Behavioral Health Redesign

The Kasich administration is continuing an effort to rebuild behavioral health system capacity by integrating physical health and behavioral health services. The Medicaid Behavioral Health population in Ohio represents 27 percent of Medicaid members but accounts for almost half of the Medicaid dollars spent (47 percent). According to the Kasich administration, people with serious and persistent mental illness who are not in the behavioral health system often receive care in nursing homes, prisons and psychiatric inpatient hospitals, impacting access, cost and quality of care.

The Ohio Association of Behavioral Health Authorities points out that:

- The Ohio Business Roundtable estimates that improving the diagnosis of depression could lead to $350-$450 million per year in increased productivity for Ohio's employers.
- Avoidable hospitalizations for people with a severe mental illness has been identified by the Governor's Office of Health Transformation as a "Medicaid Hot Spot."
- The total Medicaid cost of an individual with a substance abuse problem who receives treatment is 50% less than for an addicted individual who does not receive treatment. (Ohio Department of Jobs and Family Services (ODJFS))
- The average national cost of substance abuse treatment is approximately $1,600. This investment returns $11,487 benefit to society. (Substance Abuse and Mental Health Services Administration)

Ohio is one of five states selected by the Substance Abuse and Mental Health Services Administration to develop a statewide tobacco use and behavioral health action plan. The Ohio Department of Mental Health and Addition Services held a summit in November 2015 to obtain stakeholder input for the plan. Participants identified smoking cessation strategies that are working in Ohio and discussed ways to weave them into actionable objectives and strategies to reduce smoking rates by 10 percent in the behavioral health population by 2020. Ohioans with substance abuse disorders or poor mental health are twice as likely to smoke as other populations.

The Agency for Healthcare Research and Quality in *Integrating Mental Health Treatment Into the Patient Centered Medical Home* (PCMH) points out that mental health problems are common in primary care practices but often go untreated.

> *National studies estimate that, during a one-year period, up to 30 percent of the U.S. adult population meets criteria for one or more mental health problems, particularly mood (19 percent), anxiety (11 percent), and substance use (25 percent) disorders (Kessler et al., 2005). Mood and anxiety disorders are especially common among primary care patients and occur in approximately 20 to 25 percent of patients seen in clinics serving mixed-income populations and in as many as 50 percent of patients seen in clinics serving low-income populations (Wang, Lane, et al., 2005). Mental health problems are 2 to 3 times more common in patients with chronic medical illnesses such as diabetes, arthritis, chronic pain, headache, back and neck*

problems, and heart disease (Katon, 2003; Katon, Lin, and Kroenke, 2007; Scott et al., 2007). Left untreated, mental health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems, and excess health care costs (Almeida and Pfaff, 2005; Anda et al., 1990; Cronin-Stubbs et al., 2000; DiMatteo, Lepper, and Croghan, 2000; Kessler et al., 2005; Kinnunen et al., 2006; Martini, Wagner, and Anthony, 2002; Merikangas et al., 2007; Scott et al., 2009).

Most mental health treatment is provided in primary care settings, and the percentage provided solely in these settings is rapidly growing (Wang, Lane, et al., 2005, Wang, et al., 2006). Nonetheless, PCPs typically under identify mental health problems in their patients (Young et al., 2001). When they do identify these conditions, PCPs more often than not deliver treatment that is suboptimal and characterized by inadequate follow-up and monitoring of patients (Kessler et al., 2005; Wang et al., 2002, Wang, Berglund, et al., 2005), especially among the low-income patient population and racial and ethnic minorities (Alegria et al., 2008; González et al., 2008, 2009, 2010). When viewed from this perspective, the PCMH will not achieve its goals unless and until it embraces and addresses patients' mental health needs.

In June 2016, The Governor's Office of Health Transformation (OHT) will be rolling out a PCMH Model to at least two major markets in Ohio. The OHT further plans to roll out the model to all markets between 2017-18, with 80 percent of Ohio patients enrolled in a PCMH by the end of that two-year period. Ohio's PCMH initiatives have been developed with the advice of a PCMH Design Team, provider focus groups, meetings with over 40 commercial payers, patient advocates and population health experts. One of the components of promoting the administration's "high-quality, individualized, continuous and comprehensive care" calls for integrating behavioral health specialists into the PCMH. The Behavioral Health expectations will eventually include:

- Integrating behavioral specialists in the practice, where scale justifies it
- Creating fully integrated systems and regular formal and informal meetings between BH and PCP/team to facilitate integrated care
- Building competencies to directly provide select BH services on site, when scale justifies it
- Collaborating with community-based resources to manage BH needs

Questions

1. Why should mental health problems be priorities for primary care physicians?
2. Are the evidence-based strategies used to deliver mental health treatment in primary care consistent with the PCMH's core components?
3. How can the PCMH meet the needs of diverse patient populations with complex mental health and related problems?
4. What policy and programmatic actions are needed to ensure the feasibility of integrating mental health treatment into the PCMH?

