OOA House of Delegates Policies

Advance Directives and Complementary Documents (2015)

RESOLVED, that the Ohio Osteopathic Association continues to urge its members to educate their patients about the importance of advance directives and other complementary documents, including living wills, health care powers of attorney, do not resuscitate orders, medical orders for life sustaining treatment (MOLST), and organ donation forms and options; and, be it further,

RESOLVED, that OOA continues to urge its members to encourage their patients to download copies of the latest edition of "Choices: Living Well at the End of Life" and "Conversations that Light the Way" from the OOA website at www.ooanet.org, complete the newly revised advance directive documents, and make copies of the documents available to their attending physician and family members. *(Original 2005)*

Advocates for the OOA (2014)

RESOLVED that the Ohio Osteopathic Association continue to provide necessary administrative assistance to the Advocates for the Ohio Osteopathic Association. *(Original 1984)*

Antibiotics for Medical Treatment, Preservation of (2017)

RESOLVED, that the Ohio Osteopathic Association continues to support legislation banning antibiotics and other feed additives for non-therapeutic purposes (such as for growth promotion, feed efficiency, weight gain, and routine disease prevention), where any clinical sign of disease is non-existent. *(Original 2007)*

AOA Health Policy Fellowship (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to endorse the American Osteopathic Association Health Policy Fellowship Program and encourage Ohio's health policy fellows to participate in the formulation of state and national health policy; and, be it further

RESOLVED, that the OOA encourages interested members to apply for the program, and if accepted, request financial support through the Ohio Osteopathic Foundation. *(Original 1999)*

Automated External Defibrillator Availability (2014)

RESOLVED, the Ohio Osteopathic Association (OOA) supports placement of automatic external defibrillators (AED) in as many public places as possible and necessary legislation to limit liability resulting from such placement. (Original 2009)

Automobile Passive Restraints (2015)

RESOLVED that the Ohio Osteopathic Association continues to support state laws requiring mandatory seat belt usage and passive restraints in automobiles, including, but not restricted to appropriate safety bags. *(Original 1990)*

Cancer Clinical Trials, Exploring Incentives to Increase Patient Involvement (2016)

WHEREAS, in 2015 it is estimated that there will be over 1,650,000 new cancer cases in the United States; and

WHEREAS**,** only three percent of cancer patients are enrolled in new clinical trials; and

WHEREAS, as physicians and as a part of a health care team, we should promote avenues to seek patient healing and treatment advancement such as clinical trials; and

WHEREAS, clinical trials are often covered by insurance or drug companies and as such are no cost to the patient; and

WHEREAS, we should maximize the opportunities to improve research and our patients' health; and

WHEREAS, "The limited involvement of [primary care] physicians in clinical research reduces physician referrals of patients to clinical research studies, as well as the total number of investigators available to conduct the research;" and

WHEREAS**,** most of the patients enrolled in clinical trials are served by community oncology centers rather than academic health centers; and

WHEREAS**,** this is due to the fact that clinical investigators face many obstacles. These include "locating funding, responding to multiple review cycles, obtaining Institutional Review Board (IRB) approvals, establishing clinical trial and material transfer agreements with sponsors and medical centers, recruiting patients, administering complicated informed consent agreements, securing protected research time from medical school departments, and completing large amounts of associated paperwork;" and

WHEREAS**,** as a result of these challenges, many who try their hand at clinical investigation drop out after their first trial; and

WHEREAS, this exhibits a lack of progress and advancement in oncological innovation; and

WHEREAS**,** cancer patients in Ohio should be given any and all opportunities to enroll in existing clinical trials so that they can potentially benefit from new medications as well as contribute to research to benefit future patients; now therefore be it

RESOLVED, that the Ohio Osteopathic Association supports increasing the number of cancer patients in Ohio that are enrolled in clinical trials via educational promotions and increase patients' awareness of clinical trial opportunities. *(Original 2016)*

Burnout in Medical Students and Residents, Prevention and Maintenance of (2017)

WHEREAS, burnout syndrome has been characterized by three main areas of symptoms: emotional exhaustion, alienation from (job-related) activities, and reduced performance1; and

WHEREAS, medical students experience burnout rates at a prevalence ranging from 28 to 45% and residents experience burnout rates ranging from 27 to 75% based on their specialty (which may continue from med school to residency to professional life)2; and

WHEREAS, between 22 and 60% of practicing specialists and general practitioners have experienced burnout3; and

WHEREAS, physician shortages in 2025 have been projected to range from 61,700 to 94,700 fulltime-equivalent physicians from an analysis comparing each of five scenarios commonly expected to affect physician supply (e.g., early or delayed retirement of physicians) to each of six scenarios expected to affect the demand for physician services (e.g. changing demographics) over the next decade (14,900 to 35,600 primary care physicians and 37,400 to 60,300 non-primary care specialists)4,5; and

WHEREAS, a 2016 Austrian study demonstrated that physicians with mild, moderate, and severe burnout, as measured by the Hamburg Burnout Inventory, have elevated odds ratios of 2.99, 10.14, and 46.84, respectively, of suffering from major depression according to the Major Depression Inventory6; and

WHEREAS, using an economic model, the costs of loss of service due to early retirement from burnout were found to be $255,830 per physician per year, with the average early retirement occurring 26 years prior to anticipated retirement7; and

WHEREAS, burnout is associated with errors8, with over half of the articles in Hall and Johnson's review finding that poor wellbeing, which included depression, anxiety, job stress, mental health, and distress, was associated with poorer patient safety, and that 21/30 studies measuring burnout found that more errors were significantly associated with health practitioner burnout; and

WHEREAS, a Swiss study9 found that higher individual burnout scores were related to poorer overall safety scores and that emotional exhaustion was an independent predictor of standardized mortality ratio, and postulates that emotionally exhausted clinicians curtail performance to focus on only the most necessary and pressing tasks, and may also have impaired attention, memory, and executive function, which decreases their recall and attention to detail; and

WHEREAS, doctors have an increased risk of depressive symptoms10, and suicidal thought level was high amongst medical students, and in the first postgraduate year, mental distress was the most important predictor11; and

WHEREAS, 15% of year one students demonstrated lifetime prevalence of mental health problems, 31% of students began exhibiting mental health problems without seeking help at term two, and 14% reported in term three that they had problems in term two, meaning that, overall, a third of students reported mental health problems during the first three years, and that intervention should focus on both individual problems and contextual stress12,13; and

WHEREAS, the Maslach Burnout Inventory (MBI), consisting of 22 items that measure all three burnout dimensions is the most frequently used, highly regarded

questionnaire for burnout in medical research literature14; and
WHEREAS, the MBI exists to assess emotional exhaustion, depersonalization, and personal accomplishment in health professionals, and has recently been updated to reflect a portion for students; and

WHEREAS, the overlap between burnout and major depression has been implicated6; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports training institutions and programs in monitoring the mental health status of medical students and residents to prevent burnout; and, be it further

RESOLVED, the OOA promotes the use of tools to measure burnout for medical students and physicians, such as the MBI; and, be it further

RESOLVED, that the OOA encourages physicians, residents, and medical students to engage in open discussion and develop novel solutions to reduce the prevalence of burnout among current and future physicians; and be it futher

RESOLVED, that the OOA submit aa copy of the resolution for consideration at the 2017 American Osteopathic Association House of Delegates. *(Original 2017)*

Explanatory Statement

Existing literature indicates that burnout† is prevalent during medical school, with major US multi-institutional studies estimating that at least half of all medical students may be affected by burnout during their medical education. Studies show that burnout may persist beyond medical school, and is, at times, associated with psychiatric disorders and suicidal ideation. Studies on burnout suggest that it causes changes in professional behavior, attitude and competency, safety and quality of care, career or specialty decision making, and individual risk behaviors and ideas.

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Cell Phone Usage While Driving (2014)

RESOLVED, that the Ohio Osteopathic Association supports laws that prohibit the use of handheld cellular phones while operating a motor vehicle and encourages on-going public awareness campaigns about the dangers of using these devices while driving. *(Original 2004)*

Centers for Osteopathic Research and Education (2015)

WHEREAS, the changing health care landscape and required transition to new accreditation standards for graduate medical education programs has resulted in uncertainty for organizations involved in osteopathic medical education; and

WHEREAS, consistent with the Memorandum of Understanding among the American Osteopathic Association (AOA), the American Association of College of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME), the transition of osteopathic graduate medical education programs to a new single accreditation system must be completed on or before July 1, 2020; and

WHEREAS, the Ohio Osteopathic Association (OOA) and the Ohio osteopathic profession have a forty year history of supporting the Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) and Ohio hospitals and health systems engaged in osteopathic undergraduate and graduate medical education throughout the state; and

WHEREAS, the Ohio University Heritage College of Osteopathic Medicine OU-HCOM and the hospital members of the Centers for Osteopathic Research and Education (CORE) are committed to providing a high level of undergraduate and graduate medical education through an effective and efficient educational consortium; and

WHEREAS, OU-HCOM and its CORE hospital members have committed to promoting osteopathic medicine and osteopathic medical education by:

- Maintaining elements and characteristics of the CORE which have served to advance osteopathic medical education in our predominantly community-based training facilities;
- Understanding change created by the alignment of community-based training facilities with academic health centers and health systems;
- Recognizing how an education network creates strength in numbers with a commitment to a common goal;
- Seeking osteopathic recognition of current programs in the new single accreditation system, thereby allowing opportunity for further development of osteopathic knowledge and skills by residents as well as promoting a strong future for osteopathic medicine;
- Involving leaders and resources from across the nation and throughout the state; and
- Developing a meaningful and viable business model for both undergraduate and graduate medical education that recognizes the diversity of needs across members, recognizes the changing landscape of undergraduate and graduate medical education and is completed on a timeline that reflects understanding of the change created by the new graduate medical education accreditation environment; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) strongly supports the continuum of undergraduate and graduate osteopathic medical education through the Ohio University Heritage College of Osteopathic Medicine (OU-HCOM), it's evolving educational consortium, the Centers for Osteopathic Research and Education (CORE), and the CORE's hospital members; and, be it further

RESOLVED, that the OOA continue to work collaboratively with the Heritage College and the CORE continue to strengthen organizational ties among the OOA, the Heritage College, each other and its affiliated teaching hospitals and health systems to promote Pride, Unity, Loyalty and Legacy within the osteopathic community; and, be it further

RESOLVED, that the OOA, CORE and the Heritage College embrace transparency and engage physicians, residents, students and other members of the osteopathic family in constructive dialogue in order to define and promote osteopathic distinctiveness; and, be it further

RESOLVED that the OOA, CORE and the Heritage College encourage osteopathic residency and fellowship programs at member hospitals currently accredited by the American Osteopathic Association to apply for Osteopathic Recognition within the new single accreditation system; and, be it further

RESOLVED, that the OOA urges it members to continue to support osteopathic-focused medical education and become involved in the continuum as program directors, clinical faculty, and mentors for osteopathic learners; and, be it further

RESOLVED, that the OOA, CORE, the Heritage College and its health system partners continue to lead the transformation of health care delivery in Ohio and the nation. *(Original 1990)*

Charity Care (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to advocate for tax incentives and

credits for physicians who provide pro bono care to uninsured patients with financial need; and, be it further

RESOLVED, that the OOA encourage all physicians to participate in pro bono care programs that provide health care services to Ohio's most vulnerable and needy populations. (*Original 2009)*

Chicken Pox Vaccine for School Entry (2015)

RESOLVED, that the Ohio Osteopathic Association supports legislation requiring mandatory chicken pox vaccination for school entry requirements in Ohio. *(Original 2004)*

Childhood Obesity and School Health Policies (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to support comprehensive, evidence-based school health and physical education programs in classes K-12 in public and private schools to promote healthy choices and prevent childhood obesity; and, be it further

RESOLVED, that the OOA supports healthy food and drinks in public and private schools and eliminating the sale of unhealthy drinks and snacks on school property; and, be it further

RESOLVED, that the OOA continues to encourage OOA members to be advocates for comprehensive school health and fitness programs in K-12 in their communities and to educate parents about their role in preventing childhood obesity. *(Original 2005)*

Collective Bargaining by Physicians (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) monitor developments pertaining to collective bargaining by physicians at the state and national level; and be it further

RESOLVED, that the OOA supports state and federal legislation to enable physicians to collectively bargain with health insuring corporations and their payors. *(Original 1999.*)

Complementary and Alternative Medicine (2013)

RESOLVED, that the Ohio Osteopathic Association encourages its members to become knowledgeable about all forms of complementary and alternative medicine in order to advise their patients about the benefits or liabilities of these therapies; and be it further,

RESOLVED, that the Ohio Osteopathic Association supports legislation and regulations which protect the right of Ohio physicians to use all forms of therapies which benefit patients, provided the patient has given appropriate informed consent. *(Original1998)*

Continuing Medical Education Credits for Physicians Pursuing Further Education (2016)

WHEREAS, there are osteopathic physicians who are currently pursuing additional health care related educational training and degrees; and

WHEREAS, the American Medical Association recognizes their efforts and provides continuing medical education (CME) credits; and

WHEREAS, the American Osteopathic Association (AOA) does not recognize these efforts and therefore doesn't consider this activity as CME despite the ongoing discussions on the need for cost reduction and value increase needed to change the healthcare system; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) advocate for those individuals seeking degrees that would further provide those physicians the CME credits issued by the American Osteopathic Association; and be it further

