

1. LEGISLATION/REGULATION

1. Center for Medicine and Medicare Services (CMS)

The ACOFP opposes Medicare fraud and abuse. The ACOFP encourages CMS to simplify Medicare rules and regulations as a positive approach to reducing fraud.

2. Continuing Patient Access to Osteopathic Physicians

The ACOFP recommends that the AOA continue to coordinate efforts through the Washington office to educate the United States Congress about osteopathic medical care and advocate continued patient access to osteopathic medical care.

3. Coverage for Uninsured and Underinsured Minors

The ACOFP encourages its members to urge the U.S. Congress to vote to fully fund and implement this important health coverage change being proposed for the State Children's Health Insurance Program (SCHIP).

4. Formularies – Physician Consultation

The ACOFP supports legislation that requires a physician be available for consultation on pharmaceutical formulary decisions.

5. GME Funding for Residency Programs Using Volunteer Faculty

The ACOFP supports the enactment of Federal legislation that increases and adequately finances the training of osteopathic family medicine residents in ambulatory non-hospital sites.

The ACOFP supports the enactment of Federal legislation that clarifies Congressional intent as established in the Balanced Budget Act of 1997, allowing teaching hospitals and physicians in non-hospital sites to enter into educational agreements to train osteopathic family medicine residents regardless of financial arrangement.

6. HPV Vaccine Coverage

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.

7. Payment for Influenza Vaccine

The ACOFP Congress of Delegates calls upon the Center for Medicare & Medicaid Services (CMS) to ensure payments for influenza vaccine to reimburse physicians for their full acquisition cost of the vaccine plus the administration fee.

8. Payment for Physician Services

The ACOFP shall work to educate insurance and managed care plans on the ability of family physicians to provide comprehensive care to patients, and assist its members to resolve payment problems with specific payers. The ACOFP shall take whatever steps are necessary to ensure that osteopathic family physicians are fairly compensated for all services rendered.

The ACOFP and AOA shall work with third-party payers to eliminate the practice of withholding payment for current services rendered on the basis of past disputed services, and, that appropriate peer physician associations become involved in this decision process.

The ACOFP encourages legislation that requires managed care companies and all third party payors to reimburse for appropriate on-site testing at a rate equal to the highest rate reimbursed for the same service to off-site providers.

9. Physician Compensation

The ACOFP supports the adoption of national legislation which enables the osteopathic family physician to perform and be compensated for CLIA-certified, in-office laboratory tests. The ACOFP supports the adoption of national legislation that enables the osteopathic family physician to perform and be compensated for medically-indicated, on-site diagnostic procedures.

10. Retail Health Clinics – Quality & Patient Safety

The proliferation of retail facilities in the United States offering in-store medical clinics with a rapidly expanding list of health care services requires a renewed examination of legislation and regulation governing quality and patient safety.

Lost in the shift toward retail health clinics is the fact that the retail consumer becomes a patient, necessitating that the quality and safety required in a traditional physician's office take priority over convenience and low cost that draw consumers to retail facilities.

Threats to Quality and Patient Safety

The patchwork of state legislation and regulation governing health care services offered in retail settings raises legitimate questions regarding standards for quality and safety, especially whether the retail clinics are being held to the same requirements deemed necessary in a medical office.

- a. Are OSHA regulations for safety and health being met in a retail health clinic? Many retail clinics do not have separate bathroom facilities for specimen collection.
- b. Are adequate waiting room options or separate entrances available to prevent shopper exposure to sick patients and transmission of communicable disease? Actively ill individuals will be left to roam and shop the store, potentially exposing other shoppers unnecessarily.
- c. Are the non-physician providers (physician assistants or nurse practitioners) adequately supervised by physicians?
- d. The ACOFP maintains that on-site supervision by a licensed DO or MD provides the necessary level of quality and patient safety. Current state regulations present a wide range for the number of non-physician providers who may be supervised by one physician at a remote site. The ACOFP questions the ability of a physician to adequately supervise multiple retail clinics.
- e. Are patients being adequately informed about the educational credentials and expertise of the person providing the diagnosis and care? Perhaps they are led to believe that they are being treated by a physician when they are actually being cared for by a physician assistant or nurse practitioner who does not have the educational training to offer unlimited, comprehensive medical care.
- f. Are retail clinics able to respond to someone seeking treatment for what they perceive to be a minor medical condition when it may actually be a significant medical complication? For example, a patient thinking he has indigestion could actually be experiencing a heart attack.

g. Who will the patient contact should medications cause an adverse reaction? Physicians in medical offices maintain 24-hour coverage for their patients. True medical emergencies are best handled through Emergency Departments.

h. Without a documented patient history, how can retail clinics adequately determine an appropriate course of treatment? By their nature, retail clinics cannot provide the continuity of care that characterizes the established physician-patient relationship, which includes a medical history of the patient's allergies, a complete list of which medications the patient is currently taking, and a family history.

i. How will the storage of confidential medical records be kept to prevent identity theft in a retail store, with different employees exposed throughout the day – what safeguards will be in place?