Children At Risk: Infant Mortality

According to the Ohio Department of Health Infant Mortality Task Force (OIMTF), the United States, at a rate of 6.41, has a higher infant mortality rate than 28 other developed nations. Ohio's rate of 7.8 (2006), after steadily decreasing for years, has not substantially changed for more than a decade. In November 2015, March of Dimes released the 2015 Premature Birth Report Card. Cincinnati, Columbus and Cleveland received failing grades. Ohio as a whole earned a mediocre "C". Furthermore, Ohio is ranked 48th according to the *Race and Ethnicity Disparity Index*

The Ohio Infant Mortality Task Force (OIMTF) investigating infant mortality noted:
- Ohio's African-American infants die at more than twice the rate of white infants.
- Ohio's death rate for white infants alone is two to three times that of all infants in some nations.
- A shortage of women's health providers in many areas of the state results in long waits for prenatal care and long drives to primary care and delivery hospitals for many Ohio women.
- Many Ohio women have no reproductive health care coverage.
- Medical interventions known to be effective in preventing premature delivery are not being applied universally.
- Gaps exist in data that affect our ability to fully understand and impact infant mortality.
- Many Ohioans are unaware of the relationship between preventive health care for women, and successful pregnancies, which produce healthy infants.

Ten recommendations and accompanying strategies to reduce infant mortality and disparities in Ohio were identified by the Task Force:
1. Provide comprehensive reproductive health services and service coordination for all women and children before, during and after pregnancy.
2. Eliminate health disparities and promote health equity to reduce infant mortality.
3. Prioritize and align program investments based on documented outcome and cost effectiveness.
4. Implement health promotion and education to reduce pre-term birth.
5. Improve data collection and analysis to inform program and policy decisions.
6. Expand quality improvement initiatives to make measurable improvements in maternal and child health outcomes.
7. Address the effects of and the impact of racism on infant mortality.
8. Increase public awareness on the effect of preconception health on birth outcomes.
9. Develop, recruit and train a diverse network of culturally competent health professionals statewide.
10. Establish a consortium to implement and monitor the recommendations of the OIMTF

The Ohio Collaborative To Prevent Infant Mortality encourages physicians to:

- Provide culturally sensitive information to patients and staff on a variety of topics affecting women's and babies' health such as obesity/nutrition, alcohol/tobacco/drug use, physical activity, breastfeeding, and infant sleeping positions.
- Maximize opportunities to discuss preconception health with patients and their families.
- Educate themselves and their staff about resources and referral agencies available in the community, such as mental health services, smoking cessation, substance abuse treatment, Medicaid, WIC, food pantries, lactation support, child care, etc.
- Women's health providers should encourage women to schedule appointments for preconception counseling and early prenatal care.
- Encourage men and women to develop a reproductive health plan.

An Ohio Commission on Infant Mortality, co-chaired by State Rep. Stephanie Kunze and State Senator Shannon Jones, was established to study the current inventory of state programs and funding streams for addressing infant mortality. The Commission will develop recommendations to improve accountability and coordination in the state's efforts to combat the high rate of infant mortality in Ohio. The Commission meets bimonthly with the objective of producing a final report by the end of the year.

The Ohio Hospital Association is tackling the problem with a two-year initiative promoting (1) safe sleep; (2) eliminating elective deliveries of less than 39 weeks; (3) promoting breast feeding; (4) safe spacing; (5) progesterone for high risk mothers; (6) access to pre, post and inter conception care; and (6) eliminating health disparities.

Questions

1. What can practicing physicians in Ohio do to help reduce infant mortality?
2. Cultural competency in health care is defined by *Bentencourt et al.* (2002) as "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." Health disparities have been identified as an important part of the infant mortality problem in Ohio. There is pending legislation in the Ohio General Assembly that would require mandatory continuing medical education on cultural competency for health professionals. What can be done in medical education to ensure that physicians meet the social, cultural and linguistic needs of the population they serve?