RESOLVED, that the OOA petition the AOA Committee on CME to revisit this request and consider recognizing those efforts by current and future physicians who wish to pursue additional degrees by offering CME credits to those individuals. *(Original 2016)*

Continuing Medical Education, Ohio State Medical Board Requirements (2014)

WHEREAS, there has been an attempt to deny the right of the Ohio Osteopathic Association (OOA) to certify mandatory continuing medical education credits for all osteopathic physicians as prescribed by Ohio state law; now therefore, be it

RESOLVED, that the Ohio Osteopathic Association House of Delegates charge the Association's Board of Trustees with the responsibility to take whatever action is required to guarantee that the OOA continues to be

the body that certifies continuing medical education credits for registration of licensure for all osteopathic physicians and surgeons in the state of Ohio. *(Original 1979)*

Continuing Medical Education, Reduced Registration Fees for Retired and Life Members (2013)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to offer all OOA-sponsored continuing medical education programs at a reduced registration fee of at least 25 percent for all OOA member physicians who document their status as retired or life members; and be it further

RESOLVED that the OOA continue to encourage all osteopathic continuing medical education sponsors in the state of Ohio to offer reduced registration fees in a similar manner. *(Original 1988)*

Continuing Medical Education, State-Mandated, Subject Specific (2017)

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

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

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

Crisis Intervention Team Model, Improving Outcomes of Law Enforcement Responses to Mental Health Crises (2016)

WHEREAS, people with mental illnesses are overrepresented in the criminal justice system in the United States, and the prevalence of certain mental disorders among those being handled by criminal justice ranges from three to 12 times greater than that observed among community members; and

WHEREAS, a 2009 study found that approximately 14.5 percent and 31 percent of jailed men and women, respectively, display symptoms of serious mental illness; and

WHEREAS, a 1996 survey of 174 police departments throughout the United States revealed that seven percent of police contacts with civilians involved individuals believed to have a mental illness, while only 55 percent of the departments possessed a protocol specifically designed to manage these types of interactions; and

WHEREAS, police officers are often the "first line of response" to individuals experiencing mental health crises,[4] and, accordingly, they are frequently tasked with determining when to divert people into mental health services rather than into the criminal justice system; and

WHEREAS, a 2004 survey indicated that police officers do not believe that their departmental training in managing encounters with people in mental health crisis is adequate; and

WHEREAS, police officers fear encounters with individuals with mental illness due to a lack of understanding about their condition and the misconception that they are all violent; and

WHEREAS, without appropriate training, police officers will apply the same response to those with mental illness who resist law enforcement as to those without mental illness; and

WHEREAS, surveys of police officers have demonstrated that they perceive the mental health services into which they could divert individuals experiencing mental health crises as inaccessible, difficult to work with, and time-consuming; and

WHEREAS, the lack of adequate communication and a shared strategy for coordinating responses to individuals experiencing mental health crises between law enforcement and mental health providers observed in certain communities further compounds the difficulties police officers have in connecting people with the appropriate mental health resources; and

WHEREAS, the Crisis Intervention Team (CIT) model serves to increase the safety of encounters between police officers and individuals with mental illnesses and to train police officers to divert individuals to collaborating mental health services when appropriate; and

WHEREAS, the CIT model involves 40 hours of voluntary training for police officers within a given

police force facilitated through lectures and scenario-based skill training, and it encompasses education on recognizing symptoms of mental illnesses, mental health treatments, de-escalation techniques, social issues affecting mental health, and relevant legal concerns; and

WHEREAS, officers trained in CIT feel more confident and prepared to take on calls regarding persons with mental illness and also report greater satisfaction with the effectiveness of their police departments in handling mental health crises; and

WHEREAS, preliminary studies have suggested that CIT training in police departments corresponds to lower arrest rates of individuals with mental illnesses and higher rates of diversion to mental health services; and

WHERAS, a comparative study of sworn CIT-trained and non-CIT-police officers in the Chicago Police Department illustrated that CIT-trained officers were more likely to avoid escalation by using less overall force when dealing with individuals displaying increasing levels of resistance; and

WHEREAS, police officers surveyed pre- and post-CIT training demonstrated improved attitudes towards individuals with mental illness, increased knowledge about of signs of mental illness and treatment options, and increased application of skills relating to handling mental health crises; now, therefore be it

RESOLVED, the Ohio Osteopathic Association (OOA) supports continued research into the public health benefits of Crisis Intervention Team (CIT) law enforcement training; and be it further

RESOLVED, the OOA encourages physicians, physician practices, allied healthcare professionals, and medical communities to collaborate with law enforcement training programs in order to improve the outcomes of police interventions in mental health crises; and be it further

RESOLVED, the OOA supports the use of public funds to facilitate CIT training for all interested members of police departments. *(Original 2016)*

Cultural Competency Dialogue on Eliminating Healthcare Disparities, Longitudinal Approach to

WHEREAS, the Institute of Medicine (IOM) defines racial healthcare disparities as "racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention"[2]; and

WHEREAS, in our nation, minorities tend to receive a lower quality of health care than non-minorities, even when patients' socioeconomic differences, such as insurance status and income, are controlled[2]; and

WHEREAS, the American Medical Association (AMA) emphasizes that the profession can increase awareness of racial and ethnic disparities in healthcare, as well as the role of professionalism and professional obligation of physicians, in efforts to reduce them by engaging in open and broad discussions about the issues within the medical school curriculum[9]; and

WHEREAS, a needs assessment for medical student cultural competency training revealed that "…many of the participating students—38.8 % of the total—do not view an understanding of diverse patient cultural beliefs as important or very important in the provision of effective patient care, and more than one-third of the total (33.8 %) are uncomfortable with and unsure about how to approach culture-related issues arising in patient care" [8]; and

WHEREAS, cultural competency is seen by Accreditation Council on Graduation Medical Education (ACGME) as an important factor of "patient care, professionalism, and interpersonal and communication skills" [10]; and

WHEREAS, promoting awareness of structural forces serves as a first step toward recognition of the relationship between interpersonal networks, environmental factors, and political/socioeconomic forces that surrounds clinical encounters and a better understanding of the cross-cultural conversations that take place there within [3]; and

WHEREAS, the introduction of a longitudinal cultural competency curriculum during the undergraduate medical education that combines classroom lectures with interactive components, such as standardized patient exercises and clinical clerkships, will help medical students gain the cultural competency skills needed to reduce healthcare disparities [7]; and

WHEREAS, according to the Cochrane group meta analysis, cultural competency education has shown improvements in the care of patients from culturally and linguistically diverse backgrounds [4]; and

WHEREAS, the dialogue on health disparities should include historical and institutional implications, environmental factors, cultural considerations, and the

production of symptoms or gene methylation by the influence of socioeconomic forces, in order to present knowledge about diseases and bodies in combination with expert analysis of social systems to help put notions of structural stigma at the center of conceptualizations of illness and health[3]; and

WHEREAS, to assist medical schools in their efforts to integrate cultural competency content into their curricula, the American Association of Medical Colleges (AAMC), supported by a Commonwealth Fund grant, has developed the Tool for Assessing Cultural Competence Training (TACCT)[1]; and

WHEREAS, a revised, more user-friendly TACCT has been offered as a resource for approaching integration of cultural competency training within medical school curricula[5]; and

WHEREAS, "…the process of becoming a culturally competent clinician is to have the fundamental attitudes of empathy, curiosity, and respect that are constantly being reshaped by self-reflection"[6]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association encourages osteopathic medical institutions to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician's role in eliminating racial health care disparities in medical treatment as part of a longitudinal curriculum throughout under graduate medical education years one through four; and be it further,

RESOLVED, that a copy of this resolution be forwarded to the American Osteopathic Association for consideration at the 2017 House of Delegates. *(Original 2017)*

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Current Procedural Terminology Code (CPT) Standardized Usage for Third Party Payers (2017)

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

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

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

Diagnostic, Therapeutic, and Reimbursement Options (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to oppose any managed care policy

which interferes with a healthcare professional's ability to freely discuss diagnostic, therapeutic and reimbursement options with patients. *(Original 1996)*

Dietary Supplements Hazardous to Health (2014)

RESOLVED, that the Ohio Osteopathic Association supports legislation to require manufacturers of dietary supplements to disclose any reports they receive of serious adverse effects caused by the use of their products; and, be it further

RESOLVED, that the Ohio Osteopathic Association supports empowering the Food and Drug Administration (FDA) to investigate dietary supplement safety problems and drug interactions. *(Original 2004)*

Direct Payment by Insurers (2017)

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

Direct Primary Care (2017)

WHEREAS, direct primary care is a growing health care model in which patient's pay directly for services in a periodic fashion and third parties are not billed on a fee-for-service basis; and

WHEREAS, direct primary care has been shown to provide patients with extensive benefits such as substantial savings in health care costs, improved patient access to care, increased time spent with their physician, improved preventative healthcare, and fewer emergency department visits; and

WHEREAS, many direct primary care practices distribute prescription medications out of their office; and

WHEREAS, that within the ACA health insurance exchange rules, the U.S. Department of Health and Human Services recognizes that direct primary care medical homes are providers and not insurance companies; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the direct primary care model of practice and efforts to specify that it is not insurance; and be it further

RESOLVED, that the OOA supports patient's payments to direct primary care practices as qualified medical expenses eligible for Health Savings Accounts through federal changes to Internal Revenue Code 213(d) and 223(c); and be it further

RESOLVED, that the OOA supports a physician's ability to dispense prescription medications from their office subject to state and federal laws; and be it further

RESOLVED, that the OOA supports mechanisms allowing Medicaid and Medicare patients access to direct primary care services while preserving physician autonomy; and be it further

RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association for consideration at the AOA House of Delegates. *(Original 2017)*

References

Eskew PM, Klink K. Direct Primary Care: Practice Distribution and Cost Across the Nation. *J Am Board Fam* Med 2015;28:793–801.

McCorry, Daniel. *Direct Primary Care: An Innovative Alternative to Conventional Health Insurance*, The Heritage Foundation, 2014.

Direct to Consumer Sales of Durable Medical Equipment (DME) (2014)

WHEREAS, companies that supply Durable Medical Equipment (DME) such as diabetic testing supplies, braces, heating pads, etc. are marketing directly to patients by phone calls, print and electronic ads; and

WHEREAS, the DME companies ask the patient a small number of questions to determine what DME item their insurance may cover; and

WHEREAS, the DME companies then contact the physician office by mail or fax to attempt to obtain an order for the supplies, sometimes with repetitive requests on a daily basis that necessitate time and effort on the part of the physician's office; and

WHEREAS, at times the DME requested is not appropriate for the patient and may be for a condition that the patient either does not have or has not discussed with their physician; and

WHEREAS, even when the physician responds that the DME is not appropriate or that the patient needs to be seen prior to ordering it, the DME companies continue to send the requests daily; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) support efforts to eliminate direct to consumer sales of DME; and, be it further,

RESOLVED, that the OOA forward this resolution to the American Osteopathic Association (AOA) for consideration at the 2014 AOA House of Delegates. *(Original 2014)*

Disability Coverage for Physicians Who Are HIV Positive (2017)

RESOLVED that the Ohio Osteopathic Association supports language in all disability insurance contracts to define HIV positive status as a disability for all physicians, regardless of specialty, provided that the physician can demonstrate that this status has caused a significant loss of patients, income, or privileges. *(Original 1992)*

Driving Under the Influence of Alcohol and Other Mind- Altering Substances (2017)

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

Drug Enforcement Administration Numbers (2016)

RESOLVED, that the Ohio Osteopathic Association urges all third party payers to maintain the confidentiality of all Drug Enforcement Administration Numbers and not require them for insurance billing purposes. *(Original 2006)*

E-Cigarettes, Prohibiting Sale to Minors (2014)

WHEREAS, minors under 18 years of age are currently able to purchase e-Cigarettes; and

WHEREAS, the food and drug administration (FDA) states that, “E-cigarettes have not been fully studied so consumers currently do not know the potential risks of e-cigarettes, how much nicotine or other potentially harmful chemicals are being inhaled during use, or if there are any benefits associated with using these products;” and

WHEREAS, “It is not known if e-cigarettes may lead young people to try other tobacco products including conventional cigarettes, which are known to cause disease and lead to premature death” now therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports efforts to eliminate the sale of E-cigarettes to minors; and be it further

RESOLVED, that the OOA forward this resolution to the American Osteopathic Association (AOA) for consideration at the 2014 AOA House of Delegates. *(Original 2014)*

Effective Therapies for Patients, Maintaining (2017)

WHEREAS, there is a national trend for insurance companies to discontinue payment for medications that have been effective and without side effects for years and demanding that patient switch to a different formulary medication; and

WHEREAS, substituting medications based on cost only can expose patients to unknown side effects and adverse reactions; and

WHEREAS, substituting biologic medications of the same or different class can introduce problems with efficacy potentially allowing an exacerbation of the underlying disease process; and

WHEREAS, autoantibodies can be induced when a biologic agent is discontinued potentially decreasing efficacy if that medication needs to be restarted; and