The ACOFP supports the role of primary care physicians as the appropriate “point-of-entry” for patients to enter the health care system, leading a “team approach” to patient care.

Furthermore, the ACOFP believes that the most effective way to improve patient health is through an established, long-term relationship with a primary care physician who is the one qualified to provide unlimited, comprehensive medical care.

Concern over Economic Conflicts of Interest

A traditional medical practice does not have the same economic objectives of a retail business venture. While current laws do not restrict where a prescription or over-the-counter medication can be obtained, the economic incentives of these for profit business ventures should be closely monitored. The close proximity of a pharmacy or over-the-counter medications maximizes the likelihood that the patient will not leave the store to obtain their prescribed medications, creating the potential conflict of interest whereby the retail facility financially benefits from treatment recommendations made in the clinic.

In many states physicians are restricted from both writing and filling prescriptions in their offices, yet a double standard exists when a patient can walk through the store to fill a prescription given at the in-store clinic.

Conclusion

The American College of Osteopathic Family Physicians questions both the advisability and the need for facilities known as retail or “in-store” clinics. Although such facilities are heavily promoted by their corporate owners as “quick and convenient,” we question the real cost of circumventing the quality and continuity of care inherent in the primary care physician-patient relationship.

Osteopathic family physicians have always been required to maintain complete, 24-hour coverage for their patients, either through answering services, on-call covering physicians, or extended and flexible hours. True medical emergencies are best handled through emergency departments, while other urgent situations are properly handled through the patient's family physician. We should not support the fracturing of patient care by encouraging the use of these facilities.

11. Tax Credits for Health Profession Shortage Area

The ACOFP supports the establishment of tax credits for physicians who practice in federally designated health professions shortage areas (HPSAs) or Medicare physician scarcity areas. These tax credits should be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities.

12. Transportation Costs for Patients

The ACOFP encourages the CMS and third-party payors 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.

13. Vaccine Availability

The ACOFP encourages the United States government and its regulatory agencies to ensure that an adequate supply of vaccines be available to the American public.

14. Vaccine Safety

The ACOFP supports the recommendation of The Advisory Committee on Immunization Practices (ACIP) and the declaration of the Centers for Disease Control and Prevention (CDC) that vaccines are safe.

The ACOFP supports the education of the public payors, and government entities about the safety and effectiveness of vaccines.

15. Primary Care Incentive Payment – Adjustment to

The ACOFP supports a ten percent 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.

16. Preservation of Family Medicine Department in Hospital Setting

The ACOFP affirms that the family medicine department is an integral part of all hospitals regarding education and the provision of continuity of patient care from the in-patient to out-patient settings. Family medicine hospital staff should remain an integral part of the medical staff structure and have an opportunity to maintain a seat on the Hospital Medical Executive Committee, particularly in hospitals that have family medicine residency programs.

17. Reporting Electronic Health Records Software Errors to Physicians

The ACOFP requests 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.

18. Hospital Privileges

The ACOFP will defend the rights of patients to receive care from the physician of their choice and the rights of osteopathic family physicians to provide care in all settings for which they are trained.

19. Physician Gag Rule

The ACOFP opposes governmental actions and policies that limit the capacity of physicians and other health care providers to inquire of their patients on whether they possess guns, how they are secured in the home, to counsel their patients about the dangers of guns in the home, and safe practices to avoid those dangers.

The ACOFP opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech.

20. State Adult Immunization Registries

The ACOFP supports and encourages the implementation of lifespan state immunization registries for adults and children, thereby improving continuity of care, patient safety, and vaccination rates for all residents in the United States.

The ACOFP encourages and supports state and federal efforts to create interoperability between state immunization registries.

