BUREAU ON FEDERAL HEALTH PROGRAMS MEETING

September 21, 2013

NOAC
1090 Vermont Ave. Suite 500 NW
Washington, DC 20005

AMERICAN OSTEOPATHIC ASSOCIATION
AGENDA
Bureau on Federal Health Programs  
September 21, 2013  
8:30 AM - 11:30 AM  
National Osteopathic Advocacy Center, Washington DC

**BFHP Charge:**  
The Bureau on Federal Health Programs (BFHP) provides direction on the Federal, legislative and regulatory activities of the AOA Department of Government Relations. The Bureau studies and evaluates Federal health and education issues of interest to osteopathic physicians and those they serve.

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<td>Chairman’s Welcome/Osteopathic Oath of Commitment</td>
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BFHP Members:

George Thomas, DO - Chairman
James M. Lally, DO, MMM, FACOFP - Vice Chair
William S. Mayo, DO - Chair, Dept. of Government Affairs
Thomas L. Ely, DO - Chair, State Government Affairs
Paul A. Martin, DO, MS
James Johnson, DO, FACOS
Joseph Kuchinski, Jr., DO
Ronnie B. Martin, DO - Medical Education Representative
Robert B. Goldberg, DO
Creagh E, Milford, Jr, DO - New Physician in Practice
Regina Benjamin, MD, MBA - Public Member
Kathleen Creason, MBA - Osteopathic State or Specialty
Jay Kirkham, DO - Intern/Resident
Timothy Brian Marcoux, Jr, OMS II - Student Representative
AOA Mission Statement

To advance the distinctive philosophy and practice of osteopathic medicine.

AOA Vision Statement

To be the professional home for all osteopathic physicians.
Osteopathic Pledge of Commitment

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.
The Osteopathic Oath

This modern version of the Hippocratic Oath for administration to osteopathic college graduates began a suggestion by Frank E. MacCracken, DO, of California to his state society. Within a year, the suggestion went from the state to the national association, and a committee was formed under the Associated Colleges of Osteopathy to prepare the text. Members of that committee included Dr. MacCracken, as chairman, and Drs. R.C. McCaughan, Walter V. Goodfellow, and Edward T. Abbott. The first version was used from 1938 until 1954, at which time minor amendments were adopted. This version has been in use since 1954.

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.
Thank you, Ed, for hosting today’s event. Thank you, House of Delegates, for the opportunity to serve our profession. Welcome colleagues, friends and family. We need to talk about some things that are important for our present circumstances and to our future...about putting the challenges of the present into context with our history...about recognizing how many of our challenges are actually opportunities to help shape our own future...and about the tools we will need to keep us on course as we continue on the journey of the osteopathic medical profession.

As many of you know, I talk a lot about culture, and I’ve been thinking a lot about the importance of culture. As mentioned yesterday, Dr. Nichols often quotes Peter Drucker, “That culture eats strategy for lunch every day.”

Now you’re probably wondering why I have this picture up on the screens.

What is culture? It’s a shared set of interests, skills, values, goals or experiences. It’s a common heritage. It could be ethnic, military, professional, sports or business. It’s collegial. It’s passionate. And there’s a sense of commitment to those common interests.

Now the reason I have this picture on here...the obvious answer is I’m a surfer. Now I will have to qualify that...thanks to the hospitality of many people and organizations that are represented in this room, I’ve been having so much good food and drink that now when I paddle out, I’m more worried about getting harpooned than catching a wave.

But the less obvious answer is this picture represents a culture. This picture is the constant journey of the surfer. Surfers are in search of the perfect wave. In our surf culture, we also have our equipment, techniques, lingo: rad; awesome...you heard my friend, Pat, say awesome, which is common terminology; shaka; gnarly dude. We got a lot of that...cool. But we’re a family with a shared passion for common interests for the sport of surfing.

Now our DO profession has a strong culture. Clearly, we have a passion for what we believe in. We find our own lingo and interests and skills, which you’re all dedicated to. You’ve reaffirmed those distinctive skills just in the last 24 hours, haven’t you?

But I’ve been trying to find some commonality in these two disparate cultures. I was wondering how to share a cultural commitment to both passions, and that made me think of branding. Because with our surfboards, we say, I ride a Stewart. I ride a Rusty. I ride a Dewey Weber. But I’ve decided to create a new brand of surfboard. You see it on the screen...I’m getting ready to ride my new DO. Just to reinforce I brought it along today.

You know in our lingo, we say a board really rides well. It shreds. This board manipulates.

So what’s the point of all this—or, as Carl Pesta has said before, “Does this train of thought have a caboose?”
Well, it's about culture, and culture is important. It is the glue that holds us together. It's the key to sustainability. It holds the surf family together, and it holds the DO family together. It has for 139 years.

Let's flash back to 139 years ago. Post-Civil War chaos in medical practice, a lot of conflicting theories...purging, bleeding, leeches. You heard Dr. Krpan describe in his A.T. Still Memorial Lecture this morning about how an MD—our founder, A.T. Still, MD, DO—evolved a vision of a new philosophy of health and disease, principles and techniques designed to supplement, not replace, other available treatment modalities. He combined this philosophy with an emphasis on a humanistic approach and on evaluating and treating the whole patient.

Now that seems self-evident to us today, but his road wasn't easy. Despite a loyal following of grateful patients, despite other practitioners who wanted to learn Dr. Still's principles and share his vision, osteopathic medicine was rejected by the mainstream medical community. It was too different from current medical thinking. It was too disruptive. He and his fellow practitioners were branded as a cult.

But we know that life is a marathon and not a sprint. Dr. Still never gave up. Despite many challenges and seemingly insurmountable obstacles, he remained deeply committed to his beliefs. He was stubborn. Eventually his school of medical practice became known as osteopathy, which we know as osteopathic medicine today. The early DOs were passionate about a common vision, values and skills. They had a lingo and, most importantly, a sense of unity. They stuck together. The DOs weren't a cult. They were a culture. They endured, and our profession remains strong today.

We have many bright spots. There's more than 104,000 in our profession and about 83,000 are DOs, but here's a fascinating fact. We did some research this year. Many of you may not know that since our inception only about 105,000 DOs have received the DO degree. Of those, 80% earned their degree in the last 40 years. That's an interesting fact, isn't it? Twenty percent of all medical students are enrolled in osteopathic medical schools. We've been listed as the fastest-growing health care profession in the United States. Our degree is recognized for full licensure in 66 countries. Our legacy is a sustainable profession. We've overcome many discrimination battles. We've endured incredible challenges. We've survived. We've prospered.

And the challenges continue. One of the current challenges is graduate medical education, or GME. But that's not a new issue. Arnold Melnick, DO, who published a whole series of essays that you may remember in The DO magazine, once wrote that, when he graduated from PCOM in 1945, only one in three graduates could get a GME slot—one in three.

And I'll tell you a story about another PCOM graduate, who in 1940 graduated and could not get an internship or a residency. He knew he needed to make a living. He knew he didn't have many opportunities, so he heard a story of a country doctor down in east Texas who was looking for an associate. He went down there; he gave up everything he knew and ended up in a small town in the middle of the night with only a lone cow mooing in the distance. And he went to work for this doctor.

It was like a culture shock. He was overwhelmed. First of all, country medicine was probably a little barbaric back then. He certainly didn't feel he had the skills to be ready for that, so he left, practically broke. He went to Dallas, the nearest big city, because he heard there was a DO hospital
there and a DO named Sam Sparks. He walked up to this complete stranger and said, "I don't know what to do. I don't have any training. I'm broke. I don't know where to go. I've got to make a success of myself." Dr. Sparks says, "Why don't you put your stuff down in the basement? Relax, go into the dining room. Get a good meal. Get a good night's sleep. We'll talk in the morning."

The next day Dr. Sparks says, "Why don't you just stick around a little while, get your thoughts together and plans made? But while you're here, would you mind seeing a few patients? I can give you food, a place to sleep." He started seeing patients. Weeks turned into months. Once in a while, Dr. Sparks would come in and say, "Here's $5. You're working awfully hard. Go out, have dinner and go to a movie." Then after a year, Dr. Sparks came in one day with a piece of paper. He said, "Here's your internship certificate. You've got your internship."

That person was my father.

So what does Ed Vinn's journey symbolize? Endurance...commitment...stubbornness. I've got to tell you, he was one stubborn guy. We take care of our family members and support them. It's the kindness of strangers, another member of the DO family that pulled him out of a tough spot. It is our legacy and our destiny to continue the journey as a professional family and overcome the challenges that lay before us, and we will overcome those challenges.

I've been on my own osteopathic journey for 40 years, from Texas to Philadelphia to Michigan to California and, ultimately, to the national role where I'm honored to serve you today. Now I keep referring to my roots back in Texas, but we have a saying, "I'm gonna dance with them what brung me." I want to thank some people who helped me on this journey. First and foremost, my wife, Marsha. I met Marsha during my internship in Michigan. I took her home to Texas during the holidays. I wanted to introduce my parents to this beautiful girl. My mother was a die-hard Texan. She liked Marsha. She turned to me and said, "Norm, she's pretty nice for a little Yankee girl."

Marsha, you're the light of my life, thank you. My daughters: Vanessa, the other Dr. Vinn; Lily, who is a sophomore at Ole Miss with her Mississippi Mama and Papa, Cherri and Bill Mayo. We're not sure what she's majoring in; we think it may be sorority. And Danielle, the poet.

And my other friends and family members. For those of you present, I'm so honored to have you here with me today. This is a great day to share with you. And to my parents...to Ed Vinn...he was a character, a great guy, and I miss him. And my mother...she was the politician in the family. My father never talked to anybody other than patients. He was very quiet, very shy and never held any leadership roles. He was just a good doctor. My mother was the politician, and that's why she was up there as the president of the Texas Auxiliary. It was Rita Baker who actually found that picture so thank you, Rita, for recovering a little piece of history there.

Osteopathic Physicians and Surgeons of California...my colleagues, friends, soul mates in many ways, surf buds like Greg Pecchia...Adam Crawford...Blake Wylie...

My college, the American College of Osteopathic Family Physicians, they've been very supportive and just a great group of people.

And my mentors, the AOA past presidents, who I didn't even know the connections and how they would last. My mentors from Michigan were so great early on...so supportive, such great teachers
and role models. But especially Don Krpan, DO, my lifetime, career-long mentor...Don, stand up and be acknowledged.

You, the House of Delegates, thank you for your support.

John Crosby, 16 years of service. We’ve been kidding with John that he’s been on the “Victory Tour” here for several months, and he deserves every bit of it for being such a great part of our lives.

My fellow AOA trustees who’ve been so supportive and have been such great partners to work with as we struggle with really thorny issues. And the leaders and members of our bureaus, councils and committees, many of whom are in the audience today, who are so diligent in this volunteerism and labor of love.

And most importantly Ray Stowers. You’ve inspired us to better ourselves, to improve the level of care provided to our patients and to “stay ahead of the curve.” Thank you, Ray. Stand up and be recognized.

Now our journey is going to continue. On any journey there are going to be rocks in the road. When you’re surfing, there’s going to be some bumps in the reef. But are they challenges or are they opportunities? Thomas Edison once said, “Opportunities are often missed because they’re dressed in overalls, and they look like work.” Dressed in overalls and look like work. Things don’t always go as planned. We get knocked off. In surfing, that’s what we call “going over the falls” or a wipeout. But we paddle back out, and we keep going. We don’t give up.

There are uncertainties in our future, uncertainties about the Affordable Care Act, the sustainable growth rate, the growth paradox that Don pointed out so eloquently this morning. We’re growing, but in our studies, affinity to our profession has declined.

Despite our growth, our market share is declining, nationally and in many states. We measure that. We watch it very carefully. With 60% of our graduates going into ACGME training programs, Don pointed out that only about 10% of them stay in the AOA. That’s a fixable problem. That doesn’t have to be that way. Of course we have this pending mismatch of demand and capacity, and the ACGME situation which, as John said, was our finest hour...an extraordinary show of unity. The single pathway issue remains. We’re well aware of that, but to the students, residents and others affected by these challenges, I need to reassure you personally that we will do everything in our power to preserve existing career opportunities and to create new ones. We’re with you. We’re there for you. This is wicked strategy either way.

Despite these opportunities that look like work, our future remains bright. We hear from all sorts of sectors that we are the key to what’s missing in health care. We have a strong cultural foundation. We have endured for 139 years. We’re a family, that’s very important. And we are a well-organized minority. Margaret Mead once said, “A small, well-organized group can change the world. In fact, it’s the only thing that ever has.” That’s us...that’s us. We’re on this journey together, and we’re going to prevail.

So what are our next steps? Steven Covey says, “First things first.” We are aggressively and effectively managing a very smooth transition for our executive director to our dynamic, new
Executive Director, Adrienne White-Faines, who you’re going to meet tomorrow. Ray Stowers and I have been planning this transition for a whole year. We started out talking about how to make a smooth continuum between what Ray was doing and what I was going to do. I’ve already started working on this with Bob Juhasz about being sure there’s a smooth integration between his priorities and the things I hope we’re going to achieve this year.

But we also need to begin with the end in mind. Where do we want to be? We always talk about being great. We have our G.R.E.A.T. Family of pathways in our strategic plan: governance, research, education, advocacy, teamwork, family. We’re going to follow that plan. We need to harness and reinforce the strength of our culture to preserve our unity. We can have both culture and strategy for lunch. That’s our opportunity here.

We need to establish some guiding principles. What do I mean by guiding principles? They’re like a litmus test. They’re like the signposts on our journey into the future that we use to read, “Are we on course? Are we drifting off course?” We can test things we’re thinking about doing. Are these things we ought to be doing? Should we be changing course a little bit? I have some that I’m going to talk with you about today.

Innovation and evolution…they go hand-in-hand. Will Rogers said, “Even if you’re on the right track, if you’re not moving fast enough, the train is going to run you over.” This is not your father’s AOA. This is not my father’s AOA nor should it be. We have got to continually evolve—evolve our management processes, our governance processes. We need to be more nimble, more efficient in how we make use of our limited resources. We need new business models…non-dues revenues that will reduce dependence on our dues and the burden on you, our members. We need new alliances, internally and externally, to enhance our influence and our impact.

Winston Churchill once said, “The only thing worse than fighting with your allies is fighting without them.” We need to get past any disagreements. Sure, we’re going to have points of disagreements, but we need to look at the big picture…and look beyond that. We need to look at our new educational models, like the Blue Ribbon Commission. Customer-centric is a broader definition. It’s not just the patient. It’s payors. It’s integrated delivery systems. It’s hospital systems. We need to be churning out physicians who are efficient and ready to work in that context.

Diffusion…the Board of Trustees receives voluminous reading materials from outside sources, journal articles, government studies. The Strategic Planning Committee receives a lot of those. They review that, they digest that. But there’s no franchise of this information. We’re developing what we call the LEADRs program: Leadership Education and Development Resources. The whole idea is to start diffusing all this information to a broader base in our profession so we can raise the bar of our knowledge, raise the bar of our thinking, raise the bar of our planning and work toward the really important issues together.

Relevance…Charles Schwab said, “Ask the customers what they want.” Will Rogers stated it much more simply and said, “When you’re riding out in front of the herd, you better look back once in a while to make sure they’re still behind you.”

Now we have all these targeted segments in our profession. It’s like a company that has different types of customers. You are the guardians of the profession here. You and I have all drank the Kool-Aid. We’re the loyal troops. But what about the millennials? The ACGME trainees? Our
increasing cadre of specialists? We need to be sure we’re meeting their needs. We must maintain increased affinity to the AOA and to the profession.

Part of the way you do that is through engagement. We had some speakers here over the years who talked about the importance of just being involved, not even in a big way but maybe in a small way. We’re all pretty engaged. That’s why we’re here. But we can do better at creating a better sense of engagement, particularly with our third- and fourth-year students. As Don said, “Where are they training? Who are their role models? What’s their connection?” And those in their GME years, whether it’s OGME or GME, we need to create a sense of connectivity...how to stay connected to the DO family. There’s a lot of mentorship going on out there in various sectors that is oriented toward great career-planning, great educational choices, but what about just teaching people how to stay connected and why you should stay connected? That’s something we can do.

The Council of Interns and Residents started an extraordinary and visionary initiative to form an ambassadors program, and I believe they’ve got 58 ambassadors. They’re supposed to create a better connection to the residents. We’ve also re-engineered the President’s Advisory Council, and they’re going to be ambassadors...the whole cadre of them who are willing to serve. The goal is to try to touch those 1,000 residency programs out there and touch all those DOs...not only teach them about educational pathways but to teach them why they’re part of a family, why it’s good to be part of a family and how to stay connected with the family.

We need to be inclusive. I bet everybody in this room knows DOs who in the 70s or the early 80s were good DOs, but they wanted to take MD training because it was close to them or the best possible training they could get. We all know somebody who was told, “If you go take that MD training, don’t bother coming back.” I call them the “lost generation.” We need to reach out to those people, even if they don’t come back, and let them know that they were not rebels...that they were pioneers. They were innovators. We need to constantly look at ways to lower the barriers to re-engage with the profession, ease the restrictions for eligibility for program directors. Now I know that’s a thorny issue, but these are people who believe in the profession.

We need to “pay it forward” through stewardship. We need to be role models, and we need to encourage other people in the profession to be role models, to lay down paving stones for the road to the future and help others have the opportunities that were created for us. We’re going to enhance the effectiveness and reach of our mentor program. We’re going to be re-engineering it this year. But the first thing we said is, “Let’s do an inventory.” We gave out a STAR Award today to Ohio because of their efforts to do a state-level mentorship program. We have some specialty societies doing mentorship programs. We have an AOA mentorship program. That was an innovation and a recommendation of Darryl Beehler, DO, and it survives today. It was great, and it remains great. It can be even better. We want to eliminate the redundancy, the overlap, and we want to identify the best practices. We just need to know who’s mentoring who. That would probably be a good start, and we can do all that.