WHEREAS, the state of California has the Knox-Keene Health Care Services Plan Act of 1975 which regulates managed-care plans: “this bill would require for healthcare service plan contracts covering prescription drug benefits….benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously has been approved for coverage by the plan for a medical condition of the enrollee and the plan’s prescribing provider continues to prescribe the drug for the medical condition, provided that it is appropriately prescribed, and is considered safe and effective for the treatment."; and

WHEREAS, the substitution of medications based only on formulary change in essence places the insurance plan in opposition to the recommendations of the prescriber of record; and

WHEREAS, discontinuing safe and effective medications ethically and morally limits the physician from practicing medicine he/she has been trained for over many years; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association supports laws to protect Ohio citizens from medical plans demanding that their enrollees discontinue/change medications that have been safe and effective based on a change in formulary only. *(Original 2017)*

Electronic Health Records, Assisting the Osteopathic Profession in Leveraging EHRs for Value Based Payment (2015)

WHEREAS, CliniSync/Ohio Health Information Partnership was established in 2009 as a private, non-profit foundation with $51 million in state and federal grants to lead the implementation and support of health information technology throughout; and

WHEREAS, the Ohio Osteopathic Association, Ohio State Medical Association, and Ohio Hospital Association continue as permanent members of CliniSync's executive committee and have developed a business model to sustain CliniSync as Ohio's Health Information Exchange (HIE); and

WHEREAS, the Partnership has met its original ~~a~~ goal of assisting more than 6,000 primary care physicians with the adoption, implementation, and use of electronic health records at Stage 1 Meaningful Use; and

WHEREAS, this assistance, along with that provided by HealthBridge in Cincinnati, has resulted in 170 hospitals and at least 7,000 Ohio primary care providers receiving more than $1.2 billion in incentive payments from Medicare and Medicaid; and

WHEREAS, Ohio is ranked as the number one state in the country for helping the most primary care providers in meeting all three milestones of EHR implementation; and

WHEREAS, the Partnership is working with 143 hospitals across Ohio—all but about 20 -- to connect to a statewide health information exchange, and 79 have gone live in data-sharing as of March, 2015, and

WHEREAS, 870 practices representing over 3,880 physicians, not already connected to CliniSync via their participating hospitals, are also are connected to the Health Information Exchange (HIE) along with 240 long-term acute care, home health and hospice facilities, with 13,000 secure provider email addresses in the HIE's directory; and

WHEREAS, the Kasich Administration has asked the Partnership to lead a broad-based coalition of Ohio provider organizations in applying for an Ohio Practice Transformation Network (OPTN) grant from CMS in the amount of $ 28.6 million to assist 6,400 clinicians with practice transformation; and

WHEREAS, the OPTN grant will complement Ohio's State Innovation Model (SIM) grant, which builds on episodes of care and the Patient-Centered Primary Care Home models as well as CMS' Comprehensive Primary Care Initiative (CPCI) in Dayton and Cincinnati; and

WHEREAS, the OPTN grant, if awarded to CliniSync, will fund "boots on the ground" to help practices adapt to payment reform models by assisting practices with quality metrics focused on diabetes, COPD, asthma and heart failure; and,

WHEREAS, onsite consultation will assist practices in leveraging the use of their EHRs for clinical decision support, clinical measure reporting population stratification and HIE technology to improve care coordination for high risk and chronic care patients; now, therefore, be it,

RESOLVED, that the Ohio Osteopathic Association continue to work with CliniSync/Ohio Health Information Partnership to assist OOA members in the practice transformation process by helping them to use Electronic Health Records to prepare for a value-based payment reimbursement system in Ohio. *(Original Resolution 2010)*

Electronic Prescribing of Controlled Substances (2014)

RESOLVED, that the Ohio Osteopathic Association supports state and federal regulations that ensure that e-prescriptions for controlled substances, written for patients in nursing homes and skilled nursing facilities, can be filled in a timely yet safe manner. *(Original resolution 2009)*

Emergency Department Utilization (2017)

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

End of Life Care (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages member physicians to discuss advance directives with all their patients, and end of life options when appropriate; and be it further

RESOLVED, that the OOA continue to offer continuing medical educational programs on end of life care to update member physicians on the latest clinical and legal issues pertaining to pain management and end of life care; and be it further
RESOLVED, that the OOA supports the right of physicians to carry out the wishes of terminally-ill patients as declared in statutorily-recognized advance directives; and be it further

RESOLVED, that the OOA continues to seek regulatory and legislative protection as necessary to ensure the right of physicians to utilize all medically accepted palliative care and pain management methodologies during end of life care without fear of legal prosecution or disciplinary action; and be it further

RESOLVED, that the Ohio Osteopathic Association continue to monitor and participate in legislative and regulatory initiatives involving end of life care. *(Original 1988)*

Energy Drink Dangers (2013)

WHEREAS, the energy drink business has grown to a more than $3.4 billion-a-year industry that grew by 80 percent last year after the launch of more than 500 new energy drinks; and

WHEREAS, 31 percent of US teenagers say they drink energy drinks representing approximately 7.6 million adolescents and an increase of almost 3 million in three years; and

WHEREAS, one study of college student consumption found 50 percent of students drank at least 1-4 energy drinks monthly; and

WHEREAS, the most popular energy drinks contain elevated amounts of caffeine and often other ingredients such as L-carnitine, ginsing, ephedra, guarana (as an additional source of caffeine), taurine, and sugar all of which present health risks when consumed in large quantities; and

WHEREAS, caffeine is known to produce detrimental health effects in adolescents including dehydration, digestive problems, obesity, anxiety, insomnia, and tachycardia; and

WHEREAS, energy drinks are not regulated in the United States, are sold as dietary supplements, and are not required to have the amounts of ingredients listed on the label; and

WHEREAS, when energy drinks are mixed with alcohol the potential dangers are much greater and there is also a risk of abuse, as energy drinks mask the effect of consuming alcohol by making the effects of the alcohol less apparent; and
WHEREAS, 42 percent of emergency room cases in 2011 involved energy drinks mixed with either alcohol or medications such as Ritalin or Adderall; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association support community awareness and education regarding the effects and dangers of consuming energy drinks as well as encourage physicians to increase screening for the use of energy drinks; and be it further

RESOLVED, that upon successful passage of this resolution, a copy be sent to the American Osteopathic Association for consideration at the House of Delegates meeting in July. (Original 2013)

Engaging Osteopathic Physicians as Preceptors (2013)

WHEREAS, osteopathic medical education in Ohio relies strongly on community-based preceptors to teach students and residents; and

WHEREAS, trainees in office-based teaching environments gain educational experiences that are reflective of real-world medicine; and

WHEREAS, Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) plans to open branch campuses in Columbus and Cleveland, which will mean more students within the Centers for Osteopathic Research and Education (CORE) system in need of clinical experiences and therefore more preceptors to teach them; and

WHEREAS, it is important for the osteopathic profession that preceptors are not only effective teachers, but also quality clinicians; and

WHEREAS, continuing medical education programs provide current best practices in medicine and can help to improve clinical knowledge, physician performance, and patient outcomes; and

WHEREAS, Nationwide Children's Hospital of Columbus successfully uses voucher programs for participating preceptors to use for its CME programs to incentivize community physicians to volunteer in teaching its interns and residents; and

WHEREAS, the osteopathic profession should encourage and incentivize physicians in the state to participate as preceptors for CORE students and trainees; and

WHEREAS, physician preceptors who are training the next generation of osteopathic physicians should be recognized and valued; now therefore be it

RESOLVED, the Ohio Osteopathic Association work with Ohio University Heritage College of Osteopathic Medicine (OU-HCOM), Centers for Osteopathic Research and Education (CORE), and others to investigate incentives for physician preceptors of CORE osteopathic trainees. *(Original 2013)*

Eugenic Selection with Preimplantation Genetic Diagnosis (2016)

WHEREAS, Preimplantation Genetic Diagnosis (PGD) is a technique used for prenatal diagnosis and termination of pregnancy for couples that are at an increased risk of transmitting genetic disorders to their offspring. Only embryos shown to have favorable traits are made available for implantation into the uterus; and

WHEREAS, PGD is only carried out in a few specialized centers, but rapid advances in molecular genetics are likely to promote the use of PGD and prevent adverse genetic conditions in offspring; and

WHEREAS, challenges may arise in regulating the use of PGD technology; and

WHEREAS, PGD can be used for eugenic selection to create "designer babies;" and

WHEREAS, eugenic selection means self-selecting genetic characteristics, such as hair or eye color, to improve the human race; and

WHEREAS, designer babies refers to genetic intervention of pre-implantation embryos with the intention to influence non-pathologic phenotypic traits the resulting children will express; and

WHEREAS, there is no federal regulation of PGD in the United States; now therefore be it

RESOLVED, that the Ohio Osteopathic Association supports legislation that regulates the use of Preimplantation Genetic Diagnosis (PGD) to choose a fetus' traits unrelated to disease. *(Original 2016)*

Extended Care Facilities (2014)

RESOLVED, that the Ohio Osteopathic Association continue to work with the Ohio Department of Health to increase physician involvement in development of appropriate policies and procedures governing extended care facilities. *(Original 1994)*

False Qualification Standards and Advertising for the MD Degree (2013)

RESOLVED, that the Ohio Osteopathic Association protest any solicitations by medical schools which attempt to undermine the integrity of the DO degree by offering to confer MD degrees to DOs through false qualification standards; and, be it further

RESOLVED, that the Ohio Osteopathic Association continue to urge the Ohio State Medical Board to only recognize the DO or MD degree when full American Osteopathic Association (AOA) or Liaison Committee on Medical Education (LCME) curricular requirements have been met for each degree and when the appropriate state licensing examinations have been successfully passed. *(Original 1999)*

Family Caregivers (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages all osteopathic physicians to acknowledge the needs of family caregivers and to whatever extent possible provide resources to assist those caregivers; and, be it further

RESOLVED, that the OOA encourages its members to utilize resources from the National Association of Area Agencies on Aging and the National Family Caregivers Association to provide information about caregiving and caregiver support services to their patients; and, be it further

RESOLVED, that the OOA partner with the Ohio Association of Area Agencies on Aging to increase statewide awareness of the health implications of caregiving. *(Original 2005)*

Family Medical Leave Act (FMLA) Employee Relationship (2014)

RESOLVED, that the Ohio Osteopathic Association supports amendments to the Family and Medical Leave Act of 1993, to allow eligible employees to care for next of kin and their spouses when such individuals do not have a parent, spouse or child to care for them. (Original 1999)

Financial Aid for Ohio Medical Students (2014)

RESOLVED, that the Ohio Osteopathic Association continues to support the Ohio Physician Loan Repayment Program; and be it further

RESOLVED that the Ohio Osteopathic Association work with the Ohio Department of Health to promote the Ohio Physician Loan Repayment Program to OOA members and osteopathic students, interns and residents. (*Original 1979*)

Food and Housing Insecurity, Addressing for Patients (2016)

WHEREAS, more than one in six Ohioans (about 2 million individuals) turn to the Ohio Association of Foodbanks network for food assistance; and

WHEREAS, Ohio ranks sixth in the country for highest levels of food insecurity; and

WHEREAS, a study found a 27 percent increase in hospital admissions of low-income patients for hypoglycemia during the last week of the month compared to the first week of the month, which correlates to the exhaustion of food budgets; and

WHEREAS, malnourished patients tend to stay three times longer upon hospital admission than patients with proper nutrition; and

WHEREAS, food insecurity is strongly associated with other health-related social problems in youth such as issues with health care access, education, and substance abuse; and early screening of food insecurity may help identify other health-related social problems which can be addressed to improve health; and

WHEREAS, the US Department of Health and Human Services has defined housing insecurity as high housing costs in proportion to income, poor housing quality, unstable neighborhoods, overcrowding, or homelessness; and

WHEREAS, in 2013, 26 percent, 17 percent, and 22 percent of households in Cleveland, Columbus, and Cincinnati, respectively, were housing insecure; and

WHEREAS, housing insecure individuals were more likely to delay doctors' visits, have poor or fair health, and have 14 days or more of poor health or mental health limiting daily activity in the past 30 days; and

WHEREAS, from 2011-2014, over half of all US adults had to make at least one sacrifice, such as cutting back on health care or healthy foods, in order to pay rent or their mortgage; and

WHEREAS, there are many resources around Ohio to support food and/or housing insecure individuals and families, such as food banks, the Women, Infants and Children supplemental nutrition program (WIC), Supplemental Nutrition Assistance Program (SNAP), rent assistance, utilities assistance and shelters; and

WHEREAS, screening tools have been developed for many health outcome predictors, such as depression, anxiety, alcohol abuse, food and housing insecurity, etc.; and

WHEREAS, addressing social determinants of health (such as housing and food insecurity) can lead to fewer health care costs and improved health outcomes; now, therefore be it

RESOLVED, the Ohio Osteopathic Association (OOA) recognizes food and housing insecurity as a predictor of health outcomes; and, be it further

RESOLVED, the OOA encourages the use of housing and food insecurity screening tools by physicians and health care staff for at-risk patients; be it further

RESOLVED, the OOA supports legislation that aims to decrease food and housing insecurity in Ohio. *(Original 2016)*

Food Labeling, Expansion of FALCPA Requirements to Restaurant and School Foods in Ohio (2015)

WHEREAS, approximately two percent of adults and five percent of children and infants suffer from food allergies and adverse allergic reactions account for an estimated 30,000 ER visits and 150 deaths in the US per year; and