21. Cognitively Impaired Physicians

The ACOFP basic tenets are advocacy, education and leadership. This includes Advocacy for our members to practice osteopathic family medicine without prejudice or unwarranted restriction. It also includes Advocacy for our patients and patient safety.

The transformation of the healthcare system in the United States affords all patients an expectation of high quality patient-centered care. This care should be delivered by competent physicians who are free from physical, psychiatric and emotional illness or injury that inhibits their ability to deliver quality healthcare. As part of its commitment to the safe and effective delivery of patient care, the ACOFP also advocates for proactive educational opportunities for practicing physicians concerning mental and physical health and physician impairment issues. The goal of these sessions is to address prevention, treatment and rehabilitation of illness or potentially impairing conditions. These goals also should include the evaluation of the ability of the physician to acquire new or changing medical knowledge.

The term "cognitively impaired physician" may include a variety of conditions and populations. Cognitive impairment refers to the inability of the physician to adequately gather, evaluate, and process medical information and to apply appropriate medical knowledge and skills. This may also include the impaired ability to learn new information. A cognitively impaired physician may include but is not limited to: 1.) Physicians with specific medical conditions that despite the use of assistive devices and technology, are unable to use their senses to evaluate and treat patients; 2.) Physicians suffering from uncontrolled with drug and alcohol related illnesses; 3.) Physicians with neurodegenerative disorders with impaired working memory or the ability to process and store information. This includes physicians with dementia; 4.) Physicians with medical conditions that require medications that impair their cognitive process or memory; 5.) Physicians suffering from uncontrolled mental illness which impaired their thought process or memory.

It is the policy of ACOFP that physicians should be allowed to remain in practice as long as patient safety, quality medical practice and patient well-being are not compromised. Self-regulation is an important aspect of professionalism, but there are instances where physicians may not be aware of the significance of their own cognitive impairment. It may be the observations of colleagues, medical staff members, nurses, or employees that first notice a physician's cognitive impairment. Physician monitoring may include the following: 1.) Physicians who are members of an active medical staff at a hospital or other medical institution should be monitored by colleagues and peers on that staff. Irregularities or signs of cognitive impairment should be brought to the attention of the chief of staff, chief medical officer or their designee for further evaluation. Guidelines and standards should be an essential part of the medical staff bylaws. Routine physical examinations as required by the bylaws should include cognitive evaluation; 2.) Physicians who practice in a private group

should be monitored by their colleagues in that practice. Appropriate guidelines instituted by that practice should address cognitive impairment; 3.) Physicians in large corporate practices should be governed by the guidelines of that organization. Policies concerning cognitive impairment should be well delineated as well as a method of reporting any concerns to the chief executive officer (or designee); 4.) Physicians employed in academic institutions should be monitored by colleagues, deans and department chairs. Appropriate guidelines should be a part of the institution's standards; 5.) Physicians who are board certified may undergo routine evaluation through the re-certification and maintenance of certification processes. Face-to-face evaluation, such as the American Osteopathic Board of Family Physicians neuromuscular medicine testing, provides another valid avenue to assess a physician's cognitive abilities; 6.) Physicians in solo practice who are not active members of a medical staff or who are not actively pursuing re-certification or maintenance of certification have a limited opportunity for monitoring by others. These physicians should empower their own staff to carry out appropriate monitoring; 7.) Monitoring may include psychometric evaluation to determine the clinician's ability to safely engage in active clinical practice.

It is the duty of physicians to continually assess and evaluate their own physical and mental abilities. It is also the duty of physicians to report any significant cognitive impairment of a colleague to the appropriate hospital, or clinic authorities. Of particular concern are physicians with limited exposure to peers, who are not on active medical staff or practicing with other physicians. It is vital that these physicians have access to resources to help them in self-monitoring. These resources should be available through state and national professional societies.

It is the goal of The ACOFP to assist physicians in their care of patients. This includes proactive involvement in maintaining competency in cognitive abilities. The ACOFP shall be proactive in assisting in the development of tools for assessing cognitive skills for physicians, as well as providing guidelines for self-reporting both by the individual physician and for colleagues of any cognitively impaired physician.

