

WHEREAS, there are insufficient local opportunities for some AOA Category 1A specialty and subspecialty education credits; and

WHEREAS, most major medical centers routinely provide high quality education credits; and

WHEREAS, most of these opportunities provide the highest grade of credit for allopathic organizations; and

WHEREAS, most of these opportunities do not provide for Category 1A osteopathic credits; and

WHEREAS, there are multiple political, financial, and philosophical issues associated with this situation; now, therefore be it

RESOLVED, that the OOA establish a special committee to determine an amicable pathway to the resolution of the issues of contention by all parties; and furthermore, be it

RESOLVED, that the OOA petition the AOA for any assistance necessary to accomplish these goals at the House of Delegates meeting for 2012.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2012-12

SUBJECT: Spirituality in Medicine

SUBMITTED BY: Andrew P. Eilerman, DO

REFERRED TO: Professional Affairs Reference Committee

WHEREAS, the American Osteopathic Association (AOA) defines the osteopathic difference as a "whole person" approach to health care, and osteopathic physicians understand how all the body's systems are interconnected[1] ; and

WHEREAS, health care and spirituality have been intertwined for most of recorded history, from ancient Roman healing temples to the ministries of Mother Teresa[2]; and

WHEREAS, a growing number of rigorous studies have shown that spirituality—including prayer, meditation, and attendance at religious service benefits health in ways that science hasn't fully explained[2]; and

WHEREAS, research has shown that people who received social support for stress through spiritual avenues had better self-reported health than those who received similar degrees of support through secular sources[2]; and

WHEREAS, pain has been reported to be a multifactorial condition, with physical, emotional, social, and spiritual components, and it takes an interdisciplinary approach to care for the patient that faces end of life pain, including doctors, chaplains, spiritual directors, pastoral counselors and clergy[3]; and

WHEREAS, physicians can enable a patient to utilize the spiritual resources of their own faith tradition for healing in an ecumenical way, thereby respecting every person's religious and spiritual preference[4]; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association supports the integration of spirituality in the practice of medicine because of the positive effects that it can have on patients, and opposes regulation to limit its use; and, be it further

RESOLVED, that upon successful passage of this resolution, a copy be sent to the AOA for consideration and discussion at its annual meeting.

1. *About Osteopathic Medicine*. Available at: http://www.osteopathic.org/osteopathic-health/about-dos/about-osteopathic-medicine/Pages/default.aspx.
2. *Should religion and faith have roles in medicine*. Available at: http://health.usnews.com/health-news/articles/2008/12/22/health-prayer-should-religion-and-faith-have-roles-in-medicine
3. *Religion, spirituality, and end of life care*. Available at:

http://www.uptodate.com/contents/religion-spirituality-and-end-of-life-care
4. *Department of Pastoral Care - John Hopkins University*. Available at: http://www.hopkinsmedicine.org/pastoralcare/index.html

ACTION TAKEN: _____

DATE: _____

RES. NO.
2012-14

SUBJECT: RN Pronouncement of Death in the Hospice Setting

SUBMITTED BY: Dayton (III) Academy of Osteopathic Medicine

REFERRED TO: Professional Affairs Reference Committee

WHEREAS, Hospice patients and their families often suffer tremendous stress and grief over the course of a patient's stay in a Hospice program, and that grief is compounded for the bereaved family members by unnecessary delays in death pronouncement; and

WHEREAS, The Medicare Conditions of Participation for Hospice Care encourage the continued involvement of the attending physician in the Hospice patient's medical management and plan of care; and

WHEREAS, Many factors including time constraints, practice structure, lack of recent face-to-face encounters with homebound patients, and limited training in end-of-life care create challenges for attending physicians and/or their call group partners in meeting the needs of hospice patients, including pronouncement of death, especially for those receiving hospice care in community settings; and

WHEREAS, These challenges often result in delay in the pronouncement of death of Hospice patients which may be caused by difficulty reaching the attending physician by telephone in a timely manner or by the reluctance on the part of the attending physician's call group partner to pronounce the death of a patient unfamiliar to them over the telephone; and

WHEREAS, Delay in pronouncement of death for patients in a Hospice program may compound the grief experience of family members by delaying removal of the deceased's body by the funeral home, leaving the family with a sense of uncertainty about the official "time of death", and taking the focus of the Hospice RN away from that of providing support to the bereaved family to performing the task of attempting to contact the attending physician and/or Hospice medical director; and

WHEREAS, By definition in the Medicare Conditions of Participation for Hospice Care, all patients enrolled in a Hospice program have been certified by two physicians to have a terminal illness with six months or less to live if their illness runs its normal course; and

WHEREAS, Given that definition, death is the expected outcome for all patients enrolled in a Hospice program; and

WHEREAS, Most Hospice patients' deaths do not occur with the attending physician or Hospice medical director physically present; however, the presence of a licensed Hospice RN is routine at the time of death; and

WHEREAS, Hospice RNs attend to more patient deaths each year than any other

discipline in Ohio, with over 60,000 individuals out of the approximate 110,000 Ohioans who died in 2010 being enrolled in a Hospice program; and

WHEREAS, A Hospice RN possessing a valid license under Chapter 4723 of the Ohio Revised Code routinely attends death of Hospice patients and serves as the "competent observer" pursuant to Ohio Administrative Code 4731-14-01, which authorizes the physician to pronounce a person dead without physically assessing the body of the deceased after the RN, acting as the competent observer, has recited the facts of the deceased's present medical condition to the physician and the physician is satisfied that death has occurred; and