WHEREAS, newer food allergies and sensitivities (e.g. gluten) have been linked to preventable end-organ damage with chronic consumption; and

WHEREAS, the Food Allergen Labeling and Consumer Protection Act (FALCPA) of 2004 mandates allergen labeling on pre-packaged goods but has no mandate on restaurants or point-of-sale food preparation; and

WHEREAS, currently consumers are expected to obtain ingredient information from servers or cooks who were not directly involved in the recipe design process causing inefficiency and unreliable information; and

WHEREAS, restaurants can easily compile this information at the time of recipe design; and
WHEREAS, furthermore FALCPA 2004 fails to list gluten along with their eight key antigens; now, therefore, be it

RESOLVED, that the OOA recommends that Ohio restaurants and schools include allergen information on menus and retain ingredient lists; and, be it further

RESOLVED, that the OOA recommend to the Ohio Department of Health that gluten be considered a sensitivity to be listed with the eight FALCPA defined allergens. *(Original 2015)*

Gender Identity, Expanding Options on Physician Intake Forms to be More Inclusive of LGBTQ Patients (2016)

WHEREAS, according to the National Center for Transgender Equality and The National Gay and Lesbian Task Force, 90 percent of transgender people report experiencing harassment, mistreatment or discrimination on the job; and

WHEREAS, according to a study by the Williams Institute, it was estimated in 2010 there were 700,000 transgender individuals living in the US; and

WHEREAS, Lesbian Gay Bisexual Transgender and Queer/Questioning (LGBTQ) individuals face health disparities linked to societal stigma, victimization, and denial of civil rights; resulting in high rates of depression, anxiety, eating disorders, substance abuse, and suicide than heterosexual individuals; and

WHEREAS, according to the CDC transgender women are at high risk for HIV infection and African American transgender women have the highest percentage of new HIV positive test results; and

WHEREAS, patient intake forms routinely inquire about demographic information in order to allow physicians to provide them with the most relevant prevention information, and screen them for pertinent health conditions; and

WHEREAS, many forms that try to be inclusive of trans identities often only list three categories: “male, female, or transgender,” which does not provide ways for many gender variant people to accurately indicate their gender identity; and

WHEREAS, many genderqueer or gender variant people do not personally identify as trans due to cultural beliefs, social networks, geographic locations, or a belief that it is in their past and not a present identification; and

WHEREAS, including multiple questions will allow for more specific disclosure of a patient’s history, better care, provide a sense of inclusivity; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their sex (male, female, intersex) and gender identity (male, female, transgender, additional category). *(Original 2016)*

Gratis Medications (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) supports changes in Food and Drug Administration regulations to allow the gratis distribution of medications to needy patients after the manufacturer’s expiration date with patient consent, provided such medications are deemed safe by the FDA for clinical use, based on evidence-based studies by independent researchers. *(Original resolution 2010)*

Health Care Reform, OOA Position Statement (2014)

RESOLVED that the Ohio Osteopathic Association continues to endorse and/or support introduction of legislation, which is consistent with the following statement and propose modification or defeat of any initiatives, which are not substantially consistent with these principles:

Statistics indicate that a significant percent of non-elderly Ohioans are uninsured. The Ohio Osteopathic Association (OOA) believes:

1. There should be universal access to health care for all Ohioans through a combination of public and private programs.
2. Proposed changes in the health care system should address those who do not have insurance. A total restructuring of the system is unnecessary, and, in fact, might create serious problems for the Ohioans who now have health care insurance.
3. The OOA endorses access by all Ohioans, regardless of income, to a basic health insurance

package, which stresses preventive care and health maintenance. Basic benefits should be defined by physicians and other health care professionals.
4. Public programs should be expanded to include any Ohioans who cannot currently afford to purchase health insurance coverage in the private market.
5. Small business insurance market reforms are essential in correcting deficiencies. Insurance and health benefits plans should be required to accept applicants with preexisting conditions, and premiums should be based on a community rating system.
6. Consumers should share in the cost of health care insurance based on their ability to pay. All Ohioans who have access to health insurance in the private market should be required to purchase, at the very minimum, basic health care coverage in order to share risks and expand the financing basis. Younger, healthy consumers should not be able to opt out of the purchasing coverage.
7. Creative pilot projects should be implemented to investigate the effectiveness of medical IRAs and Medical Savings Accounts.
8. Cost, financing and delivery of care issues should be addressed through proper utilization, quality assurance and elimination of administrative costs, which are duplicative, non-standardized and unnecessary in some instances. Universal credentialing and claims forms should be required for use by all third party payers.
   The Medicare fee schedule should not be utilized as a basis for market pricing.
9. All health care reforms should emphasize full freedom of choice of physicians, hospitals and insurance plans. Managed care programs which exclude physicians and hospitals are not essential to cost containment. Any providers of accepted quality health care, who are willing to accept cost containment methods, should not be excluded.
10. Public programs should be amended to stress early intervention, education and prevention. Since one of the largest segments of uninsured Ohioans are children under the age of six; aid to dependent children should be expanded. Public assistance for families should be distributed at Women, Infant and Children program sites and health centers in order to ensure compliance with health care as a prerequisite for public assistance.
11. An entity should be created within state government to oversee and implement a private/public partnership to provide universal access to health insurance. Providers should be adequately represented.
12. Primary care physicians should be the first step for health care services and payment and market reforms should be enacted to implement the medical home concept as defined by the American Osteopathic Association initiative.
13. Language should be retained in the Ohio Revised Code to ensure that AOA-approved education, postdoctoral training programs, and specialty certification are equally recognized for hospital staff privileges and inclusion in all health insurance and health benefit plans.
14. Multiple levels of insurance coverage should be available for those who opt for more extensive benefits.
15. Reimbursement for new technologies must be addressed, including the development of electronic healthcare records and health data interchange.
16. Tort reform and regulatory revisions pertaining to medical professional liability insurance issues must be addressed in all health care reform discussions.
17. Health care policy should encourage geographic redistribution of providers and services.
18. Expanded governmental support for medical education should be addressed as part of the health care reform package.
19. Long-term health care policy and statute issues must be addressed as part of any health care reform. *(Original 1989)*

Health Literacy and Cultural Competency (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) recognizes that residents of Ohio have diverse information needs related to cultural differences, language, age, ability, and literacy skills, that affect their ability to obtain, process, and understand health information and services; and, be it further

RESOLVED, that the OOA strongly supports efforts to improve health literacy, so all individuals have the opportunity to obtain, process, and understand basic health information and services needed to make appropriate health decisions; and be it further

RESOLVED, that the OOA strongly supports programs to improve the cultural competency of healthcare providers to recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations in Ohio, and to apply that knowledge to produce a positive health outcome by communicating to patients in a manner that is linguistically and culturally appropriate; and be it further

RESOLVED, that the OOA strongly encourages all practitioners and medical facilities to incorporate health literacy improvement and cultural competency in their

missions, planning and evaluation to create a shame-free environment where all patients can seek help without feeling stigmatized *(Original 2011)*.

Health Planning (2014)

RESOLVED that the Ohio Osteopathic Association encourages and advocates for osteopathic physician participation in the health planning process at the state and local level to assure that the osteopathic profession's viewpoint is made known to those who make regulations affecting the practice of osteopathic medicine. *(Original 1978)*

Health Plans, Stability and Continuity of Care (2013)

WHEREAS, patients' well being and health is closely related to and dependent upon stable and ongoing relationships with their physicians; and

WHEREAS, patients enroll with health plans based on the availability of physicians and physician groups who are contracted providers with the health plans; and

WHEREAS, hundreds of thousands of patients in Ohio have been forced to undergo disruption and loss of continuity of health care when their health insurance/maintenance organization cancels contracts with providers; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) adopt as policy the principle that a health plan must keep the physicians, physician groups, medications and hospitals advertised when a patient enrolled available to the patient for the duration of the patient's contract. *(Original 2003)*

Health Savings Accounts (2015)

RESOLVED that the Ohio Osteopathic Association continues to advocate for Health Savings Account programs. *(Original 1995)*

Home Health Care (2015)

RESOLVED that the Ohio Osteopathic Association (OOA) continue to monitor home health services to ensure physician involvement in quality monitoring and utilization of services; and be it further

RESOLVED that the OOA continue to be actively involved with the Ohio Department of Health in the development of proposed legislation or regulations pertaining to home health care. *(Original 1995)*

Home Health Care, Physician Reimbursement (2016)

RESOLVED, that the Ohio Osteopathic Association continue to seek adequate reimbursement for physicians supervising and certifying Home Health Services. *(Original 1995, amended and affirmed 2006)*

Hospice Support (2013)

RESOLVED that the Ohio Osteopathic Association continues to support governmental funding of Hospice programs *(Original 1993)*

Hospital Medical Staff Discrimination (2016)

RESOLVED, that the Ohio Osteopathic Association continue to be vigilant and monitor for discrimination against osteopathic physicians and advocate for equal recognition of AOA specialty certification by hospitals, free-standing medical and surgical centers and third party payers. *(Original 1991)*

Hospital-Physician Relationships and Medical Staff Credentialing (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) believes that for-profit and not-for-profit hospitals and health care facilities can both provide cost-effective and quality medical services to the community and that all hospitals and health care facilities have an obligation to support the needs of the community at large; and, be it further

RESOLVED, that the OOA is strongly opposed to "exclusionary credentialing" and "economic credentialing." These practices include any process established by a hospital to:

(1) limit a physician's medical staff privileges based in whole or in part by a physician's privileges or participation at a different hospital or hospital system;
(2) impose limitations on medical privileges or participation at a hospital based in whole or in part on the physician's membership or membership of a partner, associate or employee at a different hospital or hospital system; or
(3) exclude physicians from medical staff privileges due to physician ownership or investment—or that of a partner, association or employee—in a for-profit entity including but not limited to specialty hospitals, surgical centers, outpatient healthcare

centers, radiology centers, or urgent care centers; and, be it further

RESOLVED, that the OOA believes that hospital privileges should be based on training, expertise, competence, and a staff development plan; and hospital privileges should be unrelated to professional or business relationships; investment in other healthcare facilities; associations with other physicians or groups of physicians; or having medical staff membership or privileges at another hospital system or for-profit facility; and, be it further

RESOLVED, OOA supports hospital ownership information disclosure to patients and supports the patients' right to choose where they receive medical care; and, be it further

RESOLVED, that the OOA calls on Ohio's hospitals and physicians to remain focused on working together to provide quality and cost effective healthcare services that address the needs of patients. *(Original 2005)*

Human Trafficking Education for Health Care Workers (2016)

WHEREAS, human trafficking (HT) is not only prevalent globally but also takes place in the United States; and

WHEREAS, it is estimated that 18,000 men, women, and children are trafficked from other countries into the US in addition to thousands of domestic victims every year; and

WHEREAS, heath care workers have an opportunity to help victims of trafficking because they often seek medical treatment as a result of horrible working conditions and sexually transmitted infections; and

WHEREAS, it is estimated that 28-50 percent of human trafficking victims, while in captivity, encounter a health care worker and are not recognized; and, be it further

RESOLVED, that the Ohio Osteopathic Association advocate for the training of health care workers in the recognition and care for victims of human trafficking. *(Original 2016)*

Immunization Initiatives (2017)

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

Independent Practices in Rural Areas (2015)

WHEREAS, with the current state of the healthcare system, it is financially rewarding for physicians to be employed by a hospital or take part in Accountable Care Organizations; and

WHEREAS, from 2012 to 2013 independent practices decreased, while the number of hospital-employed doctors grew from 20 percent to 26 percent; and

WHEREAS, the primary reasons physicians choose to leave private practice are high overhead cost and reimbursement cuts; and

WHEREAS, after the passage of the Affordable Care Act, the shift from a fee-for-service model to an outcome-based model for physician reimbursement has yielded more Accountable Care Organizations and far fewer independent practices; and

WHEREAS, economic theory suggests that small businesses are an integral part in stimulating communities and the economy which could play a large role in rural areas; and

WHEREAS, a significant barrier to proper healthcare for individuals living in under served areas is the accessibility of a health care office in rural parts of Ohio; and

WHEREAS, transportation issues, cultural barriers, long geographic distances keep patients living in rural areas of Ohio from receiving proper healthcare; and

WHEREAS, while actions are being taken to increase the number of primary care physicians in underserved rural areas in Ohio, there is a significant barrier for these physicians to open private practices in these areas; now, therefore, be it

RESOLVED, that the OOA supports positive incentives for physicians and healthcare systems to open rural practices, to provide better access to healthcare for Ohioans living in underserved rural areas, especially those with limited access to any type of primary healthcare. *(Original 2015)*

Infectious Waste Disposal (2013)

RESOLVED that the Ohio Osteopathic Association recommends that the Ohio Department of Health (ODH)

promote and encourage educational programs for the public regarding safe and effective disposal of home-generated medical supplies. *(Original 1993)*

Information Technology Adoption and Interchange (2017)

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

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

Health Insurance Coverage for Residential Treatment and inpatient Treatment of Eating Disorders (2017)

WHEREAS, eating disorders are the third most common chronic condition affecting adolescent females [1] with estimated prevalence of anorexia nervosa, bulimia nervosa, and binge eating disorder among adolescents in the United States is 0.3%, 0.9% and 1.6% respectively [2] and,