Our final guiding principle is celebration. Celebration, if you read much about culture in history, is the cornerstone of a strong culture. We honor and celebrate our great heroes, our Great Pioneers. We did some honoring of some very special heroes today, but we need to honor and celebrate you, the Guardians of the Profession. You’ve served the profession in leadership roles—state, county, national—and you know other people, your predecessors and role models who served. You’re all Guardians of the Profession. Like the Marines, we need to celebrate the guys on the front lines. You
all know people, living and deceased, like my father. They didn’t serve in any leadership roles, but they were great role models and as we say in our pledge, they live every day as an example of what an osteopathic physician should be.

Now the best thing, if you’re going to work on something like that, is to get started. We’re going to get started today since each one of you, I know, knows Guardians and you know Unsung Heroes. We’re going to do what salespeople call “induce an act of commitment.” I’m going to ask you to actively join me in paying homage to the Unsung Heroes and Guardians of the Profession. I’m going to ask that before you leave this ceremony, you complete recommendation forms, which the pages are going to pass out, and we have boxes out front. I’m going to ask every one of you to come up with an Unsung Hero, at least one, and you can come up with more, and a Guardian, and put them in that box out there. Our goal is to leave this House of Delegates with 400 Guardians and 400 Unsung Heroes, and we’re going to recognize and celebrate them at OMED in September.

As we get the word out on this through social media and our website, we want to hit 1,000 of each by OMED...2,000 by the end of my term, and Bob, I’m setting a big goal for you...4,000 by the end of Dr. Juhasz’s term. We can do it, right, Bob?

Now is this a reasonable request? Are you ready to do this?

Another thing we’re going to do that you’ve already been seeing a little of is called Osteopathic Media Moments, and what its acronym? OMM! This is people...this is DOs...this is family having fun as a family not practicing, not doing surgery, but having fun as a family. It’s a reminder that we celebrate together, and we’re going to encourage submissions: photos, videos, any type of media you’d like, profession-wide. They’ll be available on Facebook and YouTube. We’re going to have some awards, and as my daughter would say, “shout-outs” or recognition for the best submissions.

I’m going to leave you with one last touch point of culture: the hug. Did you ever notice how we’re always hugging each other? We were in a meeting with John Gimpel, DO, recently, who said, “I have an MD friend who says, ‘You guys are always hugging each other. It’s like you actually like each other.’” A hug is a symbol of our unique bond...a sense of family...our belief in the power of touch. Now many fraternal organizations have a secret handshake. We do not have one, but I propose that we officially designate the DO hug as the secret handshake of our profession. I’d like to close with a short video on this subject. I do think it qualifies as an Osteopathic Media Moment, but I’ll let you be the judge of that.

We can turn challenges into opportunities. We have a history of doing this. When I was a kid, my father used to say, “You know DOs will go into the areas where no one else wants to go, and they’ll make successes of themselves.” That’s what we did in inner cities. That’s what we’ve done in rural health. And we’ll do it again, and we’re going to keep doing it. We’re going to follow our plan. It’s the road to the future. We’re going to use our guiding principles and signposts. We’re going to focus on the bright spots, and we’re going to celebrate and strengthen our culture. It’s the glue that holds us together. Let’s continue our journey together as we prepare for the future. We are the solution. I look forward to working with you over the next year and thank you for your support. And remember to fill out your forms before you leave! Thank you!
Minutes
AOA BUREAU ON FEDERAL HEALTH PROGRAMS MEETING MINUTES

The Bureau on Federal Health Programs met in Washington, D.C., March 15, 2013 at the Renaissance Hotel. Meeting attendees were:

AOA Bureau on Federal Health Programs
George Thomas, DO, Chairman
Geraldine O’Shea, DO, Vice Chairman
Mark Baker, DO, Chair- Dept. of Government Affairs, AOCR
Paul Martin, DO, MS
Joseph A. Giaino, DO - Chair, State Government Affairs
James Johnson, DO
Joseph Kuchinski, Jr., DO
Ronnie B. Martin, DO - Medical Education Representative
Robert B. Goldberg, DO
Lynette McLain - Osteopathic State or Specialty, Oklahoma Osteopathic Association
Jay Kirkham, DO - Intern/Resident
Keith Egan, OMS III - Student Representative

AOA Officers & Members of the Board of Trustees
Ray E. Stowers, DO - President
Martin S. Levine, DO, MPH - Executive Committee, Immediate Past President
Robert S. Juhasz, DO – BOT, Executive Committee – Advisor
John W. Becher, Jr., DO – BOT
Ronald R. Burns, DO – BOT, Executive Committee
Boyd R. Buser, DO – BOT, Executive Committee
Joseph M. Yasso, Jr., DO – BOT, Executive Committee

AOA DC Staff
Sydney Olson - Associate Executive Director, Advocacy and Government Relations
Ray Quintero - Director, Government Relations Department
Susan Friedman - Deputy Director, Government Relations Department
Carol Monaco - Director, Federal Affairs Division
Angela Jeansonne - Assistant Director, Federal Affairs Division
Laura Wooster - Director, Congressional Affairs
Charles Cascio - Congressional Lobbyist
Holly Biglow - Congressional Lobbyist
Leann Fox - Director, Political Affairs & Advocacy
Sean Neal - Coordinator, Advocacy & Communications/Director, NOAC Operations
Margaret Hardy, JD - Director, GME Policy & Development
Keisha Taylor - Office Manager
Elizabeth Best - Office Administrator
AOA Chicago Staff
John B. Crosby, JD - Executive Director
Mike Zarski, JD - Director, American Osteopathic Information Association
Annette Gippe - Deputy Director, American Osteopathic Information Association/Executive Director, American Osteopathic Association for Medical Informatics
Monica Horton - Director, Practice Management and Delivery Innovations
Linda Mascheri - Director, State, Affiliate & International Affairs
Sharon McGill – Director, Quality & Research
Phil Atwood – Chief Information Officer, Information Technology

Bureau on Socioeconomic Affairs
David F. Hitzeman, DO, Chairman

American College of Osteopathic Pediatricians
Laura Stiles, DO
Scott Cyrus, DO – Bureau of Osteopathic Specialties Society

American Osteopathic Academy of Orthopedics
Lee VanderLugt, DO

American Association of Colleges of Osteopathic Medicine
Pamela Murphy, MSW
Luke H. Mortensen, PhD

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery
Paul Imber, DO

American College of Osteopathic Obstetricians and Gynecologists
Michael Geria, DO

Indiana Osteopathic Association
Erin Wernert

Ohio Osteopathic Association
Jon Wills

Osteopathic Physicians and Surgeons of Oregon
Rob Richardson, DO
Speakers
Rahul Rajkumar, MD, JD, Center for Medicare and Medicaid Innovation.
Joseph Antos, PhD – American Enterprise Institute.
Janet Marchibroda – Bipartisan Policy Center.

Other Attendees
Claude A. Foreit, DO, MHA – Franciscan Alliance.
Jeff Heatherington – Family Care Incorporated.
CHAIRMAN’S OPENING REMARKS

Dr. Thomas, Chairman of the Bureau called the meeting to order at 9AM. He welcomed members of the Bureau, President Ray Stowers, DO, and other Board Members and attendees.

Dr. Thomas asked the Bureau and audience to introduce themselves and give their affiliations.

Dr. O'Shea led the audience in the Osteopathic Pledge.

The agenda and January 25, 2013 minutes were approved.

John B. Crosby, JD greeted the audience and introduced the first speaker:


Dr. Thomas opened the floor to the Bureau members for their statements and comments.

The members voiced concerns or issues that need to be addressed by the Bureau and/or AOA.

Dr. Thomas asked for the AOA Reports:

Mark Baker, DO – Chair, Department of Government Affairs.

Joseph A. Giaimo, DO – Chair, State Government Affairs.

David Hitzeman, DO – Chair, and Sharon McGill, Bureau Socioeconomic Affairs.

Carol Monaco introduced the second speaker:

Rahul Rajkumar, MD, JD, Center for Medicare and Medicaid Innovation. ‘Accelerating Care and Payment Innovation’

BFHP Chairman Thomas introduced the lunch speaker:

Joseph Antos, PhD – American Enterprise Institute. ‘Bending the Healthcare Cost Curve’
Angela Jeansonne introduced the afternoon speaker:

Janet Marchibroda – Bipartisan Policy Center. ‘An Oversight Framework for Patient Safety and Health IT’

Dr. Thomas asked for the Department of Government Relations Reports:

Division of Federal Affairs, Carol Monaco and Angela Jeansonne.

Private Sector Advocacy, Susan Friedman.

Congressional Affairs, Laura Wooster, Charles Cascio and Holly Biglow.

Advocacy & Communications, Leann Fox and Sean Neal.

The Report of the Director of Government Relations was given by Ray Quintero.

Dr. Thomas opened the floor for public testimony.

The last order of business was a presentation to Mr. Crosby celebrating his years of service with the AOA and best wishes for his retirement.

The next Bureau meeting will be Saturday, September 21, 2013. This follows the Health Policy Forum, Friday, September 20, 2013. Both will be held in Washington, DC.

Chairman Thomas thanked the Bureau and audience members for attending. The meeting adjourned at 4:30PM.
EXECUTIVE SESSION

The Bureau on Federal Health Programs (BFHP) convened in Executive Session on Saturday, March 16, 2013 at 8:35am. Chairman Thomas welcomed the group and reminded them of the Bureau’s goal to advance the mission and vision of the American Osteopathic Association in all the Bureau’s activities. Dr. Thomas also complimented the Department of Government Relations staff on the previous day’s meeting and on the successful “DO Day on Capitol Hill” which took place on Thursday, March 14.

The BFHP discussed the formulation of an AOA policy on gun violence, including existing policies. Additionally, the members discussed a background paper on state interference laws. A policy will be developed by the Bureau on State Government Affairs and referred to the BFHP for its information.

The Bureau discussed those AOA policies up for five-year review that are in the jurisdiction of the Bureau. A consent agenda was approved. Additional policies which touch on BFHP subject areas are being discussed by the Bureau on Socioeconomic Affairs, the Bureau on Scientific Affairs and Public Health, and the Bureau on State Government Affairs. The BFHP will have an opportunity to review those policies.

Marie Michnich, DrPH, of the Institute of Medicine (IOM), presented a proposal for the AOA to participate in the IOM’s Anniversary Fellowship Program. The Bureau approved a motion to ask President Stowers to place the subject on the agenda for Executive Committee consideration. The Bureau supports AOA participation in the program and seeks co-sponsors.

Principals of Hart Health Strategies, a consulting firm retained by the AOA, made a presentation on regulatory issues of concern to the osteopathic profession. There was a discussion on ways the AOA can influence Federal regulatory activities beyond the submission of comments on proposed regulations.

DGR staff raised consideration of legislative issues related to the practice of podiatric medicine within the Medicare and Medicaid programs.

A motion to adjourn was made and seconded. By unanimous vote, the Bureau adjourned at 12:15pm.
AOA REPORTS
BUREAU OF STATE
GOVERNMENT AFFAIRS
The Bureau of State Government Affairs (BSGA) continues to monitor and respond to new developments as they arise, working to promote the policies and positions of the AOA through state and specialty osteopathic organizations. A policy paper on state funding of graduate medical education (GME) was submitted by the BSGA to the Board of Trustees and the House of Delegates for review and approval during the 2013 Annual Business Meeting. The BSGA also submitted a joint policy paper on interference laws with the Bureau on Federal Health Programs. Both policies were successfully adopted.

Additionally, the BSGA continues to build on its collaboration with state and specialty osteopathic organizations to promote the policies and positions of the organization in its ongoing advocacy efforts. So far this session the AOA and its affiliate organizations have sent nearly 100 advocacy letters to 33 states. The AOA is again hosting the upcoming Advocacy for Healthy Partnerships conference to help osteopathic affiliate leaders develop the skills needed to become strong osteopathic advocates. The AOA also continues to work with the Scope of Practice Partnership in response to proposed legislative and regulatory policies that would inappropriately expand the scope of practice of non-physician clinicians. Additional information on related activities follows in this report.

**Advocacy for Healthy Partnerships Conference**

The annual Advocacy for Healthy Partnerships (AHP) conference is a series of training sessions designed to impart the knowledge and skills necessary for physicians and association staff to successfully advocate for patients and the osteopathic profession. The 2013 AHP conference will be held from November 22 through 24 in Atlanta, Georgia. Registration for the conference is open now through November 8 on the AOA’s State Government Affairs website.

This program is made possible through generous contributions from the AOA, Purdue Pharma, GlaxoSmithKline, Eli Lilly and Company, Pfizer and the American Osteopathic Foundation.

**Scope of Practice Partnership**

The AOA continues its partnership with the American Medical Association and state and specialty societies as a steering committee member in the Scope of Practice Partnership (SOPP). The SOPP was formed in 2006 to challenge inappropriate scope of practice expansions, such as those that are not commensurate with a non-physician provider group’s education and training. Since its creation, the SOPP has awarded over $841,402 in grants to support state efforts. This includes $144,668 to date in 2013.

The SOPP is currently working with the Robert Graham Center to update the GeoMaps resources. The SOPP GeoMaps provide a visual representation for all 50 states showing where non-physician clinicians are practicing. These maps also show comparisons between physicians and non-physician clinicians practice locations, which is especially important, because several non-physician clinician groups have asserted that expanding scope of practice will improve access to care. The GeoMaps refute these assertions by showing non-physician clinicians practice in the same areas as physicians, even in states that have already greatly expanded scopes of practice.

**Joint Statement with the American Academy of Physician Assistants**

In July, the AOA and the American Academy of Physician Assistants (AAPA) released the joint statement “Osteopathic Physicians and Physician Assistants: Excellence in Team-Based Medicine.” The statement outlines support for physician-led, team-based and patient-centered care. To further elaborate on this position, there are also six joint statements of support:

1. AOA and AAPA believe that physicians and PAs working together in physician-directed teams is a proven model for delivering high-quality, cost-effective patient care.
2. AOA and AAPA believe that physician-PA teams, working together with other team members, are ideally suited to the comprehensive, patient-centered, coordinated, accessible, and ongoing delivery of patient care found in team-based models, such as the patient-centered medical home.
3. AOA and AAPA support interprofessional education of physicians-in-training and PA students throughout their educational programs; encourage ongoing innovations in interdisciplinary education; and support opportunities for osteopathic physicians to precept PA students and participate as faculty at PA programs.
4. AOA and AAPA encourage flexibility in federal and state regulation so that each medical practice determines appropriate clinical roles within the medical team, physician-to-PA ratios, and oversight processes, enabling each clinician to work to the fullest extent of his or her license and expertise.
5. AOA and AAPA believe that every patient should have full information about the title, credentials and role of every professional providing their care.
6. AOA and AAPA are committed to building on the common ground that osteopathic physicians and PAs share in order to ensure an adequate, well-educated workforce to meet the health care needs of the U.S. population.

Act to Action
The AOA has developed a new website, Act to Action, in order to provide information and resources on the Affordable Care Act (ACA) to the osteopathic profession. The Act to Action campaign is the result of the collaborative efforts between the AOA's Department of Communications, Department of Government Relations, Department of Practice Management and Delivery Innovations and the Division of State Government Affairs.

The BSGA developed resources for the campaign related to the implementation of the ACA at the state level, including a toolkit on health insurance exchange implementation and the Medicaid expansion. In addition, the BSGA has also provided regular updates on the status of state efforts on Medicaid expansion.

2013 Advocacy
The AOA is currently tracking and responding to legislation for the 2013 state legislative cycle on topics important to osteopathic medicine. All 50 states were in legislative session this year, with only 8 states currently in regular session at this time. So far, the AOA has tracked over 8,000 bills, and weighed in nearly 100 times in support, opposition or requesting changes of relevant legislation. These efforts have occurred in 35 different states, with victories so far in Alaska, Alabama, Arizona, Connecticut, Florida, Illinois, Louisiana, Maine, Maryland, Missouri, Montana, Nebraska, Nevada, New York, Texas, Utah, Virginia and Vermont. The AOA responds to legislation as it moves through the legislative process, generally waiting to weigh in on a bill until it is scheduled for a hearing in committee.

Scope of Practice
Scope of practice has continued to be a popular issue in state legislatures in 2013, with bills to expand scope for nurses, midwives, chiropractors, naturopaths, pharmacists, optometrists, physical therapists, physician assistants, podiatrists and psychologists.

On May 16, The New England Journal of Medicine (NEJM) published the article “Expanding the Scope of Practice of Advanced Nurse Practitioners – Risks and Rewards”, which argued for an expanded role for advanced practice nurses. However, in making this argument, the article left out certain key pieces of information. In order to alleviate any possible misconceptions, AOA President Ray E. Stowers, DO, FACOFP dist. responded to the editor with several corrections. The letters was published recently at www.nejm.org/doi/full/10.1056/NEJMc1307648?query=TOC.

Nurses continue to push for expanded practice rights in several states, and the AOA opposed legislation in Connecticut, Missouri, Nevada, Oregon, Rhode Island, Utah and Texas. The AOA successfully assisted the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS) with sending letters in opposition to two nursing scope bills in the state. This was a continuation of an effort from last session, when the AOA and MAOPS defeated two similar nursing bills.

In Nevada, the AOA collaborated with the Nevada Osteopathic Medical Association (NOMA) to oppose legislation that would eliminate the requirement that an advanced practitioner of nursing enter into a collaborative practice.

agreement with a licensed physician. While the bill was defeated in committee, a similar companion bill that the AOA and NOMA also opposed did pass and was signed by the Governor. The AOA and the Connecticut Osteopathic Medical Society also successfully defeated legislation in Connecticut which would have removed collaborative practice requirements.

Additionally, in Utah, the AOA worked successfully with the Utah Osteopathic Medical Association and the American College of Osteopathic Anesthesiologists to defeat a joint resolution that would eliminate the federal physician supervision rules that require a certified registered nurse anesthetist to enter into a collaborative practice agreement with a licensed physician. In Texas, the AOA and the Texas Osteopathic Medical Association (TOMA) worked together to oppose a bill that classified physician assistants and advanced practice registered nurses as primary health service providers. The bill was successfully defeated, as it failed to pass before the end of the legislative session.