The ACOFP supports the adoption and implementation of the following standards by hospitals, health plans, academic institutions, and state licensing boards: 1.) The practice environment should be one that allows for confidential reporting and self-reporting of illness or other potentially impairing conditions; 2.) The identity of the person(s) reporting concerns regarding the possible cognitive impairment of a physician should be in writing and should be kept confidential. If in the opinion of the appropriate officer/administrator the allegations are credible, an investigation should be undertaken. The physician in question shall be directly contacted and made aware of the allegations. The physician shall be given the opportunity to respond to the allegations; 3.) If the concern is deemed substantial, the physician should undergo a complete medical exam that is related to the performance and scope of practice, including psychometric evaluation; 4.) A drug test should be obtained to determine if the physician is using drugs illegally or abusing legal drugs; 5.) A physician deemed impaired should have access to professional resources such as counseling, medical treatment or rehabilitation services for the purpose of diagnosis and treatment of the conditions of concern; 6.) If the impairment is a disability, reasonable accommodation, as defined within the Americans With Disabilities Act should be made to enable the physician to competently perform clinical duties; 7.) If the impairment constitutes a direct threat to the health and safety of patients, the physician, or other co-workers, immediate action should be taken. Every attempt will be made to reach a voluntary agreement for adjustment of the physician's duties and privileges. If a voluntary agreement cannot be reached, the physician could be subject to the appropriate corrective action with strict adherence to any applicable medical staff by-laws, facility work rules, and state and federal reporting requirements; and 8.) If an adjustment in a physician's duties and privileges has occurred, a process for rehabilitation and reinstatement should exist. A physician suffering from a physical, psychiatric or emotional illness or injury shall be given the opportunity to demonstrate improvement in their condition. The facility may request reasonable proof of

completion of treatment and clearance to return to practice. Upon receipt of appropriate documentation the physician should be granted reinstatement of clinical privileges. The physician may be required to obtain periodic reports from the treating physician, attesting to the physician's continued ability to safely provide medical care. Physicians suffering from drug or alcohol related impairment shall be given the opportunity to demonstrate resolution of their condition. Upon receipt of appropriate documentation the physician should be granted reinstatement of clinical privileges. The patient's treating physician shall attest to the physician's condition and continued treatment as appropriate. If indicated, the physician shall provide periodic reports from the physician regarding the ability of the physician to safely provide medical care. If applicable, the physician shall provide documentation of compliance with other requirements of a physician's health/recovery committee (State or local/employer).

2. CERTIFICATION

1. Certification

The ACOFP continues to recognize 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.

2. Certification – COM Chairs

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.

3. Specialty Certification of Chairpersons

The ACOFP recommends that the Commission on Osteopathic College Accreditation (COCA) and AOA 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 certified in family medicine by the AOA through the American Osteopathic Board of Family Physicians (AOBFP).

4. Certification Eligibility for New and Existing CAQs

No new Basic Standard developed by the Committee on Evaluation and Education (CEE) of the American College of Osteopathic Family Physicians (ACOF) for the ultimate purpose of gaining Certification of Added Qualification status through the American Osteopathic Board of Family Physicians (AOBFP) shall be approved or maintained by the ACOFP Board of Governors unless the ACOFP Board receives the advanced assurance of the AOBFP that a pathway to that CAQ will be provided for certified osteopathic family physicians for a minimum of five years.

The following explanatory statement accompanies the Board's policies on certification eligibility for future new CAQs and revisions to existing CAQ: It is the responsibility of the ACOFP Board of Governors through its CEE to establish Basic Standards for postdoctoral training in osteopathic family practice. These Basic Standards are submitted to the Department of Education Affairs of the AOA for approval. The AOBFP under direction of the Bureau of Osteopathic Specialists (BOS) is responsible for the certification or verification of competence in those subjects being taught in the postdoctoral training programs. This verification process generates a primary certification for residents and/or a Certification of Added Qualification (CAQ) for certified osteopathic family physicians. New Basic Standards can be developed at any time for potential CAQs, but it would take a residency

program to implement them before an examination or certification process would be generated by the AOBFP. It is the policy of the ACOFP Board of Governors not to approve or maintain a Basic Standard for any new CAQ if that certification process does not contain a reentry pathway (grandfather clause).

5. Certification – Reentry Pathway

The ACOFP should request that the AOA streamline and expedite the certification reentry pathway to allow returning ACGME-trained osteopathic physicians to obtain AOA certification.

6. Mandatory Recertification of Physicians

The ACOFP opposes mandatory recertification as a condition of physician licensure.

7. AOA Specialty Board Certification

The ACOFP will work with the American Osteopathic Association (AOA) and the Bureau of Osteopathic Specialties (BOS) to develop the necessary strategies to ensure that any osteopathic or allopathic physician who has completed the necessary requirements for board eligibility be allowed to sit for osteopathic board exams.