WHEREAS, individuals with anorexia nervosa had a six-fold increase in mortality when compared to the general population [3] and crude mortality rates for anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified are 4.0%, 3.9%, and 5.2%, respectively [4] and,

WHEREAS, the Society of Adolescent Health and Medicine suggest weight restoration, resumption of spontaneous menses, and improved bone mineral density are important goals of treatment; and may require inpatient refeeding and nutritional rehabilitation based on the patient's physical and emotional health, rapidity of weight loss, availability of outpatient resources, and family circumstances [5] and,

WHEREAS, patients with less severe eating disorders at baseline were more likely to abstain from eating disorder behavior after family-based outpatient treatment, leaving patients with severe eating concerns needing inpatient therapy [6] and,

WHEREAS, the estimated prevalence of adolescents and children with eating disorders of inpatient psychiatric admissions is 13.3% [7] and,

WHEREAS, research studies have shown a 24% drop out rate of hospitalizations among patients suffering with eating disorders [8] and,

WHEREAS, the Mental Health Parity and Addiction Equity Act of 2008 requires doctors and insurers to treat and cover mental illness in the same manner s physical illness [9] and,

WHEREAS, reimbursement by insurance companies remains inadequate for patients with eating disorders hospitalized on medical units [10] and,

WHEREAS, 96.7% of eating disorder specialists believe that health insurance companies' refusal to cover treatment puts patients with anorexia nervosa in life threatening situations [11] and,

WHEREAS, research evaluating effective treatment of eating disorders have found competing events; for example, termination of insurance coverage competes with patient outcome [12]; now, therefore be it,

RESOLVED, that the Ohio Osteopathic Association supports improved access to treatment in residential and inpatient facilities, and efforts to reduce the financial barriers of intensive treatment for patients suffering from eating disorders; and, be it further

RESOLVED, that the Ohio Osteopathic Association encourages residential and inpatient treatment facilities caring for patients suffering from eating disorders, to manage care in consideration of the patient's overall medical and mental health needs, and to continue treatment until goals of weight restoration and physiologic status are obtained; and, be it further.

RESOLVED, that the OOA supports continued care for individuals suffering from eating disorders staying in residential and inpatient facilities, regardless of insurance criteria requiring termination of treatment; and be it further

RESOLVED, that a copy of this resolution be forwarded to the American Osteopathic Association for consideration at the 2017 AOA House of Delegates. *(Original 2017)*

Explanatory Statement

The goal of this resolution is for the Student Osteopathic Medical Association and the American Osteopathic Association to support health benefit plans that cover diagnosis and treatment of Eating Disorders on the basis of the medical necessities of an individual

patient as judged by their healthcare provider - as opposed to predetermined biometric benchmarks. Some states have passed bills in support of this, for example Missouri 2015 Senate Bill 145; however, it is not a uniform ruling across the United States.

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5. The Society of Adolescent Health and Medicine. Position Paper of the Society for Adolescent Health and Medicine: Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. *Journal of Adolescent Health* 2015; 56: 121-5. DOI: 10.1016/j.jadohealth.2014.10.259
6. Grange D, Ross C & Lock. Predictors and Moderators of Outcome in Family-Based Treatment for Adolescent Bulimia Nervosa. *Journal of American Academy of Child Adolescent Psychiatry* 2008; 47: 464-70. DOI: 10.1097/CHI.0b013e3181640816

Insurance Identification Card for Patients (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the development of universal insurance identification cards for patients utilizing advanced technology information systems. *(Original 2000)*

Jury Duty for Physicians (2014)

RESOLVED, that upon request, the Ohio Osteopathic Association advocate on behalf of any member who has been required to serve jury duty against their wishes after demonstrating the difficulty and hardships involved in rescheduling his/her practice on short notice. *(Original 1999)*

Leadership Development (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to offer periodic leadership development programs for OOA district officers and executive directors; and, be it further,
RESOLVED, that the OOA encourages all OOA District academy presidents and presidents-elects to participate in leadership development programs. *(Original 2010)*

Lead Poisoning (2014)

RESOLVED, that the Ohio Osteopathic Association continue to inform and educate its members and their associates regarding the Ohio Child Lead Poisoning Program. *(Original 1994)*

LGBTQ "Conversion Therapy" or "Reparative Therapy" by Licensed Physicians and Other Medical and Mental Health Care, Opposition to the Practice of (2017)

WHEREAS, contemporary science recognizes that being lesbian, gay, bisexual, or transgender 1 (LGBT), or identifying as queer, or other than heterosexual, is part of the natural spectrum of human identity and is not a disease, disorder, or illness 1; and

WHEREAS, the Federal Substance Abuse and Mental Health Services Administration states that "interventions aimed at a fixed outcome, such as gender conformity of heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment," 2; and

WHEREAS, investigative studies have shown there is insufficient evidence to support the use of psychological or other purportedly therapeutic interventions to change sexual orientation or gender identity 1; and the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation; and

WHEREAS, the practice of "Conversion Therapy," also known as "Reparative Therapy," or "Sexual Orientation Change Efforts (SOCE)," generally refers to any practices by medical or mental health providers that seek to change an individual's sexual orientation or gender identity. 3 Often, this practice is used on minors, who lack the legal authority to make their own medical and mental health decisions; and

WHEREAS, the practice of "Conversion Therapy" or "Reparative Therapy" does not include counseling or therapy for an individual seeking to transition or transitioning from one gender to another gender; that provides acceptance, support, and understanding of an individual; or the facilitation of an individual's coping, social support, and identity exploration and development; including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or

therapy does not seek to change sexual orientation or gender identity 4; and

27 WHEREAS, the following professional organizations affirm that non-heterosexual identities are normal and that efforts to change sexual orientation are harmful and dangerous to youth 5: American Medical Association; American Academy of Pediatrics; American Academy of Child and Adolescent Psychiatry; American Psychiatric Association; American College of Physicians 9; American Psychological Association; National Association of School Psychologists; National Association of Social Workers; American Counseling Association; American School Counselor Association; American Psychoanalytic Association; Pan American Health Organization; and American Association of Sexuality Educators, Counselors and Therapists; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association affirms that individuals who identify as homosexual, 38 bisexual, transgender, or are otherwise not heteronormative (LGBTQ) are not inherently suffering from a mental disorder; and, be it further

RESOLVED, that the OOA strongly opposes the practice of "Conversion Therapy," "Reparative Therapy," or other techniques aimed at changing a person's sexual orientation or gender identity, by licensed medical and mental health professionals; and, be it further

RESOLVED, that the OOA supports potential legislation, regulations, or policies that oppose the practice of "Conversion Therapy," "Reparative Therapy," or other techniques aimed at changing a person's sexual orientation or gender identity, by licensed medical and mental health professionals; and be it further,

RESOLVED, that the OOA submit a copy of this resolution for consideration at the 2017 American Osteopathic Association House of Delegates.

Explanatory Statement:

"Conversion Therapy" continues to be practiced in Ohio by non-licensed religious lay people, clergy, and licensed counselors, social workers, marriage & family therapists, psychologists, psychiatrists, and other physicians. The practices of licensed medical and mental healthcare professionals, who indicate to a parent or patient that being LGBTQ is a disease, disorder, or illness that can be "fixed", fit within the definition of "Conversion Therapy." This highlights the compelling interest Ohio physicians have to ensure the physical and psychological welfare of our patients, including LGBTQ individuals, by protecting them from exposure to the detrimental practices of "Conversion Therapy." *(Original 2017)*

References:

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4. American Mental Health Counselors Association. (2014, July 10). AMHCA Statement on Reparative or Conversion Therapy. Retrieved from http://www.amhca.org/news/226127/

5. American Psychological Association. Just the facts about sexual orientation & youth: a primer for principals, educators, & school personnel: efforts to change sexual orientation through therapy. Retrieved from www.apa.org/pi/lgbt/resources/just-the-facts.aspx

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7. Human Rights Campaign. The Lies and Dangers of "Conversion Therapy". Retrieved from http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

8. Ohio Senate. (2015, February). Prohibit certain health care professionals from engaging in sexual orientation change efforts when treating minor patients (S.B. No. 74). Retrieved from https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-SB-74

9. Daniel, H., Butkus, K. (2015). Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians. Annals of Internal Medicine, 163 (2), 135-137. Retrieved from http://annals.org/article.aspx?articleid=2292051

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11. AOA. (2017, March 13). Lesbian, Gay, Bisexual, Transgender, Queer / Questioning Protection Laws. Retrieved from http://www.osteopathic.org/inside-aoa/about/leadership/aoa-policy-search/Documents/H439-A2016-LGBTQ-%20QUESTIONING-PROTECTION-LAWS.pdf

Relevant AOA and OOA Policies

H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES The American Osteopathic Association (AOA) recognizes the need of same-sex households to have the same access to health insurance and health care as opposite-sex households and supports

measures to eliminate discrimination against same-sex households in health insurance and health care. The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for same-sex marriages and civil unions and the children of those families. 2014

H445-A/15 GENDER IDENTITY NON-DISCRIMINATION The American Osteopathic Association supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity. 2010; reaffirmed 2015

H439-A/16 LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING PROTECTION LAWS The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) individuals from discriminating practices and harassment and reaffirms equal rights and protections for all patient populations as stated in AOA policy H506-A14. 2016 Corresponding OOA Policy (2016): Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws

H647-A/16 EXPANDING GENDER IDENTITY OPTIONS ON PHYSICIAN INTAKE FORMS The American Osteopathic Association (AOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their sex at birth (male, female, intersex) and gender identity (male, female, transgender, additional category). 2016 Corresponding OOA Policy (2016): Expanding Gender Identity Options on Physician Intake Forms to be More Inclusive of LGBTQ Patients

Relevant legislative Efforts in Ohio and Nationwide

Ohio Senate Bill 74 (2016 – likely to be resubmitted this legislative session): To prohibit certain health care professionals from engaging in sexual orientation change efforts when treating minor patients. https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-SB-74

California Legislative Conversion Therapy Ban: Senate Bill 1172: Sexual orientation change efforts. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172

New Jersey Legislative Conversion Therapy Ban: Assembly Bill 3371: AN ACT concerning the protection of minors from attempts to change sexual orientation and supplementing Title 45 of the Revised Statutes. http://www.njleg.state.nj.us/2012/Bills/A3500/3371_I1.HTM

Oregon Conversion Therapy Ban: House Bill 2307: Youth Mental Health Protection Act https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2307/Enrolled

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws (2016)

WHEREAS, title VII prohibits discrimination in the workplace based on sex and guarantees equal employment opportunities; and

WHEREAS, despite this overarching protection of all American people, some Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) rights are not protected at the state level; and

WHEREAS, for example, housing insecure individuals were more likely to report delayed doctors' visits, poor or fair health outcome, and two or more weeks of poor health or mental health limiting daily activity in the past month; and

WHEREAS, in 2011, there was a law that passed in Ohio that prohibits discrimination under state employment in cases of sexual orientation, but not gender orientation; and

WHEREAS, oftentimes, only one parent in a same sex couple is able to claim parental rights and power of attorney, thus the other parent lacks the ability to have the same hospital rights over their own child; and

WHEREAS, there is a law in Ohio that protected same sex couples from being discriminated against adopting a child, however this does not protect these couples from unequal hospital rights; and

WHEREAS, more than 115 anti-LGBTQ bills were introduced in 2015, and 27 states have pending anti-LGBTQ legislation in 2016; and

WHEREAS, due to the aforementioned housing, employment, and hospital rights issues, LGBTQ patients and their families are at a predisposition for adverse health care outcomes; and

WHEREAS, these laws will authorize businesses, individuals, and taxpayer-funded entities to cite religion as a reason to refuse goods or services to the LGBT population as well as allowing adoption and foster care agencies to discriminate against same-sex couples; and

WHEREAS, Ohio has existing pro-equality laws and pending initiatives to combat this anti-LGBTQ legislation; and now therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) individuals from discriminating practices and harassment; and be it further

RESOLVED, that the OOA supports equal rights and protections to all patient populations. *(Original 2016)*

Licensed Practical Nurses (2015)

RESOLVED that the Ohio Osteopathic Association continues to support the training and practice rights of Licensed Practical Nurses. *(Original 1980)*

Licensure Examination for Osteopathic Physicians (2014)

RESOLVED that the Ohio Osteopathic Association continues to support the comprehensive osteopathic medical licensing examination (COMLEX) as the national licensing examination for osteopathic physicians; and be it further

RESOLVED, that the Ohio Osteopathic Association continues to support the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) and the COMLEX-USA Level 2-Preformance Evaluation as the national licensing examinations for osteopathic physicians. *(Original 2004)*

Long-Term Care Facilities (2015)

RESOLVED, that the Ohio Osteopathic Association continues to advocate for government regulations and institutional protocols in long-term care facilities that allow pharmacists to accept verbal orders from nurses acting as agents of attending physicians to ensure patients have timely access to controlled substances *(Original 2005)*

Managed Care (2014)

RESOLVED that the Ohio Osteopathic Association continue to work with the Ohio General Assembly and the Ohio Department of Insurance to identify and eliminate health insuring corporation practices and policies which limit patient access to cost-effective health care and which inappropriately interfere with the physician-patient relationship. *(Original 1994)*