Optometrists are most commonly seeking prescriptive authority. The AOA responded to efforts in Florida, Louisiana and Nebraska. The AOA sent a letter with the Florida Osteopathic Medical Association (FOMA) in opposition to a bill which would allow optometrists to administer and prescribe ocular pharmaceutical agents. The bill was defeated, as it died at the end of the legislative session. However, a companion bill that the AOA and FOMA also opposed was adopted and signed by the Governor. Additionally, the AOA also worked with the Louisiana Osteopathic Medical Association to successfully defeat an optometrist scope of practice expansion bill in that state. Finally, the AOA also defeated legislation in Nebraska that would have expanded optometrist’s scope of practice by allowing them to inject pharmaceutical agents.

Psychologists have also been active this year, with most efforts focused on gaining prescriptive authority. In Illinois, the AOA partnered with the Illinois Osteopathic Medical Society (IOMS) and the American College of Osteopathic Neurologists and Psychiatrists to oppose similar legislation that would also allow psychologists to prescribe. The bill did not pass the Illinois House before the end of the legislative session.

Finally, the AOA has continued to oppose inappropriate scope of practice expasions for naturopaths by arguing against bills in Montana and Pennsylvania. In Pennsylvania, the AOA worked with the Pennsylvania Osteopathic Medical Association and Pennsylvania Osteopathic Family Physicians Society to oppose a bill that would recognize naturopathy as a system of primary care. Pennsylvania is still in session, and the bill is still active.

**Osteopathic Equivalency**

Protecting the equivalency of the osteopathic profession is an important priority for the AOA. Often, legislators introduce legislation that impacts the practice of medicine, but exclude osteopathic education, training and certification. The AOA has worked to protect the equivalency of the osteopathic profession this year in California, Florida, Maryland, Missouri, New York, Rhode Island, Virginia and West Virginia.

The AOA, along with FOMA, successfully responded to a Florida budget proposal which did not include the AOA. The proposal would have expanded funding for GME, but only for programs recognized by the American Council for Graduate Medical Education (ACGME). After receiving the request from the AOA and FOMA, the proposal was amended to recognize AOA programs. The Florida legislature adjourned before the proposal was adopted, however, this remains an ongoing issue in the state that the AOA will continue work on with FOMA.

In Ohio, the AOA worked with the Ohio Osteopathic Association (OOA) to request changes to the State Medical Board of Ohio’s examination requirement rules. The rules as previously written referenced the USMLE examination and predecessor National Board of Osteopathic Medical Examiners (NBOME) exam, but only mentioned COMLEX-USA. The AOA and the OOA requested that the rule be changed to include the predecessor NBOME examination. The change was successfully incorporated, and has one final review by the legislative Joint Committee on Agency Rule Review before becoming effective on October 31, 2013.

The AOA worked with the Virginia Osteopathic Medical Association (VOMA) to successfully amend a joint resolution in the state that established a committee to study the physician shortage. The original version of the joint resolution included representation for the state medical society and medical schools, but not for VOMA or the Edward Via College of Osteopathic Medicine. The resolution was amended to include representative from both organizations, and subsequently was adopted.
In Missouri, the AOA joined with the MAOPS to amend a bill that changed examination requirements without recognition for an exam administered by the NBOME. The amendment was made, but the bill did not pass before the end of session.

Finally, the AOA, Maryland Association of Osteopathic Physicians (MAOP) and MedChi requested an amendment to a bill that would have made several changes to licensure statutes in the state, including amending the definition of board certification. The initial language only provided recognition for residency or fellowship programs accredited by the ACGME. The AOA, MAOP and MedChi were successful in getting an amendment included to recognize residency or fellowship programs accredited by the AOA, and the bill was approved by the Governor.

Pain Management
Pain management legislation has become popular in recent years, in response to the growing prescription drug problem across the country. Legislation in this area is usually focused on requirements for pain management clinics or prescription drug monitoring programs. The AOA has worked on pain management issues this year in Alaska, Alabama, Massachusetts, Ohio and West Virginia.

In Alabama, the AOA advocated for an amendment to a pain medicine bill in order to gain recognition for the AOA's Certification of Added Qualification (CAQ) in Pain Medicine, which was excluded from the bill as introduced. J. Mark Bailey, DO, PhD, Associate Professor of Neurology and Anesthesiology at the University of Alabama Birmingham, traveled to the state capitol to advocate for the amendment with the committee Chair. Following the efforts of the AOA and Dr. Bailey, the bill was amended and approved by the Governor with the inclusion of the AOA’s CAQ in Pain Medicine.

The AOA and the OOA responded to a request for comments from the State Medical Board of Ohio on a rule relating to standards and procedures for operation of a pain management clinic. The rule as currently written establishes certification requirements for physician owners of pain management clinics. While the AOA’s CAQ in Pain Management is recognized, the CAQ in Pain Medicine is not. The AOA and the OOA requested that this additional CAQ be added to the rule. The Board has not yet begun further review of the rule and the possible inclusion of the AOA and OOA’s suggestion; however it has been received and filed for further consideration.

Telemedicine
The AOA sent several letters in support of telemedicine legislation this year: in Arizona, California, Connecticut, Maryland, Montana, Vermont and Washington.

In Vermont, the AOA supported legislation that requires all health insurance plans in the state to provide coverage for services delivered to a patient by telemedicine to the same extent that the services would be covered if they were provided through in-person consultation. The bill was successfully signed into law by the Governor.

Healthcare Facilities Accreditation Program
Several states either do not currently recognize the AOA’s Healthcare Facilities Accreditation Program (HFAP), or have introduced legislation to accredit new facilities that does not include HFAP. The AOA is working to ensure that HFAP has recognition in all 50 states, and has sent letters to California, Florida, Hawaii, Massachusetts, Maryland, Minnesota, Montana, New Jersey, Ohio, Texas and Wyoming asking for amendments that would include the organization.

The AOA worked closely with FOMA and HFAP on several bills in Florida that were originally introduced without HFAP recognition. The AOA and FOMA were successful in getting two of these bills amended, one of which was signed by the Governor before the end of the legislative session providing universal HFAP recognition in Florida.

Tanning
Several states have introduced legislation this session to restrict the usage of tanning facilities by minors. The AOA has worked with the American College of Osteopathic Dermatology (ACOD) and several state osteopathic associations to send letters in support of tanning restrictions for minors in Delaware, Hawaii, Illinois, Maryland, Massachusetts, Nebraska, Nevada, North Carolina, Ohio, Pennsylvania, Texas and Washington.

In Nevada, the AOA collaborated with ACOD and the NOMA to support legislation that prohibits an owner or operator of a tanning establishment allowing children under the age of 18 to use the tanning equipment. The bill was
successfully passed and signed by the state’s governor. Further, in Texas, the AOA collaborated with the ACOD and TOMA to successfully support banning tanning facilities from allowing children under the age of 18 to use a tanning device. Finally, the AOA worked with IOMS in Illinois to support the Senate version of a tanning bill that prohibited tanning facilities from allowing children under the age of 18 access to using ultraviolet tanning equipment or devices. While the Senate version of the bill was not adopted, the companion House version of the legislation passed the legislature and was signed by the Governor.
BUREAU ON SOCIOECONOMIC AFFAIRS
BUREAU OF SOCIOECONOMIC AFFAIRS – David F. Hitzeman, DO, Chair

An informal meeting of the Bureau of Socioeconomic Affairs (BSA) was held on July 18, 2013. The Bureau of Socioeconomic Affairs officially convened via conference call on May 9, 2013. The following is a summary of the major issues discussed by the Bureau from May 9 to September 2013. In addition, accomplishments of the Department of Practice Management and Delivery Innovations (the Department) are detailed, including member education efforts and payment and compliance advocacy.

Education

The Centers for Medicare and Medicaid Service, AOAMI (Medical Informatics) and the AOA are collaborating to help physicians implement electronic health records (EHRs). Beginning in September, AOA will host monthly webinars at 2 pm Eastern Standard Time (EST) on the following EHR topics:

- September 25 - Introduction to the EHR Incentive Programs: Overview of Basic Eligibility, Payment Information, and Key Deadlines
- October 23 – Introduction to CMS eHealth
- November 20 – Medicare and Medicaid EHR Incentive Programs: Stage 2, Payment Adjustments, and Audits
- December 11 – Medicare EHR Incentive Program: How to Successfully Participate

In addition, the BSA plans to approve its webinar schedule for the remainder of 2013. Topics include ICD-10, EHRs and meaningful use, HIPAA compliance, employment arrangements and more.

OMED 2013 Practice Management Sessions
The AOA Bureau of Socioeconomic Affairs, the American Osteopathic Association of Medical Informatics (AOAMI), the Council on New Physicians in Practice (CNPP), the American College of Osteopathic Family Physicians (ACOPP) will offer a series of continuing medical education programs at OMED 2013. The goal of each session is to help physicians understand the essentials of running their practice. Topics will include billing and coding, surviving meaningful use audits, responding to ACCs, employment arrangements, HIPAA privacy and security and ICD-10.

Payment and Compliance Advocacy

HIPAA
Educational resources including an archived webinar are now available to assist practices with compliance for the revised HIPAA Final Rule, which has an effective date of September 23, 2013. The AOA HIPAA manual resource is updated to communicate the increased HIPAA privacy and security, and Health Information Technology for Economic and Clinical Health Act (HITECH) requirements.
Negotiations with Regence Blue Cross and Blue Shield
In December 2012, the Department met with executive directors from Oregon, Idaho, Washington and the American Academy of Osteopathy. Several physicians were concerned that Regence was targeting physicians for providing OMT on the same day as an Evaluation and Management visits.

In June 2013, audits in all four network states were suspended and funds recouped were returned to physicians. The AOA continues to work directly with Regence’s Chief Medical Officer to communicate progress on the auditing concerns, describe AOA actions to date, discuss next steps and provide resources that members can use to prepare for audits and appeals.

Update on Meeting with CMS
Modifier -25 use is targeted for payment denials. On May 8, 2013, AOA leadership met with the staff of Centers for Medicare and Medicaid Services to advocate that the global period for OMT codes be changed (from 000 to XXX) to negate the use of Modifier -25 with E/M codes. Subsequent to this meeting, the AOA followed up with a letter to CMS to recap the meeting and provide additional support for our position. The AOA also included comments in its letter regarding the proposed rule to further advocate for the change.
STATE AND FEDERAL ADVISORY PANELS
OSTEOPATHIC PHYSICIANS SERVING ON
STATE AND FEDERAL ADVISORY PANELS

Centers for Disease Control and Prevention (CDC)
- Advisory Committee on Immunization Practices – Stanley E. Grogg, DO (September 2006-
  indefinite term) Dr. Grogg represents the AOA as a Liaison Representative to this advisory
  panel.
  (January 7, 2010 – June 30, 2013)

Centers for Medicare and Medicaid Services (CMS)
- Practicing Physicians Advisory Council – Joseph A. Giaimo, DO (February 28, 2008-
  February 28, 2012) *Disbanded*

Department of Defense (DOD)
- Board of Regents of the Uniformed Services University of the Health Sciences – Ronald R.
  Blanck, DO (Chair)

Department of Health and Human Services (HHS)
- Advisory Committee on Breast Cancer in Young Women – Jean L. Steiner, DO (November
  31, 2013)
- National Center for Complementary and Alternative Medicine – John Licciardone, DO
  (term ending 2015)

Food and Drug Administration (FDA)
- Anesthesiology and Respiratory Therapy Devices Panel – George Mychaskiw II, DO (July
  7, 2011 – July 6, 2015) Dr. Mychaskiw is a consultant to this advisory panel.
- Anesthesiology and Respiratory Therapy Devices Panel – Kenneth J. Steier, DO (July 7,
  2007 – July 6, 2015) Dr. Steier is a consultant to this advisory panel.
- Anesthesiology and Respiratory Therapy Devices Panel – Sandra K. Willsie, DO
  (December 1, 2010- November 30, 2014)
- Medical Devices Dispute Resolution Panel – Michael R. Jaff, DO (December 29, 2010-
  September 30, 2014)

Health Resources and Services Administration (HRSA)
- National Practitioners Data Bank (NPDB), Executive Committee – Edward Loniewski, DO
  (December 1, 1999 – indefinite term)
- Primary Care Residency Grant Peer Review Committee – Kenneth J. Steier, DO (April
  1998 – indefinite term)
- Advisory Committee on Training in Primary Care Medicine and Dentistry – Anne C. Jones-
  Leeson, DO (September 1, 2013)

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• Advisory Committee on Training in Primary Care Medicine and Dentistry William T. Betz, DO, MBA (March 15, 2012-March 1, 2015)
• Council on Graduate Medical Education – D. Keith Watson, DO (November 30, 2014)
• National Advisory Council on the National Health Service Corps – Jay Bhatt, DO (October 2012-October 2015)
• Advisory Committee on Interdisciplinary Community Based Linkages - Jay H. Shubbrook, Jr., DO (term ending 2013)
• National Advisory Committee on Rural Health and Human Services – Gary Walton, DO (January 1, 2012-December 31, 2016)

National Institutes of Health (NIH)
• National Heart, Lung, and Blood Institute (NHLBI), National Blood Disorders Program Coordinating Committee - Cheryl D. Kovalski, DO (Appointed June 18, 2012)

U.S. House of Representatives
• Nevada-03 – Joe Heck, DO

AOA PARTNERSHIPS WITH FEDERAL AGENCIES

Agency for Healthcare Research and Quality (AHRQ)
• U.S. Preventive Service Task Force – Susan C. Sevensma, DO - represents the AOA as an AHRQ Primary Care Partner. Partners are outside experts who provide peer review of draft reports, contribute expertise to the evaluation process, and help disseminate the work of the task force to their members.

DOs SERVING ON STATE GOVERNMENT ADVISORY PANELS, COMMISSIONS AND COMMITTEES

Alaska
• Health Care Strategies Planning Council – Derek Hagen, DO
• Council of Alaska Emergency Medical Services – Donald Hudson, DO

Arizona
• Board of Osteopathic Examiners in Medicine and Surgery – Arlene England, DO, Mary Ann Picardo, DO, Scott A. Steingard, DO, David M. Steinway, DO, F.P. Wedel, DO
• Regulatory Board of Physician Assistants – Kelli M. Ward, DO
• Board of Medical Student Loans – Thomas McWilliams, DO
• Emergency Medical Services Council – Michael P. Ward, DO
• Governor’s Task Force on Emergency Departments Crisis – Charles Finch, DO
• Homeopathic Medical Examiners Board – Charles D. Schwengel, DO
• Carrier Advisory Committee – William H. Devine, DO
• State Medical and Osteopathic Licensing Board – Douglas Cunningham, DO, Arlene England, DO, Mary Ann Picardo, DO, Scott Steingard, DO, Michael Ward, DO

Arkansas
• Foundation for Medical Care- Rolland Bailey, DO, Randall Guntharp, DO
• State Board of Health - Robert Sanders, DO
• State Medical Board – Patty Pettway, DO
• Medicaid Medical Care Advisory Committee – Esther Tompkins, DO
• Pain Management Review Committee – James Rogers, DO

California
• Osteopathic Medical Board – Susan Melvin, DO, Geraldine O’Shea, DO, Joseph Provenzano, DO, Veronica Vuksich, DO, MA, Paul Wakim, DO

Colorado
• Board of Medical Examiners – Lisa Butler, DO, J. Dale Utt, DO, Eric Groce, DO
• Medical Assistance and Services Advisory Council – Douglas Hill, DO

Connecticut
• Medical Examining Board – Howard Sadinsky, DO

Delaware
• Healthy Mother Infant Consortium – Robert Locke, DO
• Task Force on Infant Mortality – Robert Locke, DO, Anthony Brazen III, DO, Julia Pillsbury, DO
• Board of Medical Practice – Nasreen Kahn, DO, Vincent Lobo, DO

District of Columbia
• Board of Medicine – Shivani Kamdar, DO

Florida
• Board of Osteopathic Medicine – Joel Rose, DO, Anna Hayden, DO, Ronald Burns, DO, Allan Escher, DO, James St. Louis, DO
• Cancer Control Research Advisory Council – Joanne Bujnoski, DO
• Carrier Advisory Committee – Ronald Burns, DO, William Silverman, DO
• Correctional Medical Authority – John Bailey, DO
• Council on Physicians Assistants – Ronald Burns, DO
• Diabetes Advisory Council – Chet Evans, DO
• Drug Utilization Review Committee: Anna Hayden, DO, Larry Mattingly, DO
• Family Practice Physicians Recruitment and Retention Advisory Committee – Gregory James, DO
• Flu and Pneumonia Coalition – Gregory James, DO
• Health Practitioner Advisory Board – Anthony Ottaviani, DO
• Health Practitioner Workforce Ad Hoc Advisory Committee – Anthony Silvagni, DO, Anthony Ottaviani, DO
• House District 17 – Rep. Ronald Renuart, DO

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- Patient Safety Steering Committee – William Silverman, DO
- Stop Tobacco Task Force – Dennis Penzell, DO
- Drug Utilization Review Committee – Anna Hayden, DO, Larry Mattingly, DO
- Medicaid Prescribing Pattern Review Panel – Joshua Lenchus, DO, Dennis Penzell, DO
- Medical and Consumer Health Information Network – Lee Shettle, DO
- Patient Safety Corporation – Joel Rose, DO
- Medicaid Prescribing Pattern Review Panel – Joshua Lenchus, DO, Dennis Penzell, DO
- Medical Care Advisory Committee – Richard Thacker, DO
- Patients Compensation Fund: Board of Governors – Bob Fedor, DO
- Pharmacist Prescribing Committee – Joel Rose, DO, Joshua Lenchus, DO
- Prostate Cancer Taskforce – Linda Delo, DO
- Public Health and Medical Preparedness Strategic Plan Team – John C. Pellosie, Jr., DO, Drew Nelson, DO
- Electronic Prescribing Advisory Panel – Lee Shettle, DO
- Pharmaceutical and Therapeutics Committee – Richard Thacker, DO
- State Electronic Prescribing Advisory Panel – Lee Shettle, DO
- Physician Workforce Advisory Council – Paul Seltzer, DO, Nicole Sirchio, DO