Medicaid Expansion

The Affordable Care Act (ACA) provides enhanced federal funding for states to expand Medicaid to childless adults between the ages of 19-64 with incomes up to 138 percent of the poverty level. The following Federal poverty levels are used to determine eligibility for assistance programs and benefits under the ACA *(Source: Medicare.gov).*

- $11,770 for individuals
- $15,930 for a family of 2
- $20,090 for a family of 3
- $24,250 for a family of 4
- $28,410 for a family of 5
- $32,570 for a family of 6
- $36,730 for a family of 7
- $40,890 for a family of 8

In 2012, after a national movement by opponents to prevent implementation, the Supreme Court ruled that the Affordable Care Act (ACA) is constitutional, but made Medicaid extension optional for states. This meant each state decides whether or not to extend coverage through Medicaid. Since the ACA went into effect at the beginning of 2014, 30 states and the District of Columbia, have decided to extend.

Governor Kasich proposed Expanded Medicaid coverage in the FY 2014-15 State Budget, Ohio, despite considerable opposition in the Ohio General Assembly. After a challenge in the Ohio Supreme Court, Ohio's Medicaid expansion began January 1, 2014. According to the Health Policy Institute of Ohio's (HPIO) *"Medicaid Basics 2015,"* average monthly enrollment in the expansion category during State FY 2014 was about 256,000 Ohioans for the first six months of 2014, the end of the state's last fiscal year. During calendar year 2014, total enrollment was more than 485,000, and the state budget for 2016-17 continues funding for the expansion eligibility group based on those figures and projections about an improving economy.

HPIO's *Medicaid Basics 2015* puts total annual Medicaid Spending in Ohio at $20.9 billion. The Federal proportion of this cost is 64.5 percent or $13.5 billion; Ohio's share is 34.9 percent or $7.3 billion. Medicaid accounts for about four percent of Ohio's total economy and is the largest payer of health care in Ohio and the largest payer of long-term care services. It covers more than 2.6 million low-income adults, children, pregnant women, seniors and individuals with disabilities each month, including 45 percent of Ohio's children age 0-19. It also pays for more than half of births in the state. It contracts with five private managed care plans to provide health services to about 1.8 million Ohioans monthly. Traditionally, the Aged, Blind and Disabled population account for about 25 percent of Medicaid caseload, but 75 percent of the service costs.

To address concerns of anti-expansion legislators in the 2016-17 state budget, the Kasich administration proposed charging premiums to some Medicaid Patients. Instead, the Ohio General Assembly mandated the Department of Medicaid to apply for a Healthy Ohio 1115 Medicaid waiver that would require nearly all non-disabled adults on Ohio Medicaid to pay premiums into a modified health savings account (HSA). According to the Center for Community Solutions, in Cleveland, if approved by the federal government, the waiver would have the effect of increasing the number of uninsured Ohioans as well as increasing Medicaid administrative costs and complexity.

The legislature also has strengthened oversight over the Kasich administration, by holding back one year of the Department of Medicaid's funding and placing it in a Health Care services account. The Director of Medicaid will now be required to request release of its second year of funding by showing that spending is meeting the administration's budget projections for FY 2017.

Elected officials at the state and national level and the public in general are deeply divided about Medicaid expansion and the ACA. Some want to keep the ACA structure and fix problems with the current legislation as issues are identified. Some legislators want to repeal the ACA, with no alternative proposal. Some legislators want to go to a "Medicare for all", single payer system. The Kaiser Family Foundation Tracking Poll (Dec. 2015) also states: "*As the U.S. Senate voted to repeal the Affordable Care Act (ACA) earlier this month, more of the public views the health care law unfavorably than favorably (46 percent vs. 40 percent). In addition, the public remains divided over what Congress should do next with the law, with 35 percent supporting repeal, 14 percent supporting scaling back the law, 18 percent who say they would like to see it implemented as is, and 22 percent who say they want the law expanded. While half of the public (51 percent) says they have not been directly impacted by the law, more say they have been hurt by the law than say they have been helped (29 percent vs. 17 percent). These perceptions of the law and its personal impacts vary starkly by political party identification as they have since the law's inception.*"

Questions:

1. How has Medicaid expansion increased access to care?
2. Are you in favor of Medicaid expansion? Why or why not?
3. If you are opposed to the ACA and support its repeal, what are you supporting as an alternative?
4. What are Health Savings Accounts? What are the challenges posed by the Healthy Ohio 115 Medicaid Waiver Proposal?
5. How does insurance affordability affect access and how will you deal with the uninsured in your practice?
6. How do we move discussion about health care coverage forward as a state and nation?