8. Osteopathic Continuous Certification (OCC)/Maintenance of Certification (MOC)

The ACOFP work with the American Osteopathic Association's Bureau of Osteopathic Specialists and the American Osteopathic Board of Family Physicians (AOBFP) to study options for Osteopathic Continuous Certification (OCC)/Maintenance of Certification (MOC) pathway for physicians who choose AOBFP certification utilizing software such as one incorporating "intelligent learning engine" capability including consideration of a pilot program by AOBFP.

ACOFP recommends that if such options cannot be adequately proven to improve patient safety, quality of care and physician competency, then current methods for MOC/OCC should be carefully studied, reviewed and possibly suspended so as not to be redundant with quality and safety reporting, as well as practice activities improvement, already enumerated in the MACRA Legislation.

3. EDUCATION

1. Continuing Medical Education

The ACOFP shall recommend to the AOA Board of Trustees and AOA House of Delegates that Category 1 allopathic CME programs remain and continue to be considered as Category 2 A for AOA CME accreditation in accordance with the current AOA CME guide and standards.

2. Disclosures Relevant to Potential Commercial Bias

The ACOFP requires that persons planning and speaking at Continuing Medical Education (CME) events disclose any relationships that may cause, or appear to cause, a conflict of interest.

All Program Committee members, teachers, presenters, editors, authors and staff must complete the ACOFP Full Disclosure for CME Activities form, indicating any relevant financial relationships. A relevant financial relationship is defined as a financial relationship in any amount occurring in the past 12 months that creates a conflict of interest.

Completed disclosure forms must be received in sufficient time to be reviewed by the ACOFP Program Committee, which monitors potential conflicts of interest. Planners, speakers, authors and staff will be notified that failure to return the form in a timely manner may result in disqualification from participation in the CME activity. Those failing or refusing to complete the disclosure form in sufficient time for Program Committee review shall be disqualified from participation. Individuals who fail or refuse to disclose their relevant financial relationship(s) will be prohibited from participation in the planning, presentation, or evaluation of a CME activity.

All disclosure information will be provided to learners prior to the beginning of the educational activity. The information from the Full Disclosure Form for CME Activities form will be presented in writing in activity materials. The source and nature of all support from commercial interests will be disclosed to learners in writing in all promotional and activity materials. The following information regarding relevant financial relationship(s) of all individuals in a position to control CME content will be disclosed to learners: a.) The name of the individual; b.) The name of the commercial interest(s) with which the relationship exists; c.) The nature of the relationship that the individual has with each commercial interest.

The source of all support from commercial interests will be disclosed to learners. When commercial support is “in kind”, the nature of the support must be disclosed to learners. Disclosure must never include the use of a trade name or a product group message.

If disclosure information is not submitted prior to the deadline for printed activity materials, that information must be disclosed verbally at the live activity prior to the presentation. An ACOFP staff member must witness the communication of the information and must complete the Verification of Verbal Disclosure Form.

For an individual with no relevant financial relationship(s) the learners will be informed that no relevant financial relationship(s) exist.

3. Graduate Medical Education

The ACOFP recommends to the AOA that it preserve elements of the osteopathic internship as an integral component within osteopathic graduate medical education, and, preserve osteopathic distinctiveness.

4. Physician Reimbursement

The ACOFP supports the current AOA policy on Physician Reimbursement in Federal Programs.

5. Pre- and Post-Doctoral Education

The ACOFP encourages the development of core curriculum guidelines in cultural diversity to address the issue of cultural competency and healthcare disparities throughout the lifelong continuum of osteopathic medical education, and that these guidelines should be included in the Basic Standards for Residency Training and be forwarded to the AOA for referral to appropriate committees for inclusion into the Basic Standards of Pre-Doctoral and Post-Doctoral Training.

4. OSTEOPATHY

1. Osteopathic Oath

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great

responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it may be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will -come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still.

2. Osteopathic Pledge of Commitment

As members of the osteopathic medical profession, in an effort to instill loyalty and strengthen the profession, we recall the tenets on which this profession is founded – the dynamic interaction of mind, body and spirit; the body's ability to heal itself; the primary role of the musculoskeletal system; and preventive medicine as the key to maintain health. We recognize the work our predecessors have accomplished in building the profession, and we commit ourselves to continuing that work.