**Georgia**
- Composite State Board of Medical Examiners – Charles White, DO

**Hawaii**
- Board of Medical Examiners – Les Barrickman, DO, Karen Sept, DO

**Idaho**
- State Board of Medicine – Ralph Sutherlin, DO

**Illinois**
- Department of Professional Regulation Licensing Board – Dennis Palmer, DO
- Medical Advisory Board Poison Center – John Graneto, DO
- Health Information Technology Development Task Force – Karen J. Nichols, DO
- PCCM/DM Steering Committee - John Graneto, DO
- Federal CMS Region Five – Anthony DeLorenzo, DO, Rodey Wassef, DO
- Federal CAC – Rodney Wassef, DO
- IL Prescription Monitoring Program – Harry Lausen, DO

**Indiana**
- Medicare Carrier Advisory Committee – Luke Nelligan, DO
- Medical Licensing Board – Thomas Akre, DO
- Health Policy Advisory Committee – James Sackett, DO

**Iowa**
- Board of Medicine – Janice Galli, DO, Analisa Haberman, DO
- Board of Public Health – Gregory Garvin, DO
- Medicaid Drug Utilization Review Commission – Laura Griffith, DO
- Medicaid Pharmaceutical and Therapeutic Committee – Carole Frier, DO
• Emergency Medical Services Advisory Council – Amy Kumagai, DO
• Trauma System Advisory Council - Amy Kumagai, DO
• Carrier Advisory Council – Sandi Birchem, DO
• Blood Center of Central Iowa – Thomas Buroker, DO
• Maternal Health and Child Health Advisory Committee – Greg Cohen, DO
• Health Information Technology Steering Committee – Greg Cohen, DO
• Healthy Children Task Force – Eric Dodson, DO
• Wellmark Physician Advisory Committee – Roberta Wattleworth, DO

Kansas
• State Board of Healing Arts – Carolina M. Soria, DO, Ronald N. Whitmer, DO, M. Myron Leinwetter, DO
• State Board of Healing Arts – Osteopathic Medicine and Surgery Review Committee
  Robin D. Durrett, DO, Thomas J. Hamilton, DO, James V. Rider, DO
• State Board of Healing Arts – Examining Committee for Physical Therapy – Stephen Rosenberg, DO
• Health Care Stabilization Fund Board of Governors – Deborah M. Burns, DO, Elaine L. Ferguson, DO
• Medicaid Drug Utilization Review Board – Roger D. Unruh, DO

Kentucky
• Board of Medical Licensure – Randel C. Gibson, DO, Boyd R. Buser, DO

Maine
• Board of Osteopathic Licensure – Joseph R. D. deKay, DO, John F. Gaddis, DO,
  David Rydell, DO, Lonnie C. Lauer, DO, Gary E. Palman, DO, Scott A. Thomas, DO
• HealthInfoNet (HIT) Board of Directors – Douglas J. Jorgensen, DO
• Quality Forum Advisory Panel – Jeffrey Holmstrom, DO, W. Stephen Gefvert, DO
• Health Data Organization, Governor Appointed Representative – Douglas Jorgensen, DO
• Asthma Health Advisory Committee – Christopher Pezzulo, DO
• Southern Maine Head Start Health Advisory Committee – Rachel Garrett, DO
• State Hospital Licensing Advisory Board – William P. Kiley, Jr. DO
• Statewide Coordinating Council for Public Health – Joel A. Kase, DO
• Finance Authority of Maine Medical Education Advisory Board – Bruce Bates, DO
• Governor’s Council on Physical Activity – Erik Steele, DO
• Prescription Monitoring Program Advisory Board – Steve Weisberger, DO
• Professionals Health Program Advisory Committee – Alex Brazalovich, DO

Maryland
• Carrier Advisory Committee – Randy Braman, DO, Ross Van Antwerp, DO, Yoon Cho, DO
• Board of Physicians – Kevin B. Gerold, DO, JD

Michigan
• Advisory Committee on Pain and Symptom Management – William Morrone, DO

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• Cancer Consortium Group – Margaret Aguwa, DO, Robert Boorstein, DO, Allan Coates, DO, Peter Gulick, DO, Thomas Petroff, DO, R. Taylor Scott, DO
• Certificate of Need Commission – Peter Ajluni, DO, Michael Young, DO
• Controlled Substance Advisory Board – Susan Sevensma, DO
• Worker’s Compensation Health Advisory Committee - John Anderson, DO
• Health and Safety Coalition – John Bodell, DO
• Center for Rural Health – Lawrence Brown, DO, Thomas Fasbender, DO, William Strampel, DO
• Health Council – Dorothy E. Carnegie, DO
• Medical Nutrition Education Consortium – John Floreno, DO
• Health Professional Recovery Program – Bobbe Kelley, DO, William Morrone, DO
• Carrier Advisory Committee – Harold Friedman, DO
• Pediatric Asthma Committee – Pamela Georgeson, DO
• Medicaid Drug Utilization Review Commission – Gerard Breitzer, DO
• Board of Osteopathic Medicine and Surgery – Steven A. Acker, DO, William C. Cunningham, DO, Dennis W. Dobritt, DO, Vincent J. Granowicz, DO, Charles E. Kelly, DO, Susan Sevensma, DO, Douglas P. Vanator, DO
• Department of Community Health – Monroe Adams, DO, Dennis Dobritt DO, Edward Haughn, DO, Steven Klein, DO, Craig Magnatta, DO, Richard Nowak, DO, Lisa Oliveri, DO, Lawrence Prokop, DO, Susan Sevensma, DO, Michael Weiss, DO
• Medicare Carrier Advisory Committee – Gerald Robbins, DO, Arno Schury, DO
• Steps Up Primary Care Initiative Committee – Myral Robbins, DO
• E-Health Care Work Group – George T. Sawabini, DO
• Osteopathic Medicine Advisory Board – Peter Ajluni, DO Susan Sevensma, DO, William Strampel, DO, Lewin Wyatt Jr., DO, Claud Young, DO, Dorothy E. Carnegie, DO, Max T. McKinney, DO
• Health Information Technology Commission – R. Taylor Scott, DO
• Board of Athletic Trainers – Lawrence Nasser, DO
• Strategic Opportunity for Rural Health – Kurt Anderson, DO
• Fall Prevention Partnership – Frank Komera, DO

Minnesota
  • Board of Medical Practice – Jim Mona, DO

Mississippi
  • State Board of Medical Licensure – William Mayo, DO

Missouri
  • State Advisory Council on Emergency Medical Services – Jim W. Pyron, DO
  • QIO Board – Bruce Williams, DO, Jeffrey Dryden, DO, Kenneth E. Ross, DO,
  • Board of Registration for the Healing Arts – Curtis Mather, DO
  • Board of Registration for the Healing Arts – James A. DiRenna, DO
  • Carrier Physician Advisory Committee – Kenneth E. Ross, DO, Bruce R. Williams, DO,
  • Drug Utilization Review Committee – Joseph M. Yasso, DO
  • Prior Authorization Committee – Henry D. Petry, DO, Conrad S. Balcer, DO
• Long Term Care Best Practices Committee – Carl Bynum, DO, Jeffrey A. Kerr, DO

Montana
• Board of Medical Examiners – Arthur K. Fink, DO

Nebraska
• Board of Medicine and Surgery – Judith Scott, DO

Nevada
• Panel on Human Dissection – Mitchell Forman, DO, Jeff Wachs, DO
• Medicare Carrier Advisory Committee – Fredrick Schaller, DO
• State Board of Osteopathic Medicine – James Anthony, DO, JD, Ronald Hedger, DO, Paul Kelekas, DO, Scott Manthei, DO, C. Dean Milne, DO
• Homeopathic Medical Examiners – Bruce Fong, DO
• Commission on Medical Education, Research and Training – Dan Royal, DO
• Pharmaceutical Abuse Task Force – R. Curt Erwin, DO
• Oriental Medicine Board – Victor Klausner, DO
• Southern Nevada Health District – Larry Sands, DO, MPH

New Hampshire
• Board of Medicine – Vacant

New Jersey
• Task Force on Child Abuse & Neglect - Martin A. Finkel, DO
• Advisory Committee on Alternatively Accredited Medical School Clinical Clerkships – Shari Robin Fine, DO
• Board of Medical Examiners – Kathryn Lambert, DO, George Scott, DO, DPM

New Mexico
• Ophthalmological Society – Kristin Reidy, DO
• Governor’s Advisory Panel on Pain – Randle Adair, DO, Tom Lindsey DO
• Board of Osteopathic Medical Examiners – Gary Jackson, DO, Tom Lindsey, DO

New York
• State Board of Medicine Licensing Board – Jerry Baleine, DO, Brenda Connolly, DO, Robert Corona, DO, Steven Sherman, DO, Donald Teplitz, DO, Paul Twist, Jr, DO
• Board for Professional Medical Conduct – Ralph Levy, DO, Paul F.Twist, DO, Cindy Hoffman, DO, Donald H. Teplitz, DO, Robert J. Corona, Jr, DO, Theodore A. Spevack, DO, Thomas A. Scandalis, DO, Steven I. Sherman, DO
• New York City Regional Emergency Medical Advisory Committee – Allen Cherson, DO
• Nassau Regional Emergency Medical Advisory Committee - Allen Cherson, DO
• Carrier Advisory Committee – Robert B. Goldberg, DO

North Carolina
• Medical Board – Donald Jablonski, DO
• Carrier Advisory Committee Members – Hal Armistead, DO
• Burke County Board of Health – G. Michael Gould, DO

North Dakota
• State Board of Medical Examiners – Gordon Leengang, DO

Ohio
• Governor’s State Health Coverage and Quality Council, Richard J. Snow, DO
• State Medical Board – Anita M. Steinbergh, DO
• Carrier Advisory Committee – Judith A. O’Connell, DO
• Patient Centered Medical Home Education Advisory Committee – Richard J. Snowe, DO
• Physician Loan Repayment Advisory Committee – DO appointment pending
• Student Loan Commission – David Bitonte, DO
• Nursing Board’s APN Prescriptive Governance Committee – Katherine A. Clark, DO
• Medical Board’s PA Policy Committee – John M. Jonesco, DO
• Pharmacy Board Rule Review Committee – Katherine A. Clark, DO
• Department of Health Public Health Council – David A. Bitonte, DO
• Medical Quality Foundation- Richard J. Snow, DO
• Stroke Council – Albert Salomon, DO
• Board of Nursing APN Prescriptive Governance Committee – Lawrence J. Kuk, DO
• Bureau of Workers Compensation Quality Committee – Paul T. Scheatzle, DO
• Department of Health’s Compassionate Care Committee – CLeanne Cass, DO
• ODJFS Pharmaceutical/Therapeutics Committee – Robert L. Hunter, DO, Ioanna Z. Giatis, DO
• Medicaid DUR Committee – Lenard Presutti, DO
• Higher Education Study Committee – John F. Brose, DO
• Department of Health Medical Surge Committee – Brian A. Kessler, DO
• Paulding County Health Department – Larry Fishbaugh, DO
• Lawrence County Health Department – Kurt Hofmann, DO
• Tuscarawas County Health Department – James Hubert, DO
• Warren City Health Department – James Lazor, DO
• Findlay City Health Department – Stephen Mills, DO
• Medina County Health Department – Daniel Raub, DO
• Guernsey County Health Department – Janice Schram-Wayne, DO
• Preble County Health Department – Mark Vosler, DO
• Department of Insurance Real Time Claim Adjudication Advisory Committee – Martha Simpson, DO
• Department of Insurance Most Favored Nation Clauses Study Committee, Stuart Chesky, DO, JD
• Health Insurance Exchange Committee – Richard Snow, DO
• State Action on Avoidable Rehospitalizations Advisory Committee – Robert Hunter, DO
• Governor’s Cabinet Opiate Workgroup – Michael V. Bourn, DO; CLeanne Cass, DO; Maury L. Witkoff, DO; and R. Aaron Adams, DO
• ODJFS Pharmacy/Therapeutics Committee – Robert L. Hunter, DO, Ioanna Z. Giatis, DO

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• Ohio House of Representatives - **State Representative Terry A. Johnson, DO**
• Ohio Health Information Partnership Board of Trustees - **Gregg Alexander, DO**
• Ohio Patient Safety Institute Board - **Francis V. Dono, DO**
• Obesity Prevention Coordinator, Ohio Department of Health - **Andrew Wapner, DO**
• Ohio Board of Pharmacy - **Assistant Executive Director, John C. Whittington, DO**
• Ohio Department of Health, Ohio Patient Centered Medical Home Collaborative - **Richard J. Snow, DO**
• Heart Disease and Stroke Prevention Council – **Albert M. Salomon, DO**
• Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board – **Jason P. Dapore, DO**

**Oklahoma**

• Board of Medicolegal Investigations – **C. Michael Ogle, DO**
• Board of Regents for Oklahoma City Community College – **Thomas J. Carlile, DO**
• Physician Manpower Training Commission – **Troy L. Harden, DO, Duane G. Koehler, DO**
• State Board of Health – **Jenny J. Alexopulos, DO**
• Physician Advisory Committee for Workers’ Compensation Reform – **LeRoy E. Young, DO, Duane G. Koehler, DO, Scott A. Mitchell, DO**
• State Bureau of Narcotics and Dangerous Drugs Control Commission – **Michael F. Stratton, DO**
• State Board of Examiners for Long Term Care Administrators – **J. T. O’Connor, Jr., D.O., Maurice W. Payne, DO**
• Advisory Council on Cord Blood Donations – **J. Todd Robinett, DO**
• Long Term Care Facilities Advisory Board – **Jean M. Root, DO**
• Health Information Exchange Trust Advisory Board – **Dennis J. Carter, DO, Jenny Alexopulos, DO**
• Genetics Advisory Council – **Kayse M. Shrum, DO**
• Medical Advisory Task Force – **Dale C. Askins, DO, Richard W. Schafer, DO**
• State Board of Osteopathic Medical Examiners - **Jay Cunningham, DO, Gordon Laird, DO, Carl Pettigrew, DO, Thomas Pickard, DO, B. Frank Shaw, Jr, DO, LeRoy Young, DO**
• Bar Association Professional Responsibility Tribunal - **William J. Pettit, DO**
• State Interagency Coordinating Council for Prevention of Adolescent Pregnancy and STD’s – **Michael W. Herndon, DO**
• Child Death Review Board - **Julie M. Morrow, DO**
• Tobacco Use Prevention and Cessation Advisory Committee – **Elliot Schwartz, DO**
• Domestic Violence Fatality Review Board – **Michell A. Cohn, DO**
• Health Information Advisory Committee – **Dale W. Bratzler, DO**
• Child Abuse Training and Coordination Council – **Sarah J. Passmore, DO**
• Immunization Advisory Board – **Stanley E. Grogg, DO**
• NE Trauma Regional Advisory Council – **Gregory H. Gray, DO**
• Breast and Cervical Cancer Prevention and Treatment Advisory Committee – **William J. Pettit, DO**
• Science and Technology Committee – **Sheri Wise, CPA, Stanley E. Grogg, DO**
• State Boxing Commission – **Larry T. Lovelace, DO**
• Respiratory Care Advisory Committee – Justin S. Sparkes, DO
• Task Force on Hospital Emergency Services and Trauma Care – Dale C. Askins, DO
• Drug Utilization Review Board – Brent D. Bell, DO, Paul L. Preslar, DO
• Medical Advisory Committee – Stanley E. Grogg, DO, C. Michael Ogle, DO
• Medicare Carrier Advisory Committee – Joseph R. Schlecht, DO, James D. Harris, DO, Elliott R. Schwartz, DO
• Advance Practice Nurse Formulary Advisory Council – Gerald D. Wootan, DO
• Foundation for Medical Quality: Ronald S. Stevens, DO, Saundra S. Spruiell, DO, Joseph R. Schlecht, DO
• Physician Assistant Advisory Committee – Gerald D. Wootan, DO, Thomas R. Pickard, DO
• Athletic Trainers Advisory Committee – Kenneth B. Smith, DO
• Medical Advisory Taskforce – Dennis J. Carter, DO, Richard W. Schafer, DO
• Opiate-Centered Medical Home Task Force: Scott S. Cyrus, DO

Oregon
• Board of Medical Examiners – John C. Stiger, DO, Lewis D. Neace, DO
• Health Services Commission – K. Dean Gubler, DO
• Medicare Advisory Committee - John C. Stiger, DO
• Oregon Medical Board - Ralph Yates, DO, Lewis Neace, DO
• Rural Health Coordinating Council - Kevin Miller, DO

Pennsylvania
• State Board of Osteopathic Medicine – Rohit K. Agrawal, DO, John P. Bart, DO, Joseph C. Gallagher, DO, Samuel Garloff, DO, Alfred Poggi, DO
• Commission for Women – Beverly Roberts-Atwater, DO

Rhode Island
• Board of Medical Licensure and Discipline – Charles Cronin, III, DO, Robert G. Dinwoodie, DO
• Department of Health Primary Care Physician Advisory Committee – Greg Allen, DO
• Department of Health – Tertiary Care Committee – Greg Allen, DO

South Carolina
• Board of Medical Examiners – James L. Hubbard, DO, Timothy Kowalski, DO
• Carrier Advisory Committee – Gabriel C. Fornari, DO, Alfred R. Frye, DO, Robert M. Amory, DO