Medicare and Long Term Care

According to the U.S. Government Accountability Office, in 2014, Medicare covered approximately 54 million people at an estimated cost of about $600 billion. The population of Medicare-eligible people began growing rapidly in 2011, when the first baby boomers (born between 1946 through 1965) reached age 65 and became eligible for Medicare. By 2030, when the youngest boomers have reached age 65, Medicare enrollment will nearly double to an estimated 80 million.

In 2011, Medicare spending reached close to $554 billion, which amounted to 21 percent of the total spent on U.S. health care in that year. Of that $554 billion, Medicare spent 28 percent, or about $170 billion, on patients' last six months of life. End-of-life care continues to be characterized by aggressive medical intervention and runaway costs.

As a result of the Accountable Care Act, CMS Medicare Quality improvement projects are now focusing on three aims: better patient care, better population health and lower health care costs. Congress has mandated CMS to assist providers in delivering better care and helping Medicare patients make more informed choices by selecting quality providers.

Quality Improvement Organizations (QIO) assist CMS with projects designed to achieve the "three aims." The QIO contractor for Ohio is Health Services Advisory Group. Targeted QIO projects with institutional providers currently include:

- increasing mobility among long-stay residents,
- decreasing unnecessary use of antipsychotics in dementia residents,
- decreasing potentially avoidable hospitalizations,
- decreasing Health Care Acquired Infections (HAIs) such as Methicillin - resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.Diff), and improving vaccination rates for pneumonia and influenza,
- decreasing other Healthcare Acquired Conditions such as: urinary tract infections, pressure ulcers, physical restraints, and ensuring an "injury and violence free living" environment as noted in the National Prevention Strategy, and
- improving resident satisfaction.

A majority of people over age 65 will require some type of long-term care services during their lifetime, and over 40 percent of people will need a period of care in a nursing home, according to CMS. CMS's Money Follows the Person (MFP) Rebalancing Demonstration Grant is helping states, including Ohio, rebalance their Medicaid long-term care systems. Nationally, over 51,000 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2014. Ohio's target is 2,100.

Approximately 182,000 Ohioans are "dual eligibles" covered by both Medicare (because they are over age 65) and Medicaid (because they have low income or are disabled). Medicaid and Medicare are designed and managed with almost no connection to each other, and the long-term care services, behavioral health services and physical health

services that are provided to individuals who are eligible for both programs are poorly coordinated. In 2012, Ohio Medicaid launched a new integrated care delivery system called *MyCare Ohio*. The goal of *MyCare* is to manage the full continuum of Medicare and Medicaid benefits for enrollees, including long-term and behavioral health care services.

The Physician Quality Reporting System (PQRS) is a voluntary CMS program that encourages health care professionals and group practices to report information on health care practices. There are payment incentives for participating in PQRS with phased in penalties for not participating. Health care professionals and group practices that participate in PQRS are given performance scores based on the quality measure information they report. The information assists them with managing "population health." According to the Health Policy Institute of Ohio: *Population health is the distribution of health outcomes across a geographically-defined group which result from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems.*

Physician Compare is a CMS website that helps Medicare Beneficiaries choose physicians and other health care professionals enrolled in the Medicare Program. Some of the quality measure performance scores are available to consumers on Physician Compare profile pages.

The Electronic Health Records (EHR) Incentive Program encourages health care professionals to use certified EHR technology in ways known to improve health care. CMS is considering changes in the traditional Medicare EHR Incentive Program as a result of the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). While the intent is to move to outcome-based incentives for payment, physicians and hospitals still need to follow existing Meaningful Use requirements. "Meaningful use" means providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity to earn payment incentives, according to regulations published by CMS.

Million Hearts is a national initiative to prevent 1 million heart attacks and strokes by 2017. The initiative encourages health care professionals to report and perform well on activities related to heart health in an effort to prevent heart attacks and strokes.

Questions

1. What can be done to decrease costs associated with end of life care?
2. How will you talk to your patients about treatment options and costs?
3. What is population health and why will it be important to your future practice?