Managed Care, Automatic E/M Down Coding (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) opposes the practice of automatic down-coding by health insuring corporations; and, be it further

RESOLVED, that the OOA continues to consider the practice of automatic down-coding by health insuring corporations inappropriate, misrepresentative and potentially fraudulent; and, be it further

RESOLVED, that the OOA continues to seek policy changes and/or regulatory and legislative mandates to prohibit automatic down coding by health insuring corporations. *(Original 1999)*

Managed Care, On-Line Formulary Directory (2015)

RESOLVED, that the Ohio Osteopathic Association continue to work with the Ohio Coalition of Primary Care Physicians, the Ohio Association of Health Plans and the Ohio Pharmacists Association to develop an online, centralized directory containing up to date formulary information for Health Insuring Corporations in Ohio. *(Original 2000)*

Managed Care Plans, Standardized Reporting Formats for (2017)

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

Managed Care Plans, Quality Improvement and Utilization Review (2017)

RESOLVED that the Ohio Osteopathic Association continue to support licensing provisions that require all managed care organizations (MCOs) doing business in Ohio to be certified by the National Committee on Quality Assurance (NCQA). *(Original 1997)*

Managed Care Plans, Termination Clauses (2014)

RESOLVED, that the Ohio Osteopathic Association continue to work with Ohio provider associations to seek and/or propose legislation mandating due process in health care contract termination clauses. *(Original 1999)*

Mandatory Assignment (2014)

RESOLVED that the Ohio Osteopathic Association strongly supports the right of the physician to directly bill the patient for services when not prohibited by contractual agreements; and be it further;

RESOLVED, that the Ohio Osteopathic Association continues to oppose any legislation that: (a) prohibits private physicians from billing their private patients; (b) mandates physicians to accept assignment of insurance

claims; and (c) requires any third party payer to reimburse the healthcare facility instead of the physician unless authorized by the physician. *(Original 1984)*

Marijuana's Impact on Patients (2014)

WHEREAS, President Barack Obama stated in an interview for New Yorker magazine that he's not convinced pot is "more dangerous than alcohol" (1), but then further clarified his stance on the issue in a subsequent interview with CNN, stating: "I stand by my belief, based, I think, on the scientific evidence, that marijuana, for casual users, individual users, is subject to abuse, just like alcohol is and should be treated as a public health problem and challenge," (4); and

WHEREAS, marijuana, and its psychoactive substance, THC (delta-9-tetrahydrocannabinol) is the most used illegal substance in the world (3); and

WHEREAS, the World Health Organization ranks the United States first among 17 European and North American countries for prevalence of marijuana use (2); and

WHEREAS, more Americans are starting to use marijuana each day and in 2010, an estimated 2.4 million Americans used marijuana for the first time, with greater than one-half under age 18 (2); and

WHEREAS, according to the Monitoring the Future — an annual survey of attitudes and drug use among the nation's middle and high school students, most measures on use in adolescents recently have not declined due to softening views by the population at large on the harmful effects of marijuana (2); and

WHEREAS, the concentration of the THC in marijuana used by the population is much more potent today than in the past (concentrations in the 1960s were 1-5 percent THC, whereas today the average concentration of THC in marijuana is as high as 10-15 percent (3)); and

WHEREAS, the effects of THC use on the body are numerous, including decreases in reaction time and impairment of attention, concentration, short-term memory, and risk assessment and these effects are additive when cannabis is used in conjunction with other central nervous system depressants (3); and

WHEREAS, the physiological effects of marijuana include increased heart rate, which may increase by 20-50 beats per minute or may even double in some cases and taking other drugs with marijuana can amplify this effect, thereby increasing the risk for heart disease in susceptible individuals (2); and

WHEREAS, repeated use of THC over an extended time can lead to harmful effects including recurrent failure to fulfill major role responsibilities, persistent social problems, and legal issues. More severe manifestations of cannabis use disorder are characterized by behavioral and physiologic symptoms: including using larger amounts of cannabis over longer periods of time, unsuccessful efforts to limit use, tolerance to cannabis's effects, and possibly physiologic withdrawal (3). Long term psychological effects may include the development of schizophrenia in susceptible individuals (2); and

WHEREAS, research has shown that some babies born to women who used marijuana during their pregnancies display altered responses to visual stimuli, increased tremulousness, and a high-pitched cry, which could indicate problems with neurological development. In school, marijuana-exposed children are more likely to show gaps in problem-solving skills, memory, and the ability to remain attentive (2); and

WHEREAS, the Drug Abuse Warning Network (DAWN), a system for monitoring the health impact of drugs, estimated that in 2009, marijuana was a contributing factor in more than 376,000 emergency department (ED) visits in the United States (2); now therefore be it

RESOLVED, that the Ohio Osteopathic Association considers marijuana to be a harmful substance for recreational use due to the potentially harmful physiological and psychological effects that it can have on patients, and encourages federal agencies to adapt consistent policies following this same position on recreational use; and be it further

RESOLVED, that a copy of this resolution is sent to the American Osteopathic Association for consideration at its 2014 House of Delegates. *(Original 2014)*

Marijuana Use by Osteopathic Physicians and Students (2014)

WHEREAS, the adverse effects of marijuana use and its active substance THC (delta-9-tetrahydrocannabinol) on the body are numerous, including decreases in reaction time and impairment of attention, concentration, short term memory, as well as potential habit formation when used for longer periods of time (1); and

WHEREAS, in the November 2012 general election, the states of Colorado and Washington legalized the use of

small amounts of marijuana for most adults in each state (2,3); and

WHEREAS, now enacted as Article 18, section 16 of the state constitution, the Colorado law allows for "personal use and regulation of marijuana for adults 21 and over, as well as commercial cultivation, manufacture, and sale, effectively regulating cannabis in a manner similar to alcohol (3)"; and

WHEREAS, the Washington State Code (RCW 69.50.101), defined and legalized "small amounts of marijuana-related products for most adults, taxing them and designating the revenue for health care and substance abuse prevention and education" (2); and

WHEREAS, as noted under Washington State Code (RCW 69.50.101), cannabis is still classified as a schedule 1 controlled substance under federal law and subject to federal prosecution under the doctrine of dual sovereignty. Possession by anyone younger than 21, possession of larger amounts, and the growing of unlicensed or unregulated marijuana remains illegal under state law (2); and

WHEREAS, osteopathic physicians practice in the states of Colorado and Washington; and

WHEREAS, federal law recognizes marijuana as a dangerous drug and prohibits its illegal distribution and sale under the Controlled Substances Act (CSA) and the United States Department of Justice has claimed it will continue to enforce the CSA with help of federal prosecutors (4); now therefore be it

RESOLVED, that the Ohio Osteopathic Association recognizes the dangers of recreational use of marijuana among practicing physicians, osteopathic physicians in training, and osteopathic medical students and encourages the American Osteopathic Association to enact a policy statement against the recreational use of marijuana by practicing osteopathic physicians in response to its legalization in states like Colorado and Washington; and be it further

RESOLVED, that a copy of this resolution is sent to the American Osteopathic Association for consideration at its 2014 House of Delegates. *(Original 2014)*

Medicaid Support of GME Funding (2017)

WHEREAS, "Ohio Medicaid subsidizes hospitals $39,000 on average annually for each graduate medical intern or resident the hospital trains [but].. some hospitals receive as much as $385,000 per resident while others receive nothing at all," according to the Ohio Office of Health Transformation; and

WHEREAS, funding formulas originally established under Ohio Medicaid to support graduate medical education have generally discouraged or penalized hospitals from creating and supporting primary care residency programs that rely on resident training in outpatient settings and physician offices; and

WHEREAS, traditional osteopathic residency programs approved by the American Osteopathic Association received significantly less direct medical education (DME) funding under cost-based formulas because they relied heavily on volunteer clinical faculty in all specialties at the time reimbursement formulas were set; and

WHEREAS, ninety-five percent of the entering class at the Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) in 2016 were from Ohio; and 70 percent of the 2016 OU-HCOM graduates from the fourth year class remained in Ohio for residency programs; and

WHEREAS, OU-HCOM had the highest percentage of any of Ohio's seven medical school for graduates entering primary care residency programs; and

WHEREAS, current national and state health policy emphasizes the importance of primary care physicians in holding down health care costs by preventing disease, maintaining wellness and managing chronic diseases outside of costly acute care settings; and

WHEREAS, there is a critical shortage of medical school graduates entering primary care specialties today that has been exacerbated by low reimbursement for primary care services and high medical student debt at the time of graduation; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) strongly supports legislation to require the Ohio Department of Medicaid to continue to support and fund the costs of graduate medical education in Ohio; and be it further,

RESOLVED, that the OOA supports recommendations contained in the *2015 Graduate Medical Education Study Committee Report to the Ohio General Assembly and the Governor* as "a starting point for future reforms" in the GME funding formula, and be it further,

RESOLVED, that OOA supports increased funding and incentives for primary care residencies in rural and underserved areas and Medicaid reimbursement policies

that encourage physicians to continue to practice and precept medical students in those areas after completion of residency training. *(Original 1997, Substitute Resolution 2017)*

Medical Error Reporting System in Ohio (2015)

WHEREAS, the Ohio Patient Safety Institute (OPSI) is a subsidiary of the Ohio Health Council, which was founded by the Ohio Hospital Association, the Ohio State Medical Association, and the Ohio Osteopathic Association; and

WHEREAS, OPSI was designated by the Agency for Healthcare Research and Quality as a Patient Safety Organization in February 2009, giving it the legal authority to collect medical error data from Ohio hospitals without subjecting individual data to unintended use as evidence in medical malpractice lawsuits; and

WHEREAS, hospital participation with a Patient Safety Organization is voluntary; now, therefore, be it

RESOLVED, that the OOA encourages its members and Ohio hospitals to participate in OPSI programs to improve patient safety for all Ohioans. *(Original 2005)*

Medical Malpractice Tort Changes (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) supports a statutory change in current medical malpractice tort law to require "clear and convincing" evidence of medical malpractice as the standard for the burden of proof required by the plaintiff attorney. *(Original 2004)*

Medical Student Access and use of Electronic Medical Records (EMR) (2014)

WHEREAS, the office of the National Coordinator for Health Information Technology reported 44.4% of acute care hospitals had implemented a basic Electronic Medical Record (EMR) system as of 2012; and

WHEREAS, the Alliance for Clinical Education found that only 64% of medical school programs allowed students to use their EMR and only 67% of these programs permitted students to document and write notes in the record; and

WHEREAS, osteopathic medical schools have a responsibility to graduate students with basic skills in medical practice, which includes meaningful use of electronic medical records; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association partner with Ohio University Heritage College of Osteopathic Medicine to develop policies which permit medical students the opportunity to document and practice order entry on the electronic medical records; and be it further

RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association for consideration at the 2014 AOA House of Delegates. *(Original 2014)*

Medicare Mandatory Assignment (2017)

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

Medicare Services (2013)

RESOLVED that the Ohio Osteopathic Association continue to work with Medicare and all health insuring corporations offering a Medicare product in Ohio to ensure osteopathic input in all policies and appeal mechanisms that deal with osteopathic procedures; and be it further

RESOLVED, that the OOA continue to support the appropriate reimbursement of osteopathic treatment modalities. *(Original 1988)*

Medicare Three-Day Qualifying Policy for Skilled Nursing Facility Care (2016)

WHEREAS, Medicare rules continue to require a three-day (three-night) stay at a hospital in order to qualify for care at a skilled nursing facility (SNF); and

WHEREAS, there are some patients whose medical clearance/care can be achieved in an overnight stay or observation care; and

WHEREAS, a study published in the August 2015 issue of *Health Affairs (vol. 34, no. 8, pages 1324 – 1330)*, comparing Medicare Advantage plans that still have the rule in place with ones that don't, concludes that hospital stays were shorter for patients in plans without the rule and no connection was found to either plan having more hospital admissions or more admissions to SNFS; and

WHEREAS, it is sometimes more cost effective and medically appropriate to provide preventive or proactive care to sub-acute patients who would benefit from skilled nursing care prior to requiring a full hospital admission; now, therefore, be it

RESOLVED, that the OOA continues to advocate for the Centers for Medicare & Medicaid Services and other insurance plans with three-day qualifying rules for skilled nursing facility payments to develop exception guidelines that facilitate care for appropriate patients in a less intense setting, without having to fulfill a three-day hospital stay. *(Original 2011)*

Medication Reconciliation (2013)

RESOLVED, that the Ohio Osteopathic Association encourages the use of medication reconciliation lists containing drug names, dosages, routes, and administration times to help the health care team identify potential drug interactions and avoid medication errors during the exchange of information between all health care settings. *(Original 2008)*

Mopeds, Motorcycles, Non- Motorized Cycles and All- Terrain Vehicles (2014)

RESOLVED that the Ohio Osteopathic Association continues to support legislation to ensure the safe and efficient operation of non-motorized cycles, mopeds, motorcycles, and all-terrain vehicles in the state of Ohio. (*Original 1988)*

Multiple Procedures During Single Patient Sessions (2015)

RESOLVED, that the Ohio Osteopathic Association strongly urges all third party payers in Ohio to provide appropriate and adequate compensatory payment for each distinct medical procedure performed during a single patient session as identified by modifiers as outlined in the current CPT manual. *(Original 2000)*