South Dakota
• Board of Medical and Osteopathic Examiners – Brent Lindbloom, DO

Tennessee
• Health Facilities Licensing Board – Jon Winter, DO
• Board of Osteopathic Examination – Donald H. Polk, DO, Jack Pettigrew, DO, Jill Robinson, DO, Karen Shepherd, DO, Paul Smith, Jr, DO
Texas
- Department of State Health Services Medical Radiological Technician Advisory Committee - Mark A. Baker, DO
- Emergency Medical Services Medical Advisory Committee for the Governor's Emergency Trauma and Advisory Council - R. Donovan Butter, DO
- Higher Education Coordinating Board Primary Care Residency Advisory Committee - Elizabeth A. Palmarozzi, DO (will be changing later this summer)
- Higher Education Coordinating Board Primary Care Residency Advisory Committee - S. Timothy Coleridge, DO
- Medical Board Health Screening Policy Advisory Committee - James E. Froelich, III, DO
- Texas Medical Board - Irvin E. Zeitler, Jr. DO, President
- Texas Medical Board - Larry Price, DO
- Texas Medical Board - James Scott Holliday, DO
- Texas Medical Board - Texas Medical Board District Review Committee: Roberta M. Kalufut, DO
- Texas Medical Board District Review Committee for Internal Medicine and Rheumatology - Frank Wellborne, DO
- Texas Medical Board District Review Committee - Hari Reddy, DO
- Texas Medical Board District Review Committee: Dan Guerra, DO
- Texas Medical Board Enforcement Stakeholder Group - Steve Yount, D.O.
- Texas Medical Board Licensure Stakeholder Group - Nancy Faigin, D.O.
- Texas Medical Foundation Health Quality Institute (QIO) — Patrick J. Hanford, DO;
- Texas Medical Foundation Health Quality Institute (QIO) - Daniel W. Saylak, DO,
- Texas Medical Foundation Health Quality Institute (QIO) — David E. Garza, DO
- Texas Medical Foundation Health Quality Institute (QIO) — John L. Wright, DO
- Immunization Services Working Group - Neil S. Levy, DO
- Physician Assistant Board - Michael A. Mitchell, DO
- Disaster Assistance Medical Team - Ray L. Morrison, DO
- Midwifery Board - Lisa R. Nash, DO
- Medicaid Disease Management Committee - Joseph M. Perks, DO
- Joint Admissions Medical Program Board - Alan L. Podawiltz, DO
- Department of Aging and Disability Services Aging Well Advisory Committee - Peggy M. Russell, DO
- Human Services Medical Care Advisory Committee - George N. Smith, DO
- Diabetes Council, Health Professions Committee - Craig Spellman, D.O.
- Public Assistance Health Benefits Review and Design Committee - Laura S. Stiles, DO
- Physician Oncology Education Program - Ray Page, DO, PhD.
- Health & Human Services Telemedicine Advisory Committee - Sam Tessen, MS, LPC

Utah
- Osteopathic Physician Board - J. Howard Loomis, DO, Warren A. Peterson, DO, Keith P. Ramsay, DO, Layne Hermansen, DO
Vermont
- Board of Osteopathic Physicians and Surgeons – William Cove, DO, John M. Peterson, DO, Howard Jonas, DO

Virginia
- Board of Medicine – Warne Reynolds, DO

Washington
- Medicare Carrier Advisory Committee – Harold Agner, DO
- State Board of Osteopathic Medicine and Surgery – Samuel Coor, DO, Catherine Hunter, DO, Peter Kilburn, DO, David Martinez, DO, Thomas Shelton, DO, John Finch, DO
- Department of Labor and Industries Industrial Insurance Medical Advisory Committee – Ruth M. Bishop, DO
- State Agency Technical Advisory Group – Amber Figueroa, DO, Mark Hunt, DO

West Virginia
- Pharmacy Collaborative Practice Task Force – Joan L. Moore, DO, Craig S. Boisvert, DO
- Medicare Advisory Council – Ernest E. Miller, Jr., DO
- Medicare DUR Committee - Ernest E. Miller, Jr., DO
- Board of Osteopathy - Ernest E. Miller, Jr., DO, Arthur Rubin, DO, Thomas S. Gilligan, DO
- DHHR Pharmaceutical and Therapeutic Committee – Thomas L Gilligan, DO

Wisconsin
- Medical Examining Board – Raymond P. Mager, DO

Wyoming
- Board of Medicine – Jane Robinett, DO
DEPARTMENT OF GOVERNMENT RELATIONS
CONGRESSIONAL AFFAIRS
SUBJECT: MEDICARE PHYSICIAN PAYMENT

Medicare Patient Access and Quality Improvement Act of 2013
On July 24, the House Energy & Commerce Committee introduced H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, to permanently repeal the SGR. This legislation grew out of several iterations of proposals and draft legislative language released by the Committee for public comment. The AOA responded with comments for each version and worked closely with the Committee as the proposal developed. The bill:

- Permanently repeals the SGR, and incorporates annual positive updates of .5% to all physicians during a 5-year period of stability;
- Authorizes new "alternative payment models" coupled with a quality-enhanced fee-for-service model, and offers an incentive structure providing appropriate motivation to physicians to transition to either of these models;
- Provides the opportunity for providers under the enhanced fee-for-service model to earn an additional 1% bonus beginning in 2019 for high performance, while low performers are at risk for a 1% payment reduction;
- Calls for specific, meaningful and timely—at minimum, quarterly—feedback on quality and performance to physicians from the Centers for Medicare and Medicaid Services;
- Provides additional incentives for physicians qualifying as a medical home who provide care coordination for patients with complex chronic conditions;
- Directs Medicare to identify improperly valued services under the fee schedule that could result in a net reduction of 1% of projected expenditures for a year during 2016 through 2018;
- Provides liability protections by clarifying that guidelines in federal health programs do not establish a standard of care to which providers can be held liable.

The bill was voted on and passed out of the Committee on July 31 with a vote of 51-0. The bill currently has 40 co-sponsors, and is awaiting action by the full House, expected sometime this fall.

Medicare Physician Payment Innovation Act
Congresswoman Allyson Schwartz and Congressman Joe Heck, DO introduced the "Medicare Physician Payment Innovation Act" (H.R. 574) on February 6, 2013. As with their legislation to repeal and reform the SGR in the last Congress, the bill:

- Permanently repeals the SGR formula
- Provides annual positive payment updates for all physicians for four years, and additional payment updates for primary care, prevention, and care coordination services.
- Tests and identifies a variety of unique payment models to provide options for providers across medical specialties, practice types, and geographic regions
- Following a period of stability, moves providers away from fee-for-service, with some limited exceptions
The bill does not include use of the Overseas Contingency Operations (OCO) funds that were part of the last legislation and had made it difficult to gain bipartisan sponsors. The AOA has sent a letter of support. **The bill currently has 36 co-sponsors.**

**Medicare Reform**
In August, the Ways & Means Committee Subcommittee on Health released two pieces of draft legislation encompassing options for reforming Medicare—the first to modernize beneficiary cost-sharing, and the second to reform post-acute care. Both drafts encompass proposals previously put forth by President Obama in his FY2014 Budget, by the Simpson-Bowles National Commission on Fiscal Responsibility and Reform, and by the Bipartisan Policy Commission. The AOA submitted letters to the Committee commenting on both pieces of draft legislation. The beneficiary reform draft legislation proposes:

- Reducing premium subsides for wealthier seniors in Medicare Parts B & D;
- Increasing the annual Medicare Part B deductible; and
- Establishing a home health co-pay.

The Post-Acute Care (PAC) draft legislation addresses the following changes:

- Reducing market basket updates for home health agencies, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and long-term care hospitals;
- Creating site neutral payments between IRFs and SNFs for certain procedures;
- Modifying the criteria required for IRF status (the so-called “75 percent rule”);
- Establishing a SNF readmissions program; and
- Creating PAC bundled payments.

**SUBJECT: MEDICAL LIABILITY REFORM**

**Standard of Care Protection Act of 2013 (H.R. 1473)**
Representatives Phil Gingrey, MD (R-GA) and Henry Cuellar (D-TX) introduced the “Standard of Care Protection Act of 2013” (H.R. 1473). This legislation clarifies that participation in quality improvement, resource utilization, continuous certification, or any such provision under the Affordable Care Act (ACA) shall not be construed to establish or influence the accepted standard of care or duty of care for the purposes of a medical liability case. The legislation does not attempt to limit an individual’s ability to pursue recourse for an alleged injury. The bill has been referred to the House Energy and Commerce Health Subcommittee and the House Judiciary Committee's Subcommittee on the Constitution and Civil Justice and currently has 11 cosponsors. The AOA is supportive of this legislation via participation in the Health Coalition on Liability and Access (HCLA). **Language from this bill was included in the “Medicare Patient Access and Quality Improvement Act of 2013” (H.R. 2810), which passed the House Energy and Commerce Subcommittee and Full Committee unanimously in July.**

**Good Samaritan Health Professionals Act of 2013 (H.R. 1733)**
Representatives Marsha Blackburn (R-TN) and Jim Matheson (D-UT) introduced the "Good Samaritan Health Professionals Act of 2013" (H.R. 1733). Their legislation would provide important civil liability protection to physicians and other health professionals who are volunteering their services in times of a declared national disaster. The provisions would correct inconsistencies in both federal and state law that leave medically trained volunteers open to civil liability, even in times of natural disaster. The AOA has sent a letter of support for this important legislation. The bill has been referred to the House Energy and Commerce Health Subcommittee and the House Judiciary Committee's Subcommittee on the Constitution and Civil Justice and currently has 15 cosponsors.
Medical Care Access Protection Act of 2013 (S. 44)
Senator Rob Portman (R-OH) introduced the “Medical Care Access Protection Act of 2013” (S. 44) which seeks to improve patient access to health care services and provides medical care by reducing the burden that the liability system places on the health care delivery system. The bill encourages speedy resolution to claims by requiring that a lawsuit must be filed no later than three years after the date of injury or one year after the claimant discovers the injury, whichever comes first. The legislation also limits non-economic damages to $250,000 and uses a “fair share” model where each defendant would only be liable for those damages attributable to their fault in addition to placing limits on contingency fees. In addition, the bill keeps medical liability statutes in place and allows future laws to supersede federal limits on damages. S. 44 has been referred to the Health, Education, Labor and Pensions Committee and currently has 3 co-sponsors.

SUBJECT: PHYSICIAN WORKFORCE

Primary Care Workforce Access Improvement Act of 2013 (H.R. 487)
Representatives Cathy McMorris Rodgers (R-WA) and Mike Thompson (D-CA) introduced the “Primary Care Workforce Access Improvement Act of 2013” (H.R. 487) in February which promotes the training of primary care physicians through a 5-year Medicare Primary Care Graduate Medical Education (GME) Pilot Project. This bill recognizes the importance of increasing payments for primary care training to support added costs of training in community-based, non-hospital settings and providing incentives for training in rural and underserved communities. The bill authorizes the Secretary of HHS to conduct a study on the results of the pilot projects and if it is determined that any of the models tested enhance the quality, quantity, and distribution of primary care physicians for Medicare beneficiaries, the Secretary may initiate comparable primary care training projects. The AOA has sent a letter of support to both offices for this legislation. H.R. 487 has been referred to the House Energy and Commerce and Ways & Means Committees and has 8 cosponsors.

Access to Frontline Health Care Act of 2013 (H.R. 702)
Representative Bruce Braley (D-IA) introduced the “Access to Frontline Health Care Act of 2013” which would provide student loan repayments for a health professional who agrees to serve for no less than 2 years at a health care facility serving a frontline scarcity area. A frontline scarcity area is designated by the State in which the area is located as having a shortage of frontline care services provided by a physician. Preference is given to applicants who have undertaken training or coursework in interdisciplinary studies. H.R. 702 was referred to the Energy and Commerce Committee and has 30 cosponsors.

Training Tomorrow’s Doctors Today Act of 2013 & Resident Physician Shortage Reduction Act of 2013
Representatives Aaron Schock (R-IL) and Allyson Schwartz (D-PA) introduced the “Training Tomorrow’s Doctors Today Act of 2013” (H.R. 1201). This legislation is similar to the “Resident Physician Shortage Reduction Act of 2013” (S. 577) that Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) have introduced in the Senate multiple times. Both bills aim to provide teaching hospitals the flexibility to train a greater number of physicians. The provisions of the bills focus on those states and communities that face the greatest need through the creation of 15,000 new residency slots over five years. Hospitals that are currently training residents over their cap, residing in states with new medical schools, and those emphasizing training in community-based settings stand to benefit most, thus providing trained physicians in areas of greatest need. H.R. 1201, unlike its Senate counterpart, also includes accountability and transparency measures for hospitals receiving GME
funding. The proposed measures encourage coordination of patient care across settings and recognize the important training that occurs outside of traditional patient care.

The AOA has sent letters of support for both bills. H.R. 1201 has been referred to the House Energy & Commerce and Ways & Means Committees and has 42 cosponsors. S. 577 has been referred to the Senate Finance Committee and has 9 cosponsors.

**Resident Physician Shortage Reduction Act of 2013**

Representatives Joe Crowley (D-NY) and Michael Grimm (R-NY) introduced the “Resident Physician Shortage Reduction Act of 2013” (H.R. 1180). This legislation seeks to address the nation’s physician workforce shortage by providing teaching hospitals an increased number of residency slots in order to train more physicians. The total number of residency slots would be increased by 15,000, an additional 3,000 slots per year. Of these, 25 percent of hospital residencies must be in primary care or general surgery. Additionally, the bill establishes that a study be conducted by the National Health Workforce Commission to identify workforce shortage specialties. The AOA has sent a support letter for this legislation. H.R. 1180 has been referred to the House Energy & Commerce and Ways & Means Committees and it has 64 cosponsors.

**Building a Health Care Workforce for the Future Act of 2013**

Senators Jack Reed (D-RI) and Roy Blunt Jr. (R-MO) introduced the “Building a Health Care Workforce for the Future Act of 2013” (S. 1152) on June 12, 2013. This legislation seeks to address barriers faced by individuals interested in pursuing health care careers by providing states matching federal funds for money invested by the state in a scholarship program to help address health professional workforce shortages in primary care and other shortage areas unique to the state, and authorizing grants to medical schools to develop mentorship programs for medical students who express interest in a primary care career. It also directs the Institute of Medicine to conduct a study to examine how current documentation requirements for physicians in Medicare for cognitive services could be modified for EHRs, and provide recommendations for less burdensome alternatives. The AOA has sent a letter of support for this legislation. S. 1152 has been referred to the Senate Health, Education, Labor, and Pension Committee and has 2 co-sponsors.

**Bipartisan Student Loan Certainty Act of 2013**

On August 9, 2013, the President signed into law the “Bipartisan Student Loan Certainty Act of 2013” (H.R. 1911). This bill was enacted into law to prevent subsidized Stafford loan interest rates from doubling on July 1, 2013. This law sets interest rates each academic year based on the U.S. Treasury 10-year borrowing rate plus 2.05 percentage points for subsidized and unsubsidized undergraduate Stafford loans, plus 3.6 percentage points for graduate Stafford loans, and plus 4.6 percentage points for PLUS loans (including GradPLUS). The interest rate would be capped at 8.25 percent, 9.5 percent, and 10 percent, respectively, and fixed over the life of the loan.

**SUBJECT: BUDGET**

In late March the House passed a budget 221-207, and the Senate passed its own budget 50-49. No additional progress was made to reach agreement on a spending bill for FY2014, which begins on October 1, 2013. The current continuing resolution (CR) funding the government expires on September 30. In order to continue to fund government operations in the new fiscal year, Congress will likely pass another temporary CR some time in September, most likely one that maintains current spending levels.
for another four to six weeks. However, if Congress fails to pass a CR, the government will shut down on October 1—though such an outcome is currently not predicted.

Complicating budget negotiations is the pending expiration of the nation’s prescribed debt-ceiling, estimated to occur sometime in mid-October. Raising the nation’s borrowing limit requires Congressional approval, and Congress already approved a short-term increase to the debt ceiling earlier this year in May. Congress could include a new temporary debt-ceiling raise as part of a budget CR, or it could pass separate bills for each, in order to buy time for discussions later this Fall to reach agreement on more comprehensive and long-term solutions to the fiscal debate.

*Bold text denotes update since previous report.*
FEDERAL AFFAIRS
REPORT OF THE DIVISION OF FEDERAL AFFAIRS
September 2013

2014 Medicare Physician Fee Schedule proposed rule (7/19/13 Federal Register)
The AOA addressed global designation of Osteopathic Manipulative Treatment (OMT) CPT Codes 98925-98929. The AOA is calling on CMS to reverse the assigned global designation from 000 back to XXX to accurately reflect that OMT provided to patients is often on the same day as E/M services. The OMT global period was not addressed in the proposed rule, but the AOA is hopeful that the revised OMT global periods will appear in the Final Rule.

Collecting Data on Services Furnished in Off-Campus Hospital Provider-Based Departments
Services once provided in the physician office setting are shifting back to hospital outpatient departments (HOPD), and hospitals are purchasing physician practices and re-designating them as off campus provider-based OPDs; CMS is considering collecting information that would allow it to analyze the frequency, type, and payment for services furnished in off campus provider-based hospital departments.

- The AOA does not agree that hospital cost reports are the most reliable source of data. We do not support a data collection activity that would emphasize the use of such reports.
- The development of a new place of service (POS) code to identify off-campus provider-based outpatient departments is worth considering with additional stakeholder input.

Misvalued Physician Fee Schedule (PFS) Codes
Despite CMS’ use of the rulemaking process to carry out much of this activity, we have found that CMS provides little in the way of detail and rationale for several of its proposals.

Medicare Contractor Medical Director (CMD)-Identified Mis-valued Codes: It is unclear how CMDs determined specific codes were potentially mis-valued given the information presented does not include the CMDs rationale. It is also unclear how CMS determined that CMD-identified codes were potentially mis-valued; the agency does not provide its criteria for making such determinations.

- CMS should broaden its collaboration with the medical specialty societies and the RUC using the established process for addressing potential discrepancies.
- CMS also should consider engaging the dominant specialty when CMDs raise concerns about potentially mis-valued codes.
- The AOA requests full disclosure and transparency in the effort to identify potentially mis-valued codes and adjust their values, and the AOA stands ready to collaborate with the agency to address truly mis-valued codes.