Pain Management and Prescription Drug Abuse

Unintentional drug overdose killed 2,482 Ohio residents in 2014, and it continues to be the leading cause of injury-related deaths, exceeding motor vehicle accidents. Ohio spotlighted the prescription drug epidemic during the last year of the Strickland Administration and convened a task to address the problem in 2010. The task force's final report identified "over-treatment" of pain with the use of opioids as the underlying reason for the epidemic.

In 2011, State Rep. Terry Johnson, DO, co-sponsored HB 93, which resulted in the closure of so-called "Pill Mills" across the state by creating a licensing process for pain clinics. To reign-in opioid prescribing in general, Governor Kasich, that same year, launched the Governor's Cabinet Opiate Action Team (GCOAT), which included the Ohio Osteopathic Association and other major provider organizations. GCOAT was charged with developing voluntary prescribing guidelines for opiods to reduce the number of unused drugs in medicine cabinets that can be diverted to street use. GCOAT has since issued three sets of guidelines for prescribing opioids in (1) Emergency Departments; (2) for chronic pain patients; and (3) the just-released guidelines for treating patients with acute pain. For more information visit the GCOAT website: http://mha.ohio.gov/Default.aspx?tabid=828 .

Some legislators have accused physicians of being oblivious to the addiction problem and view physicians as the primary source of abusive drugs that are diverted to the street. Legislators have also been skeptical of "voluntary guidelines" and prefer a legislated approach imposing mandates and penalties. The House of Representatives put more public scrutiny on the problem by creating its own Prescription Drug Addiction and Healthcare Reform Study Committee in 2013 and holding a series of public hearings around the state. Based on patient "horror stories, the Ohio House subsequently introduced and quickly passed a series of bills to address the problem. Similar stories about addiction have gotten national attention during the presidential campaign in Iowa and New Hampshire.

New Ohio laws include passed last session include: HB 170 (Drug Overdoses) which authorizes prescribers to personally furnish naloxone or issue prescriptions for it to a patient's friends and family; (HB 314) which requires informed consent when prescribing drugs to a minor; (HB 315) which requires hospitals to report opioid dependent newborns; and (HB 241), which requires prescribers to register for the Ohio Automated Rx Reporting System (OARRS) and check the registry before prescribing opioids and other controlled substances to their patients; and HB 366 which requires certain practices by Hospices to prevent drug diversion.

As a result of GCOAT's efforts and the new state laws cited above, Ohio has seen the following progress:

- The number of opioid prescriptions dispensed to Ohio patients in 2014 decreased by more than 40 million doses compared to 2013, reducing the opportunity for opiates to be redistributed or abused.

- The number of individuals “doctor shopping” for controlled substances including opioids as identified through the OARRS decreased from more than 3,100 in 2009 to approximately 960 in 2014.
- Patients receiving prescription opioids for the treatment of pain at doses greater than an 80 mg morphine equivalent dose decreased by 10.8 percent from the fourth quarter of 2013 when Ohio’s opioid prescribing guidelines were announced, to the second quarter of 2015.
- The percentage of opioid prescribers registered to use OARRS increased by 30.3 percent from the fourth quarter of 2013 to the second quarter of 2015. This upward trend will continue because prescribers are now required to show that they are registered in OARRS for re-licensing.
- Ohio patients receiving prescriptions for opioids and benzodiazepine sedatives at the same time dropped 8 percent from the fourth quarter of 2013 to the second quarter of 2015. Multiple drug use was the single largest contributor to unintentional drug overdoses in 2014.

More agencies and elected officials have gotten into the act. Attorney General Mike DeWine has established a law enforcement taskforce. U.S. Senators Brown and Portman each have their own initiatives. The Centers for Disease Control just released Prescribing Guidelines at the national level. And the White House has started its own initiative to reach prescribers. The AOA and the OOA recently committed to be part of the White House initiative, which also stresses an educational approach.

Physician groups have advocated against highly restrictive laws that essentially define the standard of practice for pain management in detail. Instead, the physician community has advocated for and helped to develop “guidelines” to make changes through education. The argument has been that laws and regulations are too restrictive when treating pain, since all pain is different and “one size does not fit all.” Stakeholder groups have also cautioned that overly restrictive and onerous guidelines will prevent patient access to treatment since many providers have already opted to stop treating pain patients altogether to avoid potential scrutiny by regulatory boards. So far, the Kasich administration has supported the educational approach to the prescription drug epidemic and has pledged, that more restrictive laws and regulations will not be enacted as long as progress is made in reducing prescription drug-related deaths and other measurable goals involving the use of OARRS.