I Pledge To: Provide compassionate, quality care to my patients; partner with them to promote health; display integrity and professionalism throughout my career; advance the philosophy, practice and science of osteopathic medicine; continue life-long learning; support my profession with loyalty in action, word and deed; and live each day as an example of what an osteopathic physician should be.

3. Research

The ACOFP encourages the AOA to identify additional funding sources and increase internal funding for research identifying the therapeutic value of OMT and then continue to study the application and usefulness of OMT in maintaining health and treating diseases.

4. Osteopathic Identity

The colleges of osteopathic medicine and osteopathic professional organizations are strongly encouraged to use the word osteopathic on all their signage, letterhead, marketing and public relations material. The ACOFP supports the clear identification of these as osteopathic entities.

5. PATIENT EDUCATION

1. Patient Advertising

The ACOFP supports the AOA policy on Prescription drugs – Direct Consumer Advertising.

2. Prescription Drugs – Direct Consumer Advertising

The ACOFP continues to recommend that pharmaceutical company direct to consumer advertising not be product specific. The ACOFP should work with the AOA to request that state and federal governments adopt policies or legislation to promote disease-specific public health education as the focus of direct to consumer advertising of prescription medicines to the general public.

3. Physician-Assisted Suicide

The osteopathic profession shall take a leadership role in providing the public with information on alternatives to physician-assisted suicide. The ACOFP opposes legislation to legalize physician-assisted suicide.

4. Soft Drinks In Schools

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.

5. Tissue and Organ Donation Education

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

6. Use of Electronic Devices While Driving

The ACOFP opposes texting while operating motorized vehicles.

7. Recreational Marijuana Use

The ACOFP opposes the recreational use and promotional marketing of marijuana and supports increased education to both adolescent and adult populations on the harmful effects of marijuana use.

8. Epidemic Opioid Overdose Deaths in America

The ACOFP supports the continued evaluation and availability of all interventions that prevent opioid overdose deaths, especially the increased availability and use of opioid antagonists.

9. Best Clinical Practices for Opioid Prescriptions

The ACOFP shall provide members with educational activities on best clinical practices and standards for opioid prescription and clinical implementation.

10. Collaboration with Organizations Advocating for the Prevention and Treatment of Prescription Narcotic Abuse and Dependence

The ACOFP initiates, develops and maintains collaborative relationships with local, state and national organizations to provide education to physicians, patients, policy-makers and other stakeholders regarding controlled substance abuse and dependence prevention. The ACOFP advocates for appropriate, adequate and available treatment options for those individuals suffering from controlled substance abuse and dependencies.

11. Prenatal Drug Screening

The ACOFP encourages prenatal drug use screening as part of prenatal care and providing education in addiction assistance to pregnant women with positive drug screens.

12. Seatbelt Usage and Endorsement of Primary Enforcement Laws

The ACOFP supports endorsing seatbelt usage in all patient populations, but especially in those with the lowest rate of seatbelt use and highest risk of death in a motor vehicle accident.

The ACOFP recommends that all states pass a primary seatbelt enforcement law.

13. Powdered Caffeine

The AOA and ACOFP oppose the use of concentrated powdered caffeine for non-medical uses.

6. PRACTICE MANAGEMENT

1. Practice Guidelines

The ACOFP endorses practice guidelines whose conclusions are based on quality osteopathic data that has adequate osteopathic input and research.

2. Practice Management

The ACOFP shall encourage and promote unity and the practice rights of osteopathic family physicians, by continuing to support periodic practice management seminars to: a.) Educate physicians as to the importance of compliance risk management, billing and coding, documentation, and fraud and abuse issues; b.) Assist in the establishment of guidelines to enhance these practice rights and safety in the areas of compliance, risk management, billing and coding documentation, in fraud and abuse issues; c.) Identify, supportive agencies, liability insurance companies, attorneys, and physicians with expertise in these issues; d.) Encourage government and insurance agencies to utilize only expert witness who are osteopathic family physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic family physicians; e.) Develop and advise the leadership and affiliate societies of the needs, trends, and issues of concern that will encourage unity, ensure a safe practice environment, and enhance the practice rights of ACOFP members.

7. BEST PRACTICE

1. Prescription Pain Medication/Long-Acting Opioid Medication

ACOFP supports 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.

2. Physician and Medical Product Manufacturer Financial Relationship Transparency

The ACOFP supports transparency with public, efficient, effective reporting - inclusive of appropriate safeguards to ensure accuracy and appropriateness - of physician financial relationships with pharmaceutical and medical device manufacturers.