Non-Formulary Medications (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to work with the Ohio Association of Health Plans, health insuring corporations, the Ohio Osteopathic Hospital Association, the Ohio Hospital Association and state governmental agencies to ensure that patients and physicians have access to non-formulary drugs, when deemed necessary by the physician to improve medical outcomes. *(Original 2000)*

Non-Medical Caregivers, Regulation of and Licensure of Home Health Agencies (2015)

RESOLVED that the Ohio Osteopathic Association support legislation to require background checks for all medical and non-medical workers providing assistance to the elderly and disabled population. *(Original 2005)*

Nursing Facilities, Tiered (2017)

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

Nursing Homes, Staffing (2015)

RESOLVED, that the Ohio Osteopathic Association supports efforts by the State of Ohio to increase the number of training programs for State Tested Nurses Aides (STNAs) to ensure appropriate staffing ratios and quality of care in Ohio's nursing homes. *(Original 2000)*

Obesity Epidemic (2015)

WHEREAS, the Centers for Disease Control and Prevention estimates that obesity costs the United States about $150 billion a year or 10 percent of all U.S. medical costs; and

WHEREAS, according to the Ohio Department of Health (ODH), Ohio ranks as the 12th worst state in terms of obesity, with about 33 percent of Ohio adults overweight and 30 percent obese; and

WHEREAS, the ODH states about 30 percent of Ohio's high-school students are overweight or obese, more than 25 percent of third-grade students are overweight or obese; and more than 28 percent of low-income children ages 2 to 5 are overweight or obese; and

WHEREAS, the Ohio Osteopathic Association (OOA) strongly agrees that Ohio is "experiencing an obesity epidemic that is threatening the health of our children, productivity of our workers, vitality of our communities, affordability of our health care system and overall quality of life," as stated in *Ohio's 2009 Obesity Prevention Plan*; now, therefore be it

RESOLVED, that the OOA supports the State of Ohio's ongoing initiatives to combat the epidemic of adult and childhood obesity across Ohio~~;~~ and, be it further

RESOLVED, that the OOA continues to support legislation, programs, and initiatives that encourages Ohio's schools, parents, and the healthcare community to work together to eliminate childhood obesity by encouraging physical activity and good nutrition standards at home and in the schools; and, be it further

RESOLVED, that the OOA urges its members to educate their patients and communities about the dangers of obesity and support community-based programs that improve nutrition, and increase physical activity. *(Original Resolution 2004).*

Ohio Automated Rx Reporting System (OARRS) (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) strongly supports the Ohio Automated Rx Reporting System (OARRS) as an important tool for identifying patients who may be "doctor shopping" and misusing or abusing controlled substances; and, be it further

RESOLVED, that the OOA continue to work with the Ohio State Board of Pharmacy and the State Medical Board of Ohio to support and improve OARRS; and, be it further

RESOLVED, the OOA strongly supports efforts to integrate OARRS directly into electronic medical records and pharmacy dispensing systems across Ohio to allow instant access for prescribers and pharmacists. (*Original 2011*)

Ohio Bureau of Workers Compensation Health Partnership Program (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to actively participate in ongoing efforts to maintain and improve the Bureau of Workers' Compensation's Health Partnership Program (HPP) as an efficient process for Ohio's injured workers and the osteopathic physicians who provide care for them. *(Original 1997, Substitute Resolution 2011)*

Ohio Chronic Non-Malignant Pain Management (2014)

WHEREAS, prescription drug abuse has reached epidemic proportions in Ohio and throughout the nation; and

WHEREAS, under the leaderships of State Rep. Terry Johnson and State Senator David Burke (a practicing osteopathic physician and pharmacist respectively), the Ohio General Assembly passed legislation (HB 93) to shit down "pill mills" and help stop drug diversion through the licensure of pain clinics, the establishment of take-back programs for unused prescription drugs, the imposition of limits on provider-furnished controlled substances, and the expanded use of the Ohio Automated Reporting System (OARRS) data base; and

WHEREAS, the Governor's Cabinet Opiate Action Team (GCOAT) has simultaneously been coordinating efforts by stakeholders to stop prescription drug abuse through five working groups focused on Treatment, Professional Education, Public Education, Enforcement; and Recovery Supports; and

WHEREAS, the Ohio Osteopathic Association is committed to continuing to work with the Ohio General Assembly, GCOAT, and other stakeholders on a holistic approach to prevent prescription drug abuse deaths and stop the diversion of prescription drugs with negatively impacting chronic pain patients; and

WHEREAS, GCOAT has created a website (www.opiodprescribing.ohio.gov) to provide educational tools and guidelines for prescribing providers, and has established metric to measure the progress that education programs and prescribing guidelines will have on helping to eliminate prescription drug diversion and drug-related deaths; and

WHEREAS, members of the Ohio House Prescription Drug and Healthcare Reform Study Committee led by State Rep. Robert Sprague, and the House Opiate Drug Treatment and Addiction Subcommittee of the Health and Aging Committee, chaired by Rep. Ryan Smith, have introduced a series of well-intentioned bills to further address Ohio's prescription drug abuse epidemic through increased regulations and mandates; and

WHEREAS, some proposed legislation could adversely affect access to pain management with unintended consequences for pain patients; now therefore be it,

RESOLVED, that the OOA urges its members to take the lead in their communities to educate patients about the dangers of prescription drug abuse and to help implement evidence-based, multimodal treatment options and drug abuse programs throughout Ohio; and be it further

RESOLVED, that the OOA continue to work with governmental agencies and the Ohio General Assembly to address Ohio's prescription drug abuse epidemic, and be it further

RESOLVED, that the OOA petition the Ohio General Assembly to establish an on-going task force of stakeholders, public officials and legislators to oversee states chronic pain treatment and prescription drug abuse education and prevention initiatives to ensure that patients have access to effective pain management, addiction screening, treatment, and recovery resources; and be it further

RESOLVED, the OOA urges the Ohio General Assembly to immediately conduct a comprehensive study to determine the impact HB 93 and GCOAT initiatives have had on prescribing practices, continued access to pain management, drug abuse, drug-related deaths, the closure of "pill mills," registration for and use of OARRS data, take-back programs implemented in communities across the state, etc. to better identify what specific deficiencies in existing laws need to be addressed be legislation. *(Original 2014)*

Ohio Insurance Guaranty Association (2013)

RESOLVED, the Ohio Osteopathic Association Continue to advocate for increasing the Ohio Insurance Guaranty Association's claims limits to adequately cover the claims of liquidated medical professional liability insurance companies; and be it further

RESOLVED, that the Ohio Osteopathic Association continue to actively seek financially stable sources of medical liability, in order to protect its member physicians. *(Original 1998)*

Ohio KePRO, Inc. (2014)

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has restructured the Quality Improvement Organization Program for the Eleventh Statement of Work (SOW) by regions rather than individual states; and

WHEREAS, CMS has separated the traditional combined responsibilities of the existing QIOs, such as KEPRO, into two separate contractor responsibilities including (1) Beneficiary and Family Centered Care (BFCC) or (2) Quality Innovation Network – Quality Improvement Organization (QIN-QIO); and

WHEREAS, each QIN-QIO contractor will cover three to six states and bidders can define each proposed region when submitting proposals; and

WHEREAS, BFCC Contractors that can apply for contracts in up to five regions that are specifically defined by CMS; and

WHEREAS, a winning BFCC contractor is prohibited from also being a QIN-QIO contractor at the same time; and

WHEREAS, the Ohio Osteopathic Association (OOA) has been approached by at least four separate potential QIN-QIO contractors to support specific competing proposals for the state of Ohio; and

WHEREAS, it is important for the OOA to be work closely with all CMS contractors in Ohio to ensure that osteopathic physicians are represented in both the BFCC and QIN-QIO initiatives; now therefore be it

RESOLVED, that the Ohio Osteopathic Association pledges to work collaboratively with any contractor that is awarded the Beneficiary and Family Centered Care (BFCC) or Quality Innovation Network – Quality Improvement Organization (QIN-QIO)contract covering the State of Ohio; and be if further;

RESOLVED, the OOA seek osteopathic representation on any state governing board or advisory committee formed by the winning contractor for the State of Ohio for either the BFCC or QIN-QIO work; and be it further;

RESOLVED that the OOA help recruit osteopathic physicians and osteopathic institutions in Ohio to participate in any review work and care innovation initiatives required by the 11th Statement of Work (SOW) which includes any of the following Quality Improvement Aims, each of which has separate Tasks, and technical assistance projects:

AIM: Healthy People, Healthy Communities: Improving the Health Status of Communities
Goal 1: Promote Effective Prevention and Treatment of Chronic Disease
Task B.1: Improving Cardiac Health and Reducing Cardiac Healthcare Disparities
Task B.2: Reducing Disparities in Diabetes Care: Everyone with Diabetes Counts (EDC)
Task B.3: Using Immunization Information Systems to Improve Prevention Coordination
Task B.4: Improving Prevention Coordination through Meaningful Use of HIT and Collaborating with Regional Extension Centers
AIM: Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible, Safe Care
Goal 2: Make Care Safer by Reducing Harm Caused in the Delivery of Care
Task C.1: Reducing Healthcare-Associated Infections
Task C.2: Reducing Healthcare-Acquired Conditions in Nursing Homes
Goal 3: Promote Effective Communication and

Coordination of Care
Task C.3: Coordination of Care
AIM: Better Care at Lower Cost
Goal 4: Make Care More Affordable
Task D.1: Quality Improvement through Physician Value-Based Modifier and the Physician Feedback Reporting Program
Task D.2: QIN-QIO proposed Projects that Advance Efforts for Better Care at Lower Cost
Other Technical Assistance Projects
Task E.1: Quality Improvement Initiatives
(Original 2004)

Ohio Medical Reserve Corps (OMRC) (2012)

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

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

Ohio's Indoor Smoking Ban (2014)

RESOLVED, that the OOA strongly supports Ohio's indoor smoking ban to eliminate the dangers of environmental tobacco smoke (ETS) and opposes any legislation that would generally weaken or make exceptions to the ban. *(Original 2004)*

OOA House of Delegates Code of Leadership *

RESOLVED, that the Ohio Osteopathic Association (OOA) House of Delegates hereby adopts the OOA House of Delegates Code of Leadership. *(*Original 2003: does not require automatic five-year reconsideration)*

OOA Physician Placement Information Service (2016)

RESOLVED, that the Ohio Osteopathic Association encourage physicians to advertise practice opportunity information by utilizing osteopathic publications, OSTEOFACTS; and the OOA website; and be it further

RESOLVED, that the Ohio Osteopathic Association continues to support Medical Opportunities in Ohio (MOO) as a centralized, comprehensive statewide career source for use by osteopathic residents and OOA members seeking employment opportunities; and be it further

RESOLVED, that the OOA encourage Ohio's hospitals and other institutional healthcare employers to become members of MOO. *(Original 1991)*

OOA Professional Liability Insurance (2014)

RESOLVED that the Ohio Osteopathic Association continue to monitor the stability of all medical professional liability carriers doing business in Ohio, encourage nondiscriminatory policies toward osteopathic physicians (DOs) by the companies, provide complete information and referral services on sources available, and encourage members to consider all the pros and cons of each company when selecting a carrier, and to not base their decision on premium amount alone. *(Original 1992)*

OOA Professional Medical Liability Program (2015)

RESOLVED that the Ohio Osteopathic Association (1) maintain a centralized information source for competent expert opinion and advice within our profession; (2) reaffirm lobbying efforts for legislative malpractice reform; and (3) sponsor and promote postgraduate programs on medical/legal aspects of osteopathic practice. *(Original 1985)*

OOA Smoking Policy (2017)

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

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

Ohio State Medical Board, State Funding (2014)

RESOLVED, that the Ohio Osteopathic Association reaffirms its current position that all fees collected by a state licensing board should support that agency only, and be it further

RESOLVED that the Ohio Osteopathic Association opposes any further increase in Ohio medical licensure fees that are not publicly justified and that do not directly support the programmatic needs of the Ohio State Medical Board as endorsed by the Ohio Osteopathic Association Board of Trustees. *(original 1984)*

Osteopathic Anti-Discrimination (2013)

RESOLVED that the Ohio Osteopathic Association continue to seek, whenever necessary, amendments to the Ohio Revised Code and the Ohio Administrative Code, which prohibit discrimination against osteopathic physicians by any entity on the basis of degree, AOA approved training or osteopathic specialty board certification. *(Amended by Substitution in 1998, originally passed in 1993)*

Osteopathic Education, Promoting A Positive and Enthusiastic Approach (2013)

RESOLVED that the Ohio Osteopathic Association (OOA) continue to challenge its physician membership to maintain and promote a positive and enthusiastic outlook about the future of osteopathic medicine; and be it further

RESOLVED that the OOA in conjunction with the Ohio Osteopathic Foundation, the Ohio Osteopathic Hospital Association and the Ohio University College of Osteopathic Medicine urge practicing physicians to serve as enthusiastic and compassionate role models in spite of rapidly evolving changes in the healthcare delivery system which are sometimes demoralizing to practicing physicians; and be it further,

RESOLVED, that the OOA membership and affiliated groups continue to aggressively recruit and help retain bright, energetic, enthusiastic and compassionate young people as osteopathic students. *(Original 1988)*

Osteopathic Identity (2015)