Services with Higher Total Medicare Payments in the Office vs Facility: CMS proposes to limit the non-facility PE Relative Values Units (RVUs) for individual codes so that the total non-facility PFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting.
• We ask CMS to cite its authority that allows it to establish an upper payment limit for PFS services based exclusively on the Outpatient Prospective Payment System (OPPS).
• Additional analysis is necessary to ensure the proposal is fair and appropriate.
• If this policy is implemented, it may no longer be viable for a physician to provide certain services in his/her office, forcing seniors into HOPDs or ASCs which, may be less accessible, particularly in rural and underserved areas.
• The AOA recommends at least a one-year delay in implementation. If a delay is not possible, CMS should phase in the policy over a 4-year period to minimize disruptions for those providers who will be impacted by this proposal, as well as to beneficiary access to care.

Multiple Procedure Payment Reduction Policy (MPPR)
CMS is not proposing any new MPPR policies for 2014, however it continues to look at expanding the MPPR based on efficiencies when multiple procedures are furnished together.
• The AOA recommends that CMS work with the RUC to reach more appropriate solutions.
• CMS should evaluate services based on a complete analysis of quality rather than a superficial view of location or perceived efficiencies.

Geographic Practice Cost Indices (GPCIs)
Issue: CMS is assessing a variety of approaches to changing the locality structure under the Physician Fee Schedule and will continue to study the options.
• The AOA opposes payment reductions to rural areas. The AOA does agree that CMS should continue to develop and apply policies that promote access to primary care services in areas where patients continue to experience access problems. The Medicare program should pay for services that improve access to primary and specialty care for patients in medically underserved urban and rural areas.

Medicare Telehealth Services for the Physician Fee Schedule
The AOA commends the agency’s proposed efforts to expand Medicare’s telehealth footprint by increasing the number of beneficiaries eligible for telemedicine by modifying their urban/rural definitions.
• We are concerned, however, that the proposal adds a complicated formula to the process, requiring local clinics and providers to search hard-to-find census tract information to determine their eligibility. We urge CMS to consider the impact of this proposal on these practices and provide the tools necessary to help them determine eligibility.
• We also support CMS’ proposal to expand telehealth coverage by adding the transitional care management services (CPT codes 99495 and 99496). We urge CMS to continue efforts that would expand the list of services available and reimbursed via telehealth.

Requirements for Billing “Incident To” Services
CMS proposes that incident-to services and supplies must be furnished in accordance with applicable state laws and individuals performing incident-to services must meet any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished.
• While the AOA supports compliance with State laws, we question how CMS plans to enforce this provision.
• We urge CMS to be transparent in implementing this provision and to provide ample education on the policy and how it will be enforced.
• We encourage CMS to work with medical societies, particularly those that represent providers in rural communities, to ensure the policy is well understood and does not impede beneficiary access to care.

Complex Chronic Care Management Services
For CY 2015, CMS proposes to establish a separate payment under the PFS for complex chronic care management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

• The AOA supports the agency’s efforts to address complex chronic care services.
• We encourage CMS to set the payment rate for these services at a level that takes into account the infrastructure physicians will need to adopt.
• The around-the-clock, 7 days a week access to healthcare providers requirement sets a standard that may be too high, especially when EHR systems still face interoperability challenges.
• The AOA also believes CMS should work within the CPT coding process rather than establish two new G-codes. CMS should work with the RUC to determine the appropriate relative values for these codes so that physicians are paid appropriately for this level of care.
• We ask that the agency review the scope of services with small and rural practices in mind, and develop less burdensome requirements.

Investigational Devices Exemption (IDE)
CMS proposes to establish new criteria governing coverage of the costs and routine items and services in Category A and B IDE studies and trials. In addition, CMS proposes to make all IDE coverage decisions centrally rather than leaving decisions to its contractors. CMS contends that the “IDE coverage approval process created national variability that made it difficult for study sponsors to conduct national IDE studies.”

• The AOA is concerned that although the proposals establish uniformity and centralization, they also could prove to be a significant barrier.
• Beneficiaries could be at risk of losing coverage for medical emergencies and other healthcare items and services. We urge CMS to clarify that such coverage would continue to be available to seniors.
• We do not believe local contractors should be taken out of the decision-making process; this could diminish the role of the physician community. CMS should ensure that physicians remain active in the process.

Physician Compare Website
For 2014, CMS proposes to expand the quality measures posted on Physician Compare by publicly reporting performance on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program (MSSP). The data reported in 2014 would include performance rates for measures that meet a minimum sample size of 20 patients.
• CMS’ proposed 30-day preview period is insufficient and will not provide physicians with the time needed to review the data, identify errors and to gather the evidence needed to refute any errors.
• Overall, we oppose expanding the information reported on Physician Compare until CMS can ensure the accuracy of the underlying database, as well as performance calculations.
• The AOA urges CMS to reconsider its decision to publicly report on meaningful users.
• The AOA also encourages CMS to continue to verify the accuracy of the data posted on Physician Compare.
• We question whether the infrastructure processes and methodologies in place are sound enough to produce valid, reliable, and accurate information.

**Physician Quality Reporting System (PQRS)**
CMS believes alignment of the agency’s quality improvement programs is critical for programs involving physicians and other healthcare eligible professionals and will decrease the burden of participation on physicians and allow them to spend more time and resources caring for patients.
• The AOA appreciates the agency’s efforts to better align program requirements across the PQRS, EHR Incentive Program, Medicare Shared Savings Program, and value-based payment modifier. While we commend CMS for its efforts to make revisions to the PQRS to ensure adherence to the highest standards of care over time, some of the proposed revisions may be problematic.
• A three-fold increase in the reporting PQRS requirement is drastic and will result in either non-compliance or reporting simply for the sake of reporting as physicians scramble to find more general “check-box” measures that are easy to report, but not specifically relevant to their practice. We recommend that CMS scale back this reporting requirement.
• We encourage CMS to make multiple reporting mechanisms available to smaller groups participating in the PQRS.
• We request that CMS clarify the reporting criteria for those opting to report measures groups for purposes of qualifying for the 2014 incentive payment and avoiding the 2016 penalty.
• We request that CMS clarify its intent in regards to promoting “core” measures.

**Physician Value-Based Payment Modifier**
The AOA strongly opposes the agency’s proposal to more than double the number of physicians who are subject to the VBM and increase penalties under the program from a maximum of 1% to a maximum of 2% in 2016 considering the number of unresolved methodological issues related to the program’s performance calculations.
• CMS should not apply the modifier to so many physicians when pay-for-reporting rates remain so low.
• Smaller practices should not be held to this higher penalty during their first year of being subject to the modifier when large practices were only subject to a 1% penalty during their first year (2015).
• A GAO study found that private plans tend to reward performance improvement rather than incentivizing high performers and penalizing low quality. We urge CMS to consider this concept for the VBM since it would minimize confusion and provide a much more reliable understanding of how CMS sets performance benchmarks.
Sustainable Growth Rate and Conversion Factor
The estimated Calendar Year (CY) 2014 conversion factor of $26.8199 represents a Physician Fee Schedule (PFS) update of -24.4 percent and will exacerbate these issues. These deep cuts threaten the viability of many physicians’ practices and imperil patient access to care.

The AOA is encouraged by recent progress in Congress to finally repeal the SGR and build a payment system based on quality performance. This bipartisan legislation puts an end to years of annual patches that freeze payment levels, impede access to quality health care, stifle innovation and are simply no longer financially viable. By providing a period of stability with positive payment updates to all physicians, as well as incentives to move health care towards a system that rewards quality instead of volume, this legislation has the potential to ensure access to high quality care for Medicare beneficiaries in the years to come.

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-P.html

Physician Payment Data
The Centers for Medicare & Medicaid Services said Aug. 6 that it is seeking public comment about the most appropriate policy for the agency to follow regarding the release of Medicare physician payment data. The request stems from a recent legal development: In May, the U.S. District Court for the Middle District of Florida lifted a 1979 injunction that had prohibited the Department of Health and Human Services from releasing Medicare physician reimbursement data that would identify specific physicians based on the Privacy Act of 1974.

While there is value to using claims for internal quality improvement purposes, less is known about the value of providing the public with such data, especially when presented at a granular level. Therefore, the AOA believes releasing individual physician data should be delayed until such time as:
• Satisfactory technology and adequate statistical models have been developed and widely adopted to ensure the accuracy of such data;
• Research has shown that such data are not only meaningful and valuable, but are actually used by consumers for health care decision-making;
• Health care transparency requirements and requests do not add further cost and administrative burden to physician practices; and
• Physicians have the opportunity to review their data before it is published and that they are permitted to attach comments to any reports produced with the data.

While the AOA recognizes the value of involving consumers in their care as partners, we urge CMS to exercise caution when considering the release of individual level physician payment data. When raw data are presented to the public, they can very easily lead to false conclusions and greater confusion, which seems to contradict CMS’ intent to empower the public through education. Payment data are particularly confusing since various complex factors contribute to their variability. Public disclosure of such data should not occur until it has been proven that such data are actually of value to the public, and that the public can and will use that data in meaningful manner. The CMS request is at http://downloads.cms.gov/files/Request-fcr-Public-Comment-rePhysician-Data-8-6-2013.pdf.

Requirements for the Medicare Incentive Reward Program and Provider Enrollment
CMS proposes to increase the reward amount to help incentivize beneficiaries and others to report suspicious and potentially fraudulent and abuse activity. The AOA believes providing significant
financial rewards for reporting potential fraud and abuse is more likely to lead to an increase in frivolous reports that, in fact, stem from beneficiary misunderstandings about Medicare’s rules and regulations for billing, payment, and coverage, not to mention basic coding conventions.

Physicians also need more information and education on common billing and coding mistakes that could be corrected easily and better guidance on how to avoid audits, which would minimize hassles for both physicians and CMS. To that end, the AOA recommends:

- CMS collect and make publicly available data on common billing and coding errors. CMS should make aggregate statistics on the common coding and billing errors available on a local (MAC level) and national level.
- CMS educate providers on these errors through its existing education channels, such as National Provider Calls, MedLearn Matters articles, and through the monthly and quarterly bulletins published by the various Part B MACs.
- CMS develop a dedicated website for publishing the aforementioned information, as well as an associated CMS email list-serv to disseminate new information as it is posted to the website.
- CMS provide technical assistance for physician practices, primarily those with a high volume of coding and billing errors, on how to avoid these errors. This could be accomplished through an expanded scope of work for Medicare’s quality improvement organizations (QIOs).

In addition, physicians should not be at risk of having their Medicare privileges revoked due to the appearance of fraud, when in fact the coding changes are for legitimate reasons. It also is important to note that appealing a Medicare decision can be a costly endeavor. Oftentimes physicians give up their right to appeal because they cannot afford the time and resources necessary to engage in an appeal. (www.gpo.gov/fdsys/pkg/FR-2013-04-29/pdf/2013-09991.pdf)

**Medicaid Program: State Disproportionate Share Hospital Allotment Reductions**

The AOA is greatly concerned about the potential impact that the Disproportionate Share Hospital (DSH) payment cuts, enacted by the Affordable Care Act (ACA), will have on hospitals and indigent patients. CMS must ensure that safety-net hospitals have the capacity to treat those individuals who cannot get health care anywhere else.

Overall, the agency’s proposed rule would “reduce state DSH allotment amounts and limit the states’ ability to make DSH payments and claim Federal Financial Participation (FFP) for DSH payments at FY 2013 levels.” By statute, the rule would reduce state DSH allotments by $500,000,000 for FY 2014 and $600,000,000 for FY 2015. However, due to the complexities of the methodologies involved, CMS acknowledged it “cannot provide a specific estimate of the total federal financial impact for each year.”

The AOA recommends close evaluation of the formula, including its definitions and calculations, on an annual basis to assess its impact on access to care and hospital viability as this payment policy is gradually implemented. (www.gpo.gov/fdsys/pkg/FR-2013-05-15/pdf/2013-11550.pdf)

**AHRQ Prototype Consumer Reporting System for Patient Safety Events**

The AOA commented on the Agency for Healthcare Research and Quality’s (AHRQ’s) proposed Consumer Reporting System for Patient Safety (CRSPS) Intake Form. The AOA commended
AHRQ for its efforts to design and test a system for collecting information from patients about health care safety events that adheres to standard definitions and formats. There is no doubt that patients provide a unique and valuable perspective on health care and that patient reports could complement and enhance provider input and thus produce a more complete and accurate understanding of the prevalence and characteristics of medical errors. The document refers to safety concerns, including medical mistakes and negative effects. Negative effects can be physical or emotional and they may include infections, drug reactions, or other complications. The AOA believes the agency’s inclusions are too broad. (www.ahrq.gov/news/newsletters/e-newsletter/384.html)

Patient Safety
In July 2013, the Department of Health and Human Services (HHS) published the final Health Information Technology Patient Safety Action and Surveillance Plan. HHS will collaborate with the private sector (including health care providers, patients, and accrediting entities) to promote patient safety in a HIT-enabled health care delivery system. This will include: clinician reporting of HIT-related events through certified EHR technology, incorporating HIT safety into education and training of health care professionals, and investigating serious adverse HIT events.

The AOA submitted comments on the draft plan in February 2013. We stated that we concur with the agency that safety of HIT systems could be improved by: collecting more and better data about HIT-related risks, targeting of resources and corrective actions to improve HIT safety, and promoting a culture of HIT safety at federal and state levels. We also provided specific examples of feedback received from our members on challenges they have encountered which include lack of trust that the EHR will catch every important detail and lack of ability to get important information quickly from the EHR in an emergency.

EHR Super User Network
Earlier this year the AOA established, in conjunction with AOA, the EHR Super User Network. Establishing the network is an outcome of a productive discussion at the January BFHP meeting. The network is comprised of osteopathic physicians, staff from CMS Office of E-Health Standards and Services, and AOA Government Relations, and Practice Management & Delivery Innovations staff.

The network will engage CMS and ONC in an ongoing dialogue with regard to the challenges physicians face with the EHR Incentive Program and meeting meaningful use criteria. The goal of the network is to provide enhanced training and education about the EHR Incentive Program to a core group of AOA physicians and administrators who will serve as “liaisons” to the larger AOA membership on the EHR Incentive Program, as well as provide regular, ongoing feedback to CMS about concerns and challenges from the field.

As part of these efforts, AOA is working with CMS on educational tools that would assist physicians with adoption and use of certified EHR technology. Beginning in September, the AOA will be holding monthly webinars at 2 p.m. Eastern Standard Time (EST) in which CMS staff will provide information on various EHR topics. For next year, we are working toward having webinars at the same time (2 p.m. EST) on the third Wednesday of the month. The first webinar for next year would be on January 15, 2014. The schedule for this year is:
• **September 25** - Introduction to the EHR Incentive Programs: Overview of Basic Eligibility, Payment Information, and Key Deadlines

• **October 23** – Introduction to CMS eHealth

• **November 20** – Medicare and Medicaid EHR Incentive Programs: Stage 2, Payment Adjustments, and Audits

• **December 11** – Medicare EHR Incentive Program: How to Successfully Participate

**ICD-10**
CMS has posted updated resources to its website to provide assistance to physicians and other providers with the transition to ICD-10 by October 1, 2014. These resources include: informational fact sheets, checklists, and implementation guides for small, medium, and large provider practices. Beginning October 1, clinicians should be testing ICD-10 with business trading partners such as payers, clearinghouses, and billing services. Additional resource information: http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

**Health Information Technology**
DGR staff attended in August the first CMS eHealth Summit The summit was an opportunity for the agency to hear from stakeholders on eHealth issues. Topics included health information exchange, interoperability, and privacy and security. CMS acknowledged the importance of outreach and education to providers and targeting communications to ensure no one is left behind, particularly smaller and rural providers. CMS will be rolling out “e-health University” materials to provide outreach, education, and technical assistance to providers.

CMS also indicated that “we hear you” on feedback received to date and stated that they are currently examining timing for Stage 3 meaningful use. No specific dates for Stage 3 have been determined.

The HIT Policy Committee is currently examining the possibility of an alternate pathway for eligible professionals to achieve meaningful use. This approach would allow high performing eligible professionals to achieve meaningful use by satisfying a specified subset of objectives.

**Health Information Exchange**
In March, the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released the Request for Information (RFI) on Advancing Interoperability and Health Information Exchange (HIE). In April, the AOA submitted comments to CMS and ONC on the RFI. In our comments, we note that the issue of a common data structure must be addressed in order for the seamless exchange of information to occur across providers, systems, and settings. Additional issues that we state must be further addressed include: lack of inter-communication between EHR systems, including those of the same vendor, standardized interfaces in such areas as labs and drug formularies, and inclusion of functionality within EHR systems to address to assist with problem lists, medication lists, and medication allergy lists.

More than 200 comments were received on the RFI from a broad range of stakeholders. Many comments recommended addition of specific requirements for: health information exchange in new payment models. In addition, some comments submitted suggested that CMS explore adding codes to reimburse for: care coordination, e-visits, radiology queries, and evaluation and management within fee for service as part of new models for care.
The AOA did discuss innovative payment models in our comment letter. We state we support the transition away from the current fee for service system. However, we note that given the current Medicare payment structure, we anticipate implementation challenges in new models of care, including risk-adjustment, attribution, and lack of some specialty clinical guidelines on which to base payments. Given these challenges, we state that no additional requirements such as HIE be added at this time, but be considered when models have been tested and are working well.

Based on comments received from the RFI, HHS identified the need to develop a set of principles to guide development of health information exchange. The following principles will guide HHS in the making of future decisions about health programs and policies:

- **Accelerating HIE** - HHS will implement incrementally policies that encourage HIE. This could evolve from incentives to considering HIE a standard business practice for providers. CMS is evaluating strategies that begin with incentives or rewards through value-based payment programs and end with defining well-established types of HIE as part of quality standards in reimbursement under the Medicare and Medicaid programs.

- **Advancing Standards and Interoperability** – HHS will, when appropriate, align HIT standards for quality measurement and improvement across Medicare and Medicaid programs. HHS will accelerate alignment and implementation of electronic clinical quality measures, electronic decision support interventions, and electronic reporting mechanisms.