3. Needle Exchange Programs

The ACOFP encourages the ongoing efforts and creation of needle and/or syringes exchange programs based upon the Department of Health and Human Services implementation guidelines.

4. HIV Consent Form Elimination

The AOA and ACOFP support the elimination of the requirement of physicians and health care settings to have consent forms completed before an HIV test.

8. RESIDENCY PROGRAMS

1. Residency Training Programs

ACOFPP policy and relevant communication stipulate that each specialty residency training program should continue to be inspected by physicians approved by the specialty college of that discipline.

The statement is presented to clarify the position of the ACOFP on the osteopathic family medicine residency training program.

The cornerstone in osteopathic healthcare has always been the family physician. Osteopathic family physicians are physicians oriented to delivery of healthcare to the family. They commonly use more than one of the traditional specialty fields of medicine providing the necessary training, and they are trained to coordinate the care required by reference to other physicians and allied health personnel. Training equips them to assume the responsibility for the patient's comprehensive and continuing health care, serving the family unit with skill and understanding.

Historically, the osteopathic family physicians who have completed their year of rotating internship have attained this level of competence.

However, medicine is a dynamic art and science, and the accumulation of knowledge cannot stop after internship. Family physicians are morally obligated to pursue their own area of specialty to excellence, and then to maintain this expertise for the duration of their careers in medicine.

One of the important measures of academic excellence in the specialty of family medicine is certification. Residency training represents the avenue of preparation to attain this specific body of knowledge characteristic of a certified osteopathic family physician. It enables the resident to accumulate those skills and competencies which ordinarily require long years of practice exposure. It accelerates the usual process of specialty attainment. It develops in the family medicine resident an appreciation of the need for a life-long process of learning and encourages mastery of those disciplined habits which result in continuous scholastic development.

The osteopathic family medicine residency provides that body of knowledge which identifies the primary care most commonly required in practice. Moreover, it intensifies the understanding of both the shared-care and supportive-care roles exemplified by this responsible coordinator of the health care team.

With the increasing complexities of medical knowledge, the following characteristics emphasize some of the most important facets in the osteopathic family medicine residency training programs: a.) Emphasis on formalized outpatient and inpatient longitudinal primary care, including curriculum specific to training year and clinical service; b.) Further emphasis and integration of the practical application of osteopathic principles and practices in an ambulatory setting; c.) Encouragement of cooperation with other osteopathic specialists to accomplish osteopathic medicine's distinctive approach to patient care; d.) Expansion of humanistic or behavioral science training, e.g. family dynamics, family counseling, care for the dying patient and his family, etc.; e.) Development of competency in the art of "problem solving" as in undifferentiated or multiple-complaint

illness; f.) Teaching the strategies of interdisciplinary team approach in providing comprehensive health care; g.) Improvement of interviewing and communication skills; h.) Initiation in utilization of communication medical resources; i.) Commitment to the importance of preventive medicine in patient care; j.) Provision for the necessary training in the mechanics of office management and the economics of practice; k.) Exposure to the patient/physician responsibility of third-party medicine; l.) Development of proper office and hospital recordkeeping systems; m.) Recognition of the personal and professional needs of physicians and their families; n.) Association with the proper role model who encourages behavioral adjustments that result in the resident emulating the characteristics of the certified osteopathic family physician; o.) Provide mandatory, ongoing and timely faculty development training for all faculty in family medicine residency training programs.

The residency program addresses the needs stated above. It provides the osteopathic family physician with the special skills and competencies necessary to provide primary, continuing, comprehensive healthcare to all members of the family, regardless of age, sex, or type of medical problem.

The osteopathic family medicine residency program reinforces what has already been taught: that the osteopathic family physician is in charge of the patient's health needs and is the primary coordinator of the entire health care team, both in an ambulatory and in an institutional setting.

In summary, the osteopathic family physician is the solidifying agent who captains, guides, and encourages the total care which is the keystone of osteopathic medicine. To address this on-going educational responsibility, the ACOFP shall continue to improve, develop, and encourage the residency training program in osteopathic family medicine.

2. Separate Osteopathic Match

The ACOFP continues to support the separate osteopathic match that is currently in place.

3. Ambulatory-Based Family Medicine Residency Programs

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 of ambulatory-based family medicine residency programs.