RESOLVED, that the Ohio Osteopathic Association continues to encourage OOA members to take action on a grassroots level to educate and correct those who misuse the initials "MD" when they mean "physician;" and, be it further

RESOLVED, that the OOA post a sample letter and supporting information on the OOA website for members to download, adapt and distribute to correct instances where osteopathic physicians are incorrectly identified as MDs or required to sign forms that have a preprinted "MD." *(Original 2005)*

Osteopathic Medical Student, Resident, and Physician Mental Health (2015)

WHEREAS, in 2014 Rita Rubin, MA in the *Journal of the American Medical Association*, states that in "each year in the United States, 300 to 400 physicians take their own lives—roughly equal to the number of students in three medical school graduating classes"; and

WHEREAS, According to the American Foundation of Suicide Prevention, male physicians have a 70 percent higher suicide rate than males in other professions; and

WHEREAS, female physicians die by suicide at a 400 percent higher rate than females in other professions; and

WHEREAS, even if students, residents, and physicians realize they need help, they are reluctant to get help because of the stigma surrounding mental illness and a fear of inadequacy as a physician; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) shall promote mental health awareness and provide medical students, residents, and physicians with educational information on recognizing mental health issues among themselves and their colleagues; and, be it further

RESOLVED, that the OOA shall work to reduce the stigma associated with mental illness to reduce the barrier to treatment while advocating for increasing the resources for care; and, be it further

RESOLVED, that the OOA advocates to the American Osteopathic Association and American Association of Colleges of Osteopathic Medicine to increase resources for students, residents, and physicians to identify mental health issues in themselves and their colleagues. *(Original 2015)*

Osteopathic Pledge of Commitment (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) hereby enthusiastically adopts the Osteopathic Pledge of Commitment and resolves to recite the pledge at appropriate OOA-sponsored ceremonies, events and formal business meetings; and be it further,

RESOLVED, that the OOA print the Osteopathic Pledge of Commitment in various publications and post a copy of the pledge on the OOA website; and be it further,

RESOLVED, that the OOA encourages all OOA District Academies and affiliated groups to also adopt the Osteopathic Pledge of Commitment and similarly promote its use at district meetings and functions. (Originally adopted 2003)

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

Provide compassionate, quality care to my patients; Partner with them to promote health; Display integrity and professionalism throughout my career; Advance the philosophy, practice and science of osteopathic medicine; Continue life-long learning; Support my profession with loyalty in action, word and deed; and Live each day as an example of what an osteopathic physician should be. (Adopted 2003)

Osteopathic Practice and Principles Through the Continuum of Osteopathic Education (2017)

RESOLVED that the Ohio Osteopathic Association (OOA) continues to support the development of training in osteopathic principles and practice throughout the entire continuum of osteopathic education; and be it further

RESOLVED that OOA and its members promote and encourage all graduate medical education training programs in the State of Ohio to seek osteopathic recognition as outlined by the Accreditation Council for Graduate Medical Education (ACGME); and be it further

RESOLVED that the OOA continue to monitor the progress of the transition to the ACGME Single Accreditation System. *(Original 1997, amended and affirmed 2002, reaffirmed 2007, amended and affirmed 2017)*

Osteopathic Unity (2014)

RESOLVED that the Ohio Osteopathic Association continue efforts directed to all persons bearing the degree D.O. to recognize the need for unity and the importance of belonging to national, state, and district osteopathic associations and their affiliated societies. (*Original 1979)*

Pain Management Education (2016)

WHEREAS, the Ohio Osteopathic Association has been a leader in Ohio initiatives to improve patient access to safe and appropriate treatment of pain for more than a decade; and

WHEREAS, the OOA has been participating as an active member of the Governor's Cabinet Opioid Action Team (GCOAT) since 2010 to address an alarming prescription drug abuse epidemic in Ohio; and

WHEREAS, GCOAT has issued three sets of guidelines for safely prescribing opioids for emergency department patients, chronic pain patients, and patients with acute pain in outpatient settings; and

WHEREAS, education on addiction and prevention of diversion and drug abuse can help the physician to manage patients experiencing pain with non-opioid treatment options whenever possible and limiting the amount of opioids prescribed when appropriate; and

WHEREAS, the OOA and the American Osteopathic Association have joined 40 other provider groups in working with the White House Opioid Working Group to have more than 540,000 health care providers complete opioid prescriber training in the next two years; double the number of physicians certified to prescribe buprenorphine for opioid use disorder treatment, from 30,000 to 60,000 over the next three years; double the number of providers that prescribe naloxone to reverse an opioid overdose; double the number of health care providers registered with their state prescription drug monitoring programs in the next two years; and, reach more than four million health care providers with awareness messaging on opioid abuse, appropriate prescribing practices, and actions providers can take to be a part of the solution in the next two years; now therefore, be it

RESOLVED, that the Ohio Osteopathic Association continue to work with the Governor's Cabinet Opioid Action Team (GCOAT) and the White House Opioid Working Group to educate practicing DOs, residents and osteopathic students on the use of neuromusculoskeletal medicine in pain management, addiction prevention and intervention, buprenorphine treatment, naloxone prescribing and how to educate patients to safely store and dispose of excess medications to prevent drug diversion in Ohio. *(Original 2011)*

Patient Medical Care Expense Control (2013)

RESOLVED, that the Ohio Osteopathic Association encourages and supports the development of a Centers for Medicare & Medicaid Services (CMS) website designed to provide simple, straight-forward, and user-friendly public access to the Medicare reimbursement schedule for all medical services in all US geographical market segments. *(Original 2008)*

Physician Choice to Participate in Health Plans (2013)

WHEREAS, the Affordable Care Act of 2010 helps create a private health insurance market through the creation of Affordable Insurance Exchanges with state-based marketplaces, which will launch in 2014, providing an estimated 36 million newly-insured Americans and small businesses with a place to find a suitable insurance plan; and

WHEREAS, osteopathic medical practices may decide to accept a variety of insurance plans while others may not find it financially acceptable to do so based on location of practice, reimbursement rates, number of patients in an individual plan, or other factors; and

WHEREAS, the Ohio Osteopathic Association, in recognizing the autonomy of the practicing osteopathic physician, respects the choice of a physician on whether or not to participate in each individual insurance plan, including government insurance; and

WHEREAS, the American Osteopathic Association, in its H215-A/06 policy statement opposes any legislation that requires mandatory participation of physicians in Medicare or Medicaid programs as a basis for licensure; now therefore be it

RESOLVED, that the Ohio Osteopathic Association reaffirms and expands the H215-A/06 policy statement to oppose any legislation that requires mandatory participation of physicians in ANY insurance plan, including Medicare, Medicaid, private insurance plans or any plan derived under the Affordable Care Act's state-based insurance exchanges as a basis for licensure; and therefore be it further

RESOLVED, that upon successful passage a copy of the resolution be sent to the AOA for consideration at its annual House of Delegates meeting in July. *(Original 2013)*

Physicians Exclusive Right to Practice Medicine (2017)

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

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

Physician Fines by Third Party Payors (2017)

RESOLVED, that the Ohio Osteopathic Association opposes all punitive fines levied on physicians for acts committed by patients that are not under the absolute control of the physician. *(Original 2007)*

Physician-Patient Relationships (2017)

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

Physician Placement in Rural Areas (2017)

RESOLVED that the Ohio Osteopathic Association work closely with the Ohio University Heritage College of Osteopathic Medicine, the Ohio Association of Community Health Centers, and the Ohio Department of Health to encourage the placement of osteopathic physicians in rural and underserved areas in Ohio; and be it further

RESOLVED that the OOA support the establishment of physician practices in rural areas by identifying appropriate sources of information and financial assistance. *(Originally passed, 1992)*

Physician-Scientist Residency Training, Expansion of (2015)

WHEREAS, the state of Ohio has only four research-residency programs, all of which are allopathic; and

WHEREAS, the American Osteopathic Association/American Council on Graduate Medical Education single accreditation imposes more stringent expectations with regards to research or scholarly work; and

WHEREAS, physician-scientists are unique in that they balance both research and clinical skills throughout their career; and

WHEREAS, osteopathic medical schools and the medical community at large have recognized the need for an increase in research at osteopathic schools since, of the $11 billion given to medical schools by the National Institute of Health only 1.2 percent went to osteopathic institutions; and

WHEREAS, physician-scientists are expected to achieve and maintain adequate research skills while also satisfying clinical milestones in traditional residencies, and

WHEREAS, inefficient allocation of resources and time during this critical career development phase discourages osteopathic scholarly research; and

WHEREAS, lack of faculty mentors has been defined as a major barrier to conducting research in non-university residencies, however, this does not seem to limit the programs' ability to conduct scholarly work; now, therefore, be it

RESOLVED, the Ohio Osteopathic Association (OOA) explore funding options for osteopathic physician-scientist training programs in both university and non-university training sites; and, be it further

RESOLVED, that a copy of this resolution be sent to the Centers for Osteopathic Research and Education (CORE), Osteopathic Heritage Foundations, Brentwood Foundation, OhioHealth, Cleveland Clinic and other potential partners for consideration in Ohio. *(Original 2015)*

Photo IDs for Scheduled Drug Prescriptions (2016)

RESOLVED, that the Ohio Osteopathic Association encourages pharmacists through the Ohio Pharmacists Association, to request photo IDs from individuals who present a prescription or pick up the prescribed medication when the pharmacist has concerns about the identity of that individual. *(Original 2006)*

Postponing ICD 10 (2014)

WHEREAS, the year 2014 has posed many challenges to the practice of osteopathic medicine due the efforts in implementation of the Affordable Care Act, implementation of electronic health records and achieving Meaningful Use, implementation of the Patient Centered Medical Home, and more recently, achieving population-health initiatives; and

WHEREAS, such bold undertakings have required significant investments of time and resources for practicing physicians in purchasing equipment, investing in software and EMR systems, training staff, hiring additional staff, decreasing patient visits, establishing newer work flows, and researching/updating forms and records; and

WHEREAS, the Centers for Medicare & Medicaid Services (CMS) mandated that on October 1, 2014, the International Classification of Disease version 9 (ICD-9) code sets used to report medical diagnoses and inpatient procedures will be replaced by International Classification of Disease version 10 (ICD-10) code sets (1); and

WHEREAS, ICD-10-CM is intended for use in all US health care settings (1); and

WHEREAS physicians and providers have been recommended by CMS to take *additional* actions to implement ICD-10, including developing new business plans, ensuring that leadership and staff understand the extent of the effort ICD-10 transition requires, as well as securing budgets that account for: software upgrades/software license costs, hardware procurement, staff training costs, work flow changes during and after implementation, and contingency planning. In addition, CMS recommends providers talk with payers, billing staff, IT staff, and vendors to confirm their readiness status. Providers are also to coordinate ICD-10 transition plans among partners and evaluate contracts with payers and vendors for policy revisions, test timelines, and evaluate overall cost related to the ICD-10 transition (1); and

WHEREAS, the Workgroup for Electronic Data Interchange (WEDI) conducted a survey of providers, vendors and health plans in December 2013 which indicated that significant disruption from a lack of ICD-

10 preparedness could result unless progress occurs very quickly and also found: Only 25 percent of vendors surveyed say they are ready for ICD-10, and one-fifth of the vendors indicate they are halfway or less than halfway complete with product development.
About 40 percent of health plans have not yet completed an impact assessment regarding ICD-10. The majority of providers said they will not complete impact assessments, business changes or external testing until well into 2014. Only about 50 percent of providers will begin external testing in the first half of 2014; and

WHEREAS, it has been reported in another recent survey that although 76 percent of health care providers had completed an ICD-10 impact assessment, only about half of respondents had not determined what effect it will have on their revenue cycles and cash flow (3); and

WHEREAS, the mandated implementation of the ICD-10 code set will be dramatically more expensive for most physician practices than previously estimated, according to a 2014 cost study conducted by Nachimson Advisors (4); and

WHEREAS, according to the study, costs for a small physician practice could be more than $225,000, while a typical large physician practice could expect to spend as much as $8 million on implementation; and

WHEREAS, this cost study shows the estimates include much higher figures due in part to significant post-implementation costs, including the need for testing and the potential risk of payment disruption; and

WHEREAS, CMS has estimated that claims denial rates could increase 100-200 percent in the early stages of coding with ICD-10; and

WHEREAS, ICD-10 has potential to have catastrophic disruption to practices; now therefore be it

RESOLVED, that the Ohio Osteopathic Association supports postponing transition to the International Classification of Disease, version 10 (ICD-10) code set for the reporting of medical diagnoses and inpatient procedures as set on October 1, 2014, by the Centers of Medicare & Medicaid Services (CMS), to allow providers more time to adapt new policies for implementation and prevent disruption of services and payments; and be it further

RESOLVED, that a copy of this resolution is sent to the American Osteopathic Association 2014 House of Delegates instructing them to issue a letter to US Health and Human Services Secretary Kathleen Sebelius to reconsider the mandated adoption of the ICD-10 code set by October 2014. *(Original 2014)*

Pre-Authorized Medical Surgical Services, Denial of Payment (2017)

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

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

Prescriptions, Generic Substitution (2014)

RESOLVED that the Ohio Osteopathic Association opposes any mandatory generic substitution programs in Ohio that remove control of the patient's treatment program from the physician; and be it further

RESOLVED that the