WHEREAS, A Hospice RN possessing a valid license under Chapter 4723 of the Ohio Revised Code possesses the clinical skills required to perform the standard assessment for determination that death has occurred including the assessment of no palpable carotid pulse, no heart tones for two minutes, no breath sounds for two minutes, fixed and dilated pupils, and no response to verbal and tactile stimuli; and

WHEREAS, Pursuant to Chapter 3705.16 of the Ohio Revised Code, the physician who attended the decedent is required to, and would remain responsible for, completing the death certificate; and

WHEREAS, Delays in death pronouncement will be avoided by authorizing Hospice RNs possessing a valid license under Chapter 4723 of the Ohio Revised Code to perform the physical assessment and pronounce that death has occurred for Hospice patients, which will ease the suffering of grieving family members; **therefore be it**

WHEREAS, That the Ohio Osteopathic Association support legislation that would allow Hospice RNs possessing a valid license under Chapter 4723 of the Ohio Revised Code to pronounce the death of patients who expire while receiving care in a Hospice program.

ACTION TAKEN _____

DATE: _____

Talking Points:

Benefits of Registered Nurse Death Pronouncement for Patients Receiving Care in a Hospice Program in Ohio:

- ☒ The Medicare Hospice Conditions of Participation for Hospice Care encourage the continued involvement of the attending physician in the daily of care of patients receiving Hospice services. However, many community physicians are challenged in this role by time constraints, practice structure, and limited training in end-of-life care.
- ☒ Community physicians are tasked with receiving phone calls to address Hospice patient needs 24/7. Often, in the group practice setting, the physician receiving the call(s) is not the actual attending physician, but his or her partner. This can lead to a delay in addressing the needs of the hospice patient, including pronouncement of death, due to the lack of personal knowledge or relationship with the individual patient.
- ☒ Any delay in pronouncement of death for a patient receiving care under a Hospice program subsequently results in a delay of funeral home removal of the deceased patient's body. Delay can also lead to uncertainty on the part of the patient's family as to the "time of death". Both of these consequences may compound the bereavement experience of family members.
- ☒ Pronouncement of death is the final gift clinicians give to their patients and families. Any delay in death pronouncement can change the perception of the experience by a family from a "good death" to a "bad death". The time immediately following death can be a time of extreme grief and high anxiety for the decedent's family. Actions to make that transition as seamless as possible may help relieve some of that burden. Timely death pronouncement also allows families to feel confidence in knowing the accurate "time of death".
- ☒ All patients enrolled in a Hospice program have been certified by two physicians to have a terminal illness with 6 months or less to live if their illness follows its expected course. Therefore, death is the expected outcome for all patients enrolled in a Hospice program. Most deaths do not occur when the physician is in attendance. However, Hospice RNs routinely attend death and serve as the "competent observer" under Ohio law to relay the facts to the physician, who then may pronounce death without examining the patient.
- ☒ The standard assessment to determine death (no palpable carotid pulse, no heart tones for 2 minutes, no breath sounds for 2 minutes, fixed and dilated pupils, and no response to stimuli) are clinical assessment skills any Hospice RN possesses.
- ☒ By allowing RNs in the state of Ohio to pronounce death for patients receiving care in a Hospice program and subsequently notify the attending physician in a timely manner, we avoid delays in death pronouncement for Hospice patients and therefore, ease the potential suffering of bereaved families.

Midwest Care Alliance
The source for home, hospice & palliative care

RN Pronouncement of Death in the Hospice Setting

Midwest Care Alliance
Midwest Care Alliance represents home care, hospice, and palliative care members throughout Ohio. Our membership serves patients across the state utilizing or in need of vital home- and community-based care and end of life services, including over 55,000 Ohio patients each year who utilize hospice services.

What is Hospice?
Hospice is an interdisciplinary model of patient centered care where decision making is shared among the patient, family, and a team of providers including a physician, nurse, social worker, and spiritual care provider. Other support team members include volunteers, hospice aides, hospice homemakers, licensed practical nurses (LPNs), therapist, and administrative personnel. Medical care needs focus on controlling pain and symptoms related to end-stage diseases, terminal illness, and complicating factors. Psychosocial support includes advance care planning, dealing with emotional concerns, providing education related to symptoms control, complicating factors, burdens, grieving, setting realistic goals, socialization needs, and family grief support.

Patient Deaths in Ohio Hospices
Around 110,000 Ohioans die each year. In 2010, hospice cared for over 60,000 individuals, or 46% of Ohioans who died. Over 56,000 of those individuals received hospice services as Medicare benefits, while the rest received services through Medicaid or private pay. When death occurs in hospice, which is the expected outcome, it is rare that a registered nurse (RN) does not respond or attend to the family and the patient's bedside.

RN's Role When Death Occurs
When a death occurs in hospice, a registered nurse attends to finalize details regarding patient and family immediate needs:

- RN makes assessment to determine death has occurred;
- RN calls physician and reports vital signs;
- Physician, over the phone, pronounces patient as dead;
- Family support needs are evaluated and final body care needs and documentation requirements are addressed;
- Hospice provides unfunded support services to the family for up to 13 months following the death of the patient.

Expanding Pronouncement to RNs
By far, hospice RNs experience and care for more patient deaths than any other professional discipline in Ohio. Expanding RN authority to pronounce death in the hospice setting—where the expected outcome is death—would allow continuity in the dying process for Ohio patients, families, physicians, and caregivers. Midwest Care Alliance supports expanding pronouncement of death to RN providers for patients receiving hospice services.

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