9. INNOVATIVE MEDICINE

1. Human Genome Project

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 easily 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.

2. Stem Cell Research

The ACOFP advocates the following policy on stem cell research: a.) Stem cells differentiate into specialized cell lineages; b.) Stem cells have and will be used in regenerative medicine to replace diseased or damaged tissues, in such conditions as diabetes mellitus, Parkinson's disease, and cardiovascular disease; c.) Stem cell research has the potential to impact the fields of drug discovery, toxicology, and therapeutic drug delivery. The AOA supports biomedical research on stem cells and must continue to monitor developments in stem cell research and sources of stem cell funding.

3. Telemedicine

Definition of Telemedicine - Telemedicine is an area of medicine that utilizes information and telecommunication technology to transfer medical information that assists in the diagnosis, treatment, and education of the patient.

Primary Care versus Consultation - For the purpose of telemedicine: A primary care doctor/patient relationship can only be established through, at least, one physical face-to-face meeting. Treatment via telemedicine can be utilized only after the establishment of the doctor/patient relationship.

Medical consultation may occur when a licensed physician, who has not met the patient in a face to-face meeting, is called upon to give treatment advice within the scope of practice to another licensed practitioner who is treating the patient.

State versus federal regulatory oversight - Regulatory oversight for telemedicine should be administered at the state level, utilizing licensure requirements developed by individual states and their medical boards. To regulate the practice of telemedicine across state lines, the ACOFP asks the Federation of State Medical Boards to develop a system wherein a physician may be granted licensure to practice telemedicine in a state where the physician is not currently licensed.

10. SUPPORT RESOLUTIONS

1. Support Resolutions

AOA Policy (ACOFP Reaffirmed)

- a. ACOFP supports AOA policy to maintain osteopathic medicine as a separate and distinct school of medicine.
- b. ACOFP supports the AOA policy to attempt to reduce healthcare costs.
- c. ACOFP supports the AOA policy on "National Health Insurance."

11. SPORTS MEDICINE

1. Sports Medicine – Team Physician Consensus Statement

A team physician shall be a DO or MD in good standing with an unrestricted license to practice medicine.

2. Team Physician Definition

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: a.) Possess a DO or MD degree as a licensed physician in good standing, with an unrestricted license to practice medicine; b.) Possess a fundamental knowledge of emergency care regarding sporting events; c.) Be trained in CPR; d.) 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: a.) Specialty Board certification; b.) Continuing medical education in sports medicine; c.) 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); d.) Additional training in sports medicine; e.) Fifty percent or more of practice involving sports medicine; f.) Membership and participating in a sports medicine society; g.) Involvement in teaching, research and publications relating to sports medicine; h.)

Training in advanced cardiac life support; i.) Knowledge of medical/legal, disability, and workers' compensation issues; j.) 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: a.) Medical management of the athlete; b.) Coordinate pre-participating screening, examination, and evaluation; c.) Manage injuries on the field; d.) Provide for medical management of injury and illness; e.) Coordinate rehabilitation and return to participation; f.) Provide for proper preparation for safe return to participation after an illness or injury; g.) Integrate medical expertise with other health care providers, including medical specialists, athletic trainers and allied health professionals; h.) Provide for appropriate education and counseling regarding nutrition, strength and conditioning, substance abuse, and other medical problems that could affect the athlete; i.) Provide for proper documentation and medical record keeping.

Administrative and Logistical Duties

The following administrative and logistical duties include: a.) Establish and define the relationships of all involved parties; b.) Educate athletes, parents, administrators, coaches, and other necessary parties of concerns regarding the athletes; c.) Develop a chain of command; d.) Plan and train for emergencies during competition and practice; e.) Address equipment and supply issues; f.) Provide for proper event coverage; g.) 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 medic (Web sites, CD-ROMs).

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.

12. NON PHYSICIAN

1. Non-Physician Clinicians

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.

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

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.

2. Veterans Administration Credentialing of Non-Physician Providers

The ACOFP supports the establishment of well-defined credentialing and privileging criteria within the Veterans Administration that prohibits non-physician providers who have been granted expanded scope of practice rights in a minority of states from demanding such privileges in the VA system; and, be it further,

The ACOFP support the establishment of a consistent requirement for the privileging of non-physician providers in the VA system that reflects the opinion of a majority of states.

13. PUBLIC SAFETY

1. War on Terrorism

The ACOFP supports the war on terrorism and the continued development of appropriate homeland security measures.