- **Consumer/Patient Engagement** – HHS policies and programs will support appropriate patient access to their health information. HHS will make HHS standardized data available to patients wherever possible.

**HHS Regulatory Review**

To date, HHS has published 27 proposed rules and 28 final rules related to retrospective regulatory review as part of the Administration’s ongoing effort to streamline federal regulations. As part of this process, a proposed rule was published February 4 that would eliminate or revise existing requirements that are burdensome, unnecessary or obsolete on healthcare providers and suppliers.

The AOA submitted comments in April on the proposed rule. In our comments, we noted our concern that if the regulatory burden is not alleviated for physicians they will leave their private practices to pursue other opportunities and may in some cases leave medicine altogether. This proposed rule also sought to expand the definition of physician to other providers for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). We state that we are opposed to the suggested definition change and cite our policies on usage of the terms physician and doctor. These policies note that we endorse the position that only fully trained DOs and MDs should be identified as physicians, and we are opposed to non-physician clinician use of the title physician or doctor.

HHS is also continuing its work in identifying new approaches for involving the public in retrospective review activities. This includes posting of a toolkit for the public (www.hhs.gov/regulations) on how to participate in the regulatory process and also updating the retrospective review webpage to include a form that asks for suggestions for regulations or policy to
review. Future plans include publishing in the Federal Register a Request for Information (RFI) seeking new ideas for retrospective view. Additional information: http://www.hhs.gov/open/execorders/13563/index.html

**National Practitioner Data Bank**
Edward Loniewski, DO serves as the AOA representative to the NPDB Executive Committee. Dr. Loniewski and DGR staff participated in the Committee’s May webinar meeting. Here is the meeting report:

- **Data Bank Merger** - The merger of the NPDB and HIPDB became effective May 6. All data are now reported to the NPDB. With the merger, there is no more duplicative reporting, only one query is necessary and there is no effect on what is reported. Reports must be submitted within 30 days of action. Analysis of usage is currently taking place to help establish a new user fee. HRSA has additional resources on its website at www.npdb.hrsa.gov

- **NPDB Guidebook** - HRSA plans to issue a new guidebook and will be seeking input from the Committee before publication. No specific timeframe was mentioned for the guidebook’s release.

- **Research and Data** – HRSA is examining ways to improve information in the data bank. This includes: looking at and examining use required and optional data fields, and conducting a survey of eligible users of the NPCB. This project will be working first with the Federation of State Medical Boards (FSMB). FSMB data includes data from all medical boards. In addition, HRSA is also looking at examining the integrity of its geographic data through the use of geocoding – finding of coordinates such as longitude and latitude by using other geographic data.

- **Policy** – The policy and disputes area is working to streamline its current paper-based process and is in the process of developing a better business model. This model may contain over 50 areas of improvement and is scheduled to be completed by mid-July.

- **Compliance** – Current efforts include examining data of each of the state boards in the top twelve health professions every two years. The first set of state boards was completed on April 1 and the next group of boards to be examined will be complete by October 1. There is also a hospital compliance effort underway which includes examination of hospital data and AHA data.

- **Data Integrity** - Data integrity is how data are maintained to be accurate, reliable, and consistent in the data bank. Data integrity is important for: quality health care, advancement of patient safety, and deterring fraud and abuse.

**Advisory Committee on Immunization Practices**
Stanley Grogg, DO serves as the AOA liaison representative to the CDC Advisory Committee on Immunization Practices (ACIP). ACIP is charged with advising the CDC Director on the appropriate use of immunizing agents. Attached is Dr. Grogg’s report from the June ACIP meeting.
**Vaccine Information Statements**
On July 26, CDC released updated 2013-2014 vaccine information statements (VIS) for inactivated and live intranasal influenza vaccine. The updated statements are at:
http://www.cdc.gov/vaccines/hcp/vis/index.html

**CDC Webpage**
The AOA has developed a new webpage which includes important and timely information from the Centers for Disease Control and Prevention. The webpage has information on topics including diseases and conditions, emergency preparedness, and immunization. The webpage is at:
http://www.osteopathic.org/inside-aoa/advocacy/regulatory-issues/Pages/cdc.aspx
PRIVATE SECTOR ADVOCACY
REPORT OF THE
DIVISION OF PRIVATE SECTOR ADVOCACY
September 2013

The Division of Private Sector Advocacy advances the legislative/regulatory agenda and strategic plan of the AOA by building and maintaining partnerships with private and public sector organizations and coalitions.

Agency for Healthcare Research and Quality (AHRQ)

- AHRQ will again be an exhibitor at OMED. Please encourage your colleagues to visit the AHRQ Booth and pick up the latest information on preventive services and evidence-based research.

- AOA continues its involvement as an Effective Health Care Program (EHC) partner by distributing evidence-based information from the EHC Program on our comparative effectiveness research (CER) Web page (http://www.osteopathic.org/cer). AHRQ contractors have informed us that they use our Web page as a model for CER information when they discuss the EHC Program with other organizations.

- On August 19, the Department of Health and Human Services announced that Richard Kronick, PhD, would replace Carolyn Clancy, MD, as AHRQ Director upon her retirement in late August. Dr. Kronick is a respected researcher, a professor of family and preventive medicine at UC San Diego, and former senior health care policy advisor in the Clinton Administration. We will arrange for AOA leaders to meet with Dr. Kronick.

U.S. Preventive Services Task Force (USPSTF)

- AOA continues its involvement as a Partner Organization to the Task Force and a Dissemination and Implementation Partner. The most recent meeting occurred on July 18-19, in Rockville, MD. Susan Friedman was in attendance on both days and represented the AOA at the Partners meeting while Dr. Sevensma was attending the House of Delegates. The next meeting will take place on November 7-8. The Department of Government Relations and the Department of Quality and Research work collaboratively to provide the Task Force with comments on its draft recommendation statements on clinical preventive services. The 2012 Guide to Clinical Preventive Services is available at http://www.ahrq.gov/clinic/pocketgd.htm.
• The AOA and AACOM jointly nominated two outstanding osteopathic physicians (Jed Magen, DO, and Michael Clearfield, DO) for the 2014 openings on the Task Force. Nominees will be interviewed during August-September, recommendations will be made to the AHRQ Director during October-November, and those selected will be contacted in December.

• The July issue of *The Journal of the American Osteopathic Association* contained a Letter to the Editor from Trustee Susan C. Sevensma, DO, AOA physician representative to the Partner Organizations explaining the updated recommendations regarding HIV Screening. This was the first time a Task Force recommendation was distributed to the osteopathic community via a *JAOA* Letter to the Editor. It was greatly appreciated by the Task Force staff and sets the stage for additional Letters to the Editor when there are major updates to the screening recommendations.

• As a member of The Friends of AHRQ, AOA continues to advocate for adequate funding for the agency during Congressional budget negotiations. This year The Friends asked Congress for $434 million to fund the agency in FY2014. The Friends met with Dr. Clancy in late March for an update on AHRQ’s activities and future plans.

**Patient-Centered Outcomes Research Institute (PCORI)**

• On May 6, Jeffrey Swigris, DO, MS, of National Jewish Health in Colorado received a PCORI Cycle II Award in the priority area of Assessment of Prevention, Diagnosis and Treatment Options to conduct a study entitled, “Patient Participation Program for Pulmonary Fibrosis (P4f); Assessing the Effects of Supplemental Oxygen.” It is a $1,285,547 award. PCORI approved 51 Cycle II awards totaling $88.6 million over three years. To the best of my knowledge, Dr. Swigris is the only osteopathic physician to receive PCORI funding since it began funding projects in 2012 (*Attachment 1*)

• On May 22, Kendi Hensel, DO, PhD, UNTHSC/TCOM, and Susan Friedman participated in an AMA stakeholder meeting with physician organizations, PCORI Executive Director Dr. Joe Selby, and PCORI senior staff. PCORI requested feedback and input regarding its National Priorities, Topic Generation, Methodology, Research Grants, and Distribution and Use of CER Findings.

• On June 26, Susan represented the AOA at a meeting convened by PCORI Deputy Executive Director Dr. Anne Beal with AOA, ACP, AAP, and AAFP to discuss how PCORI could best engage physicians and physician organizations in the conduct of research and partner with physician organizations to distribute research findings.

• On August 13, PCORI convened a meeting with AOA, ACP, AAP, and AAFP to gauge interest in collaborating on a survey of primary care physicians to determine their views on and understanding of patient-centered outcomes research. There was a high level of interest among the groups and another meeting will be scheduled to examine next steps.
Institute of Medicine Examines Partnering with Patients

- On February 25-26, the IOM held a workshop to explore Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement – a learning system activity of the IOM Roundtable on Value & Science-Driven Health Care. Former Bureau on Federal Health Programs Public Member, Christine Bechtel, MA, chaired the IOM Planning Committee. The workshop released a summary of its proceedings highlighting the necessity of increased patient, family, and caregiver engagement in achieving better health outcomes and lowering health care costs (http://www.iom.edu~/media/Files/Report%20Files/2013/Partnering-with-Patients/Pwp_meetingssummary.pdf).

Together Rx Access Program to End in 2014

- The Together Rx Access Program, which provides uninsured Americans with access to savings on prescription medications, will end on February 28, 2014. TRxA reviewed the program and concluded that patients may be better served by the Health Insurance Marketplace. The AOA and TRxA have had an excellent partnership over the past several years. TRxA increased the AOA’s visibility as a trusted source of health care information by featuring our articles for patients on their Website and distributing our messages via their social media outlets. The TRxA Website contains additional information about the conclusion of the program (http://www.togetherrxaccess.com). (Attachment 2)

Partnership to Fight Chronic Disease (PFCD)

- The Partnership to Fight Chronic Disease is developing a White Paper on obesity and the behavioral components of change from programs proven to support long-term weight loss. We provided a case study from John W. Sealey, DO, of Detroit MI – “Dr. Sealey’s Healthy Living Program: Adopting a Healthy Lifestyle through Behavior Modifications” for inclusion in the paper. (Attachment 3)

Health Affairs – November 2013 Workforce Issue

- The AOA and AACOM will each co-sponsor the November 2013 thematic Workforce issue of Health Affairs. A paper was submitted for inclusion in the issue and we are awaiting word as to whether it will be accepted. A briefing will also be held in Washington, DC when the new issue is published. We will provide more information as details become available.

List of AOA Coalitions and Group Memberships

- The Department of Government Relations participates in 58 coalitions, alliances, and groups in Washington, DC. Levels of activity vary depending upon where an issue sits at any given moment. (Attachment 4)
Pulmonary fibrosis (PF) is a rare condition that causes severe shortness of breath, a nagging dry cough, profound fatigue, and early death. Although nearly every PF patient will be prescribed supplemental oxygen (O2), we actually know very little about whether or how O2 might help patients with this horrible disease. For example, we do not know what patients and prescribers expect (or can expect) PF patients to gain by using O2; whether O2 use creates durable, meaningful improvements in PF patients’ daily lives; or if such putative improvements outweigh patients’ perceptions of being “tied to (their) hoses (oxygen cannulas).” In summary, thousands of PF patients are prescribed O2 despite a globally insufficient understanding of whether or how it affects them. Our overall objective is to enhance understanding of O2—its utility in and adoption by PF patients—by examining how PF patients perceive it and by determining how those perceptions and several things important to patients (such as symptoms, quality of life, activity levels) change from before to after O2 is prescribed. This research program embraces PCORI’s mission to involve key stakeholders even in the earliest planning phases, targets PCORI’s interest in addressing care for patients with rare conditions, and directly aligns with its emphasis on studies conducted in “typical clinical populations” and “considering the full range of patient-centered outcomes.”
American Osteopathic Association Facebook Messages and Twitter Tweets
Round VI

AOA Facebook Messages (for Together Rx Access to post on its page)

Message 1:

Parents, your children may like to enroll in the American Osteopathic Association’s Mini Medical School. It offers educational games to introduce children to basic health concepts in a fun, engaging way. http://ow.ly/nVTUE

Message 2:

Have you heard of a Patient-Centered Medical Home? Do you know what it is?

[Post after first comment, or a day or two later]

A Patient-Centered Medical Home is a group of healthcare professionals who work together to care for you, led by your personal physician. Watch this video from the American Osteopathic Association to learn more about this whole-person approach to care. http://www.osteopathic.org/osteopathic-health/about-your-health/Pages/patient-centered-medical-home.aspx

Message 3:

Take the Pledge to never text and drive. September 19 is Drive 4 Pledges Day, marking the end of this year’s IT CAN WAIT campaign. Join the American Osteopathic Association and get involved….make your pledge today or spread the word. http://www.osteopathic.org/osteopathic-health/about-your-health/aoa-partnerships/Pages/default.aspx

AOA Twitter Tweets (to post at @TRxA)

.@AOAforDOs wants to help DOs & osteopathic medical students whose homes & clinics were damaged in natural disasters. http://ow.ly/nVRE7

Register for @AOAforDOs’ Health Policy Forum about various issues impacting physicians & healthcare today. http://ow.ly/nVSuQ
@AOAforDOs Mini Medical School is a great way to educate your kids on basic health concepts via fun, engaging games! http://ow.ly/nVTf3

@AOAforDOs provides info/resources to various orgs & governmental agencies on general & specific health topics. http://ow.ly/nVUcu

Need a health calculator? Use @AOAforDOs to assess risk 4 stroke/heart attack, calc body mass or find target heart rate. http://ow.ly/nVUS7

If ur an #osteopathic physician, you may be interested in AOA’s Advocacy for Healthy Partnerships conference. http://ow.ly/nXgkD

If you’re an #osteopathic medical student & interested in advocacy, check out AOA’s “DO Day To Go” program. Go to --> http://ow.ly/nXhii

Have you heard of Patient-Centered Medical Homes? Learn about this approach to healthcare from @AOAforDOs. http://ow.ly/nXigG
Case Study
Dr. Sealey's Healthy Living Program:
ADOPTING A HEALTHY LIFESTYLE THROUGH BEHAVIOR MODIFICATION

BACKGROUND

Nearly 34 percent of U.S. adults and 17 percent of U.S. children are obese. Obesity is associated with increased disability, disease, and death and has substantial health, economic, and social costs. (Institute of Medicine, Accelerating Progress in Obesity Prevention, 2011). Research has shown that behavior modification plays a major role when adopting a healthy lifestyle. Adopting a healthy lifestyle has numerous benefits, some of which are increased energy, decreased body weight, possible disease prevention, and increased lifespan. In an effort to reverse these alarming statistics, Dr. John Sealey, a cardiothoracic and vascular surgeon, has developed a comprehensive program of behavioral modification, stabilization and maintenance that is supervised for safest results and nutritionally designed to develop proper eating habits. The Healthy Living with Dr. Sealey program requires participants to journal their eating habits, along with a daily exercise program to obtain and maintain good health. Weight loss is a natural by-product of this program. Participants in the Healthy Living program are taught the importance of healthy eating habits, exercise, and making good food choices.

FOOD JOURNAL

A key component of making good food choices is knowing exactly what you’ve consumed throughout the day. The Healthy Living program requires participants to maintain a daily food journal. A food journal is a self-reported summary of all foods and beverages eaten by the participant on that day. Food journals allow the participant to see food consumption patterns over a period of days, weeks, or months and identify eating trends and emotional
eating triggers. The food journal, when taken seriously, gives participants an opportunity to hold themselves accountable for their food intake by making the participant think before consuming foods that are not conducive to weight loss and/or a healthy lifestyle. By knowing that every bit of food consumed must be documented in the food journal, it teaches the Healthy Living participant to pause and evaluate the food that’s about to be consumed. In essence, the participant must stop and think before s/he eats. A good food summary includes all food and beverages consumed that day, reported by meal (e.g. breakfast, lunch, dinner, snack) the time of food consumption, the amount of time needed to consume the food, where the food was consumed (e.g. in a restraint, the dining room table, cafeteria at work), what other activity besides eating the participant was engaged in (e.g. out with friends, lunch break, relaxing in front of the TV), and how the participant feels during the meal. Also to be included the duration and intensity of physical activity for the day, and daily or weekly goals. If the participant captures and records all this information, s/he will have an insight of eating habits and possible emotional triggers. It also allows the participant to evaluate consumption patterns, make the necessary adjustments, and chart his/her progress over time.

EMOTIONAL OVEREATING

One of the more common triggers of overeating is due to emotional triggers. Knowing how to recognize and respond to emotional eating is a key component to the Healthy Living program. The Healthy Living program incorporates the mind, body and spirit, which encourage a person to love themselves through behavioral changes that facilitate a healthier lifestyle. The program participants adjust their current lifestyle or station, i.e. where they are currently in life, to a mental and physically healthier lifestyle that is
consistent with their personal goals.

**DAILY EXERCISE**

Participants in the Healthy Living program are encouraged to pursue an active lifestyle that includes daily exercise. Participants walk for a minimum of 45 minutes per day to get the heart pumping, combat sedentary habits, and to develop habits that will improve their cardiovascular health and aerobic endurance. Brisk walking is known to increase muscle form, strengthen the heart and lungs, lower anxiety levels, and decrease blood pressure. Participants are encouraged to walk shortly after waking-up, which helps to burn the glycogen stores and improves the fat-burning process. Walking is an exercise that most can do without assistance or training, it can be done either indoors or outdoors depending on the weather and personal preference. There isn’t any costly equipment to buy aside from a pair of comfortable walking shoes, heart-rate monitor, and a pedometer. Walking can be done at the participant’s own pace; however, participants are encouraged to walk briskly and to increase their walking time periodically to obtain the full health benefits of walking. In addition to walking a minimum of 45 minutes per day, participants are encouraged to do abdominal crunches immediately after their walk. These crunches tighten the core and strengthen the back muscles. It is important to build muscle slowly as not to build muscle over stored fat. The key is to rid your body of its excess body fat first, and after that has been achieved, then one may begin to build muscle. A strong core improves overall balance and stability and may prevent back injuries. Core exercises, including abdominal crunches, do not require any special equipment or a gym membership, and can be done almost anywhere.

**SOCIAL AND GROUP SUPPORT**
Dr Sealey's Healthy Living program is one example of how participant and peer group support is incorporated into a successful lifestyle modification program. The Healthy Living program meets weekly from September to June and every other week during the summer. These group sessions allow the participants, called "Healthy Livers" to share their successes, learn from their short-comings, share insights and ask questions of the group leader and of peers. There is a level of accountability to which each group participant must adhere throughout his/her Healthy Living journey. Participants agree to be straightforward when recording and submitting their weekly food summary, to read and understand the philosophies and contextual basis for the principles of the Dr Sealey's Healthy Living Program, and to always do his or her best in order to reach their goals. On a weekly basis, participants are required to share with the group their progress, including the number of pounds lost, current weight, and any setbacks s/he may have encountered throughout the week. Participants are encouraged to always do their best and anything short of goal attainment is not considered progress. When this occurs, the participant is encouraged, but not required, to share those positive behaviors as well as those negative behaviors, such as overeating, poor portion control, eating high-fat, high-sodium, or prepared foods, that may have caused the setback. The peer-group helps the participant to devise a plan to overcome this setback and gain control of the cycle. Upon adoption of the Healthy Living program, several participants have seen results such as significant weight loss, medication alleviation from the use of daily pills for hypertension, increased energy, and an overall understanding of strategies to achieve optimal health.
<table>
<thead>
<tr>
<th>COALITION GROUP</th>
<th>AOA STAFF</th>
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<tbody>
<tr>
<td>AcademyHealth*</td>
<td>Ray Quintero, Susan Friedman</td>
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<tr>
<td>ACPM-AMA National Coalition for Adolescent Health</td>
<td>Holly Biglow</td>
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<tr>
<td>Ad Hoc Group for Medical Research [AAMC]</td>
<td>Susan Friedman</td>
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<tr>
<td>Agency for Healthcare Research and Quality (AHRQ) U. S. Preventive Services Task Force (USPSTF) Partner Organizations [Susan C. Sevensma, DO, Physician Representative to USPSTF Partner Organizations]</td>
<td>Susan Friedman</td>
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<tr>
<td>Alliance for Aging Research – Aging in Motion (AIM) Coalition</td>
<td>Susan Friedman</td>
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<tr>
<td>Association of Clinicians for the Underserved</td>
<td>Susan Friedman</td>
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<tr>
<td>AQA Alliance</td>
<td>Sharon McGill</td>
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<td>Biotechnology Industry Organization Alliance Development</td>
<td>Susan Friedman</td>
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<tr>
<td>Campaign to End Obesity (CEO)</td>
<td>Susan Friedman</td>
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<tr>
<td>Children’s Health Group</td>
<td>Holly Biglow</td>
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<tr>
<td>Choice and Competition Coalition (health insurance exchanges)</td>
<td>Ray Quintero</td>
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<tr>
<td>Coalition for Anabolic Steroid Precursor and Ephedra Regulations [CASPER]</td>
<td>Angela Jeansonne</td>
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<td>Coalition for Health Funding</td>
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<td>Coalition for Health Services Research [Academy Health]</td>
<td>Susan Friedman</td>
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<td>Coalition to Protect the Provider-Patient Relationship</td>
<td>Ray Quintero</td>
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<td>Coalition to Transform Advanced Care (C-TAC)*</td>
<td>Ray Quintero, Laura Wooster</td>
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<td>Common Good</td>
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<td>Council for Affordable Health Coverage (CAHC)*</td>
<td>Susan Friedman</td>
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<td>Essential Health Benefits Coalition</td>
<td>Ray Quintero, Laura Wooster</td>
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<td>Exercise is Medicine Coalition</td>
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<td>Friends of AHRQ [AcademyHealth]</td>
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UPDATED: 9/10/13
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<tr>
<th>Organization Name</th>
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<tbody>
<tr>
<td>Friends of Indian Health</td>
<td>Holly Biglow</td>
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<td>Friends of National Center for Health Statistics (NCHS) [AcademyHealth]</td>
<td>Susan Friedman</td>
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<tr>
<td>Friends of the National Library of Medicine*</td>
<td>Susan Friedman, Mike Fitzgerald</td>
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<td>Health Care Liability Alliance (HCLA)*</td>
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<td>Healthcare Leadership Council (HLC) National Dialogue for Healthcare Innovation (NDHI)</td>
<td>Susan Friedman, Dr. Silverman</td>
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<td>Health Choices Coalition</td>
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<td>Health, Medicine and Research Partners of the Society for Women's Health Research</td>
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<td>Health Professions and Nursing Education Coalition</td>
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<td>Hospital Association Lobbyist Organization (HALO)</td>
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<td>Immunization Action Coalition</td>
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<td>Limited English Proficiency (LEP) Roundtable</td>
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<td>Medicare Today</td>
<td>Leann Fox</td>
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<td>Men's Health Network</td>
<td>Susan Friedman, Dr. Silverman</td>
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<td>National Coalition of Healthcare Providers (NCHP)</td>
<td>Ray Quintero</td>
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<td>National Osteoporosis Foundation Interspecialty Medical Council</td>
<td>Susan Friedman</td>
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<td>National Quality Forum*</td>
<td>Sharon McGill, Angela Jeansonne</td>
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<td>National Rural Health Association*</td>
<td>Charles Cascio</td>
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<td>New England Healthcare Institute (NEHI)*</td>
<td>Susan Friedman</td>
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<td>Partnership for Community Safety</td>
<td>Carol Monaco</td>
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<td>Partnership for Patients: Better Care, Lower Costs</td>
<td>Carol Monaco, Angela Jeansonne</td>
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<td>Partnership for Prescription Assistance</td>
<td>Susan Friedman</td>
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<td>Partnership for Prevention Health Professionals Roundtable on Preventive Services – activities on hold due to cutback in CDC funding</td>
<td>Susan Friedman</td>
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<td>Partnership for Primary Care Workforce</td>
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<td>Partnership to Fight Chronic Disease (PFCD)</td>
<td>Susan Friedman, Laura Wooster</td>
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<td>Partnership to Improve Patient Care (PIPC)</td>
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<td>AOA COALITION AND GROUP MEMBERSHIPS Represented by AOA Staff</td>
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<tr>
<td><strong>Patient-Centered Primary Care Collaborative</strong></td>
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<td><strong>Patient Safety Coalition</strong></td>
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<td><strong>Pfizer Alliance Development and Pain Management Roundtable</strong></td>
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<td><strong>PhRMA Alliance Development</strong></td>
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<td><strong>Physician’s Electronic Health Record Coalition</strong></td>
<td>Laura Wooster</td>
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<td><strong>President’s Council on Fitness, Sports, and Nutrition</strong></td>
<td>Angela Jeansonne</td>
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<td><strong>Produce for Better Health Foundation (PBH)</strong></td>
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<td><strong>Rural Health Care Coalition</strong></td>
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<td><strong>Rural Health Information Network</strong></td>
<td>Angela Jeansonne</td>
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<td><strong>Together Rx Access (program will end 2/28/14 – patients will be directed to Health Information Marketplaces)</strong></td>
<td>Susan Friedman</td>
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<td><strong>Trust for America’s Health “The Healthier America Project”</strong></td>
<td>Susan Friedman</td>
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<td><strong>Trust for America’s Health Working Group on Pandemic Flu Preparedness</strong></td>
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<td><strong>U. S. Chamber of Commerce</strong></td>
<td>Susan Friedman</td>
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<td><strong>Women’s Health Research Coalition Advisory Committee of the Society for Women’s Health Research [SWHR]</strong></td>
<td>Susan Friedman</td>
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<td><strong>WomenHeart</strong></td>
<td>Susan Friedman</td>
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*Dues Payment Required*
ADVOCACY & COMMUNICATIONS
GOAL
The Grassroots Osteopathic Advocacy Link (GOAL) program continues to grow. Currently, there are 17,153 participating e-advocates. GOAL will continue its efforts to advocate on multiple legislative initiatives in the 113th Congress.

DO Day on Capitol Hill
DO Day on Capitol Hill has been scheduled for March 6, 2014. Registration will open on September 30, launching at OMED 2013 and close on Wednesday, January 24, 2014.

Advocacy Campaigns
The Department of Government Relations continues efforts to maintain a diverse rotation of issues on the Write to Congress section of the Advocacy webpage; including medical liability reform, graduate medical education and Medicare physician payment.

Over the course of the August Recess, GOAL capitalized on the opportunity to promote the Medicare physician payment legislation being advanced by the House Energy and Commerce Committee. With the impending return of Congress on September 10 and only 60 legislative days remaining in the session, the AOA's advocacy efforts on achieving permanent repeal of the sustainable growth rate (SGR) formula will begin ramping up into a multi-faceted campaign.

Town Hall Meetings
This year the AOA has hosted two Town Hall Meetings; topics have included the State of Medicine and Graduate Medical Education (GME) and Accreditation Council for Graduate Medical Education (ACGME). The focus of the town hall meeting at OMED will be implementation of the Affordable Care Act (ACA).

Press Releases
Since the March Bureau meeting the Department of Government Relations has issued two news releases on the progress of the Medicare physician payment reform proposal through the Energy and Commerce Committee.

Copies of our releases can be viewed in the Media Center or the DGR Document Repository; See Resources.
**Advertising**
The AOA Department of Government Relations has not run any advertising thus far in 2013.

**Key Dates**
September 30-October 4, 2013 – OMED, Las Vegas, NV
September 30, 2013 – DO Day Registration Opens
January 24, 2014 – DO Day Registration Closes
March 6, 2014 – DO Day on Capitol Hill

*Additional Town Hall Meetings will be announced as they are scheduled.*

**Resources**
**AOA Media Center** – [www.osteopathic.org](http://www.osteopathic.org), select News and Publications, then Media Center, then 2011 News Releases
**DO Advocacy Action Center** – [www.osteopathic.org](http://www.osteopathic.org), select Advocacy, then Write to Congress
**Agenda 113th Congress** – [www.osteopathic.org](http://www.osteopathic.org), select Advocacy, then AOA Legislative Priorities
**DGR Document Repository** – By email only; to be added please see Sean Neal (sneal@osteopathic.org)
**DO Washington Update** - By email only; to be added please see Sean Neal (sneal@osteopathic.org)
POLITICAL AFFAIRS
BATTLEFIELD TO BEDSIDE INITIATIVE
From the Battlefield to the Bedside:

How military medical and combat experience can help civilian patient care

Given that military experience provides benefits to patient care, the AOA has launched From the Battlefield to the Bedside program. The goal is to provide resources and information to DOs who treat military service people, veterans, and the general public as well as provide resources to osteopathic students on the latest research, best practices, etc.

Currently, the AOA is a partner in the White House’s Joining Forces Initiative to raise awareness within the osteopathic physician community about the medical needs of military veterans. In addition, the nation’s 29 osteopathic medical schools have pledged to grow the body of knowledge leading to the improvement of health care and wellness of our veterans. (www.osteopathic.org/veterans; www.aacom.org/programs/joiningforces/Pages/default.aspx; www.hsc.unt.edu/orc/research_completed.aspx; www.hsc.unt.edu/orc/research_publications.aspx)

AOA’s Battlefield to Bedside program takes AOA’s participation in Joining Forces to the next level -- to raise awareness within the osteopathic profession about the military medical advances that can be passed on to civilian counterparts. Ten percent of medical officers in the U.S. military are osteopathic physicians. A program that uses the benefits of military experience contributes to the osteopathic philosophy of treating the whole person, not just symptoms which is the cornerstone of patient-centered care. (The Hero Next Door: www.do-online.org/TheDO/?p=140981; In the Field: http://www.do-online.org/TheDO/?p=124561; Training Ground: http://www.do-online.org/TheDO/?p=125791)

In the effort to raise awareness, the AOA has compiled a list of educational resources for DOs and osteopathic medical students.
U.S. Army Medical Department Journal
Trauma and Acute Care Surgery
http://journals.lww.com/jtrauma/toc/2012/12005

Armed Forces Institute of Regenerative Medicine Annual Report 2012

Defense Medical Research and Development Program
http://cdmrp.army.mil/dmrpd/highlights.shtml#2_12

Military Medicine Journal
www.highbeam.com/publications/military-medicine-p61575

U.S. Army Medical Research Institute of Infectious Diseases
www.usamriid.army.mil/

Medical Advances as a Result of War

Walter Reed National Military Medical Center
www.wrnmmc.capmed.mil/SitePages/home.aspx

Samueli Institute: Center for Military Medical Research
www.samueliinstitute.org/our-research/military-medical-research

US Army Institute of Surgical Research Clinical Practice Guidelines

MHS (Military Health System) Publication Search: - ability to search peer-reviewed articles - subject areas includes TBI

VA Epidemiology Research Listed by Title
http://www.publichealth.va.gov/epidemiology/publications.asp

VA Research on Military Exposures
http://www.publichealth.va.gov/exposures/

Environmental Exposure Pocket Card

List of VA Research by Topic Areas - includes TBI and PTSD
http://www.research.va.gov/research_topics
Association of Military Surgeons of the U.S.
http://www.amsus.org/index.php/journal

Federal Practitioner: A peer reviewed journal for health care professionals
http://www.fedprac.com/

Other Information
Brainline.org - Comprehensive TBI site - contains section for health care professionals
which includes research information, fact sheets, and other tools/resources
http://www.brainline.org/index.html

National Resource Directory - Contains research and health information for health
professionals providing care to veterans
https://www.nrd.gov/health/health_care_provider_resources

The information below references information re: our Joining Forces webpage, but
provides direct links to specific information:

VA Patient Treatment
http://www.publichealth.va.gov/patient-treatment.asp

Guidelines and Best Practices for such areas as: Hepatitis C, HIV/AIDS etc.
Clinician Pocket Guides:
Mild Traumatic Brain Injury - Concussion
http://www.publichealth.va.gov/docs/exposures/TBI-pocketcard.pdf

Malaria
http://www.publichealth.va.gov/docs/exposures/malaria-pocketcard.pdf

VA/DOD Clinical Practice Guidelines
http://www.healthquality.va.gov/

Topics listed for chronic disease, mental health, military-related conditions, pain,
rehabilitation, and women’s health. Webpage includes pocket card for clinicians on
shared decision-making

Webpage also includes link to articles on pain care in military:
**VA National Center for PTSD:** Website contains information which includes a section specifically for physicians on screening and referring for PTSD, informational research and resources.

**Addiction Medicine**
American Osteopathic Academy of Addiction Medicine Journal:
http://www.tandfonline.com/toc/wjad20/current

Other journals and information:
http://www.asam.org/publications/journal-of-addiction-medicine
http://www.acpm.org/?UseAbuseRxClinRef

**Allergy and Immunology**
Allergy and Immunology Resources
http://hsl.med.nyu.edu/subject/10

**Anesthesiology**
Military Advanced Regional Anesthesia and Analgesia Handbook

**Dermatology**
Chemical Warfare Agents
www.ncbi.nlm.nih.gov/pubmed/14673274

**Emergency Medicine**
Advances in pre-hospital trauma care
www.ncbi.nlm.nih.gov/pmc/articles/PMC3209938/
Evaluation of Junctional Tourniquet Designed for combat, human tissue study
Trauma and Acute Care Surgery
http://journals.lww.com/jtrauma/toc/2012/12005
Pre-hospital Combat Casualty Care

**Family Medicine**
Military Family Doctor:
http://militaryfamilydoctor.org/

**Internal Medicine**
History of military contributions to the study of diarrheal diseases
www.ncbi.nlm.nih.gov/pubmed/15916281

**Medical Informatics**
Standardizing Medication Error Event Reporting in U.S. Department of Defense
www.ncbi.nlm.nih.gov/books/NBK20623/
Neurology and Psychiatry
www.ncbi.nlm.nih.gov/pubmed/?term=military--advances+pathology
Cortical Thinning in Patients with PTSD
www.ncbi.nlm.nih.gov/pmc/articles/PMC3374792/
Neuropsychological and neuroimaging findings in TBI and PTSD
www.ncbi.nlm.nih.gov/pmc/articles/PMC3182009/
Advances in neuroimaging of TBI and PTSD
www.ncbi.nlm.nih.gov/pmc/articles/PMC3233771/
Enhanced neuro-rehabilitation techniques in the DVBIC Assisted Living Pilot Project
www.ncbi.nlm.nih.gov/pubmed/20448315
Defense and Brain Injury Information Center: Site contains section for medical providers, which includes: online information on TBI, includes online education information, fact sheets, and webinars.
http://www.dvbic.org/audience/medical-providers
National Intrepid Center of Excellence
DoD institute dedicated to the evaluation, treatment, and research of TBI and psychological health conditions
www.nicoe.capmed.mil

Obstetrics and Gynecology
http://www.brooksidepress.org/Products/Military_OBGYN/Home.htm

Ophthalmology and Otolaryngology
Resident Manual of Trauma to the Face, Head, and Neck
www.entnet.org/mktplace/upload/Trauma-Chapter-8.pdf

Management of Facial Trauma: Lessons of War
www.ncbi.nlm.nih.gov/pubmed/21086234

Innovations in Military Handling of Facial Trauma
www.ncbi.nlm.nih.gov/pubmed/19164991

Orthopedics
Orthopedic Surgery in the U.S. Army: Historical Review
www.ncbi.nlm.nih.gov/pubmed/21702390

Osteopathic Manipulative Medicine
http://www.jaoa.org/content/111/10/574.full
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267441/

Pediatrics
Virtual Reality & Interactive Gaming Technology for Obese and Diabetic Children: Is Military Medical Technology Applicable?
www.ncbi.nlm.nih.gov/pmc/articles/PMC3125910/
http://contemporarypediatrics.modernmedicine.com/contemporary-pediatrics/news/aap-children-military-have-unique-health-needs

Physical Medicine and Rehabilitation
New Nerve and muscle interfaces aid wounded warrior amputees
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