Questions

1. How do state guidelines differ from laws and regulations?
2. What is the physician’s ethical responsibility to take care of pain patients?
3. What opportunities exist for osteopathic physicians to treat pain patients differently?

Women's Health Issues

The U. S. Department of Health and Human Services' *Healthy People 2020* identifies the following health issues that are specific to women: breast and cervical cancer, reproductive health (including unintended pregnancy, STDs), domestic abuse and sexual violence, and maternal health and prenatal care. Some of the most controversial legislative issues today involve women's reproductive health. For example, recently enacted legislation and pending bills in Ohio include:

Enacted Laws

- HB 147 (Mastectomy Guidance) (To require a surgeon performing a mastectomy, lymph node dissection, or lumpectomy in a hospital to guide the patient and provide referrals in accordance with the standards of the National Accreditation Program for Breast Centers and to name this act the "Lizzie B. Byrd Act." En. 4731.73
- HB 124 (STD Prescriptions) which gives physicians authority to prescribe without examination a drug for a sexual partner of a patient diagnosed with certain sexual transmitted diseases or infections

Pending Bills

- HB 135 (Abortion) To prohibit a person from performing, inducing, or attempting to perform or induce an abortion on a pregnant woman who is seeking the abortion because of a test result indicating Down Syndrome in an unborn child or a prenatal diagnosis of Down Syndrome in an unborn child.
- HB 255 (Abortion) To expand the regulation of inducing an abortion with certain drugs.
- HB 360 (Abortion) To repeal the prohibitions against including abortion coverage in insurance plans purchased through the federal health insurance exchange and in health insurance policies, contracts, or plans offered to public officers and employees.
- HB 376 (Pregnancy Program) To require entities funded through the Ohio Parenting and Pregnancy Program to provide only medically accurate information.
- SB 101 Contraception (Coverage) To require coverage for prescription contraceptive drugs and devices, the provision of certain hospital and pregnancy prevention services for victims of sexual assault, and comprehensive sexual health and sexually transmitted infection education in schools.
- SB 68 (Contraception Coverage) To require health insurers to provide coverage for contraceptive drugs and devices approved by the United States Food and Drug Administration and to prohibit employment discrimination under the Ohio Civil Rights Law on the basis of reproductive health decisions made by a person or a person's dependent or on the basis of the employer's personal beliefs about drugs, devices, and services related to reproductive health.
- From the previous session: HB 200 (Abortion Notification) To modify the notification requirements given by a physician 48 hours prior to the performance or inducement of an abortion, to require the physician to perform an obstetric ultrasound examination 48 hours prior to the performance or inducement of an abortion, to modify the definition of medical emergency that applies to the law regulating abortion, and to eliminate medical

necessity as a reason to perform an abortion without complying with the 48-hour notification requirements.

Physician associations, in general, have declined to take organizational stands on bills like these because members are polarized by abortion issues. The American Osteopathic Association has the following policy:

The AOA supports the protection of the patient-physician relationship as especially paramount to the osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole patient and the use of preventive medicine. The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient, which relies heavily on communication. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner they believe is best for their patients.

The AOA affirms that legislation, which interferes with the patient-physician relationship impairs the autonomy of osteopathic physicians and prevents osteopathic physicians from using their best judgment based on years of rigorous education and training.

The AOA asserts that physicians must be able to communicate freely with patients without fear of government intrusion in order to assure safe, comprehensive and effective medical treatment.

The AOA considers that legislation, which undermines physician judgment is a barrier to evidence-based medicine. The AOA supports the use of evidence-based medicine to ensure high quality patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating a "one size fits all approach," thereby preventing an individualized assessment of what is in a particular patient's best interests.

The AOA affirms that legislation, which interferes with the patient-physician relationship undermines patient-centered care. Patient-centered care actively involves the patient in making decisions regarding their own medical care. Statutorily required medical practices prevent patients from being involved in making medical decisions, because the patient has no choice.

The AOA affirms the ethical principle of informed consent is undermined when patients are statutorily required to undergo certain treatments or procedures, because the patient has no choice.

The AOA opposes all legislation at the state and federal level, which requires physicians to discuss or perform certain treatments or procedures not supported by evidence-based guidelines, because such legislation undermines physician judgment.

Questions:

1. Do you agree with the AOA's position?
2. How can physicians balance personal and patient beliefs in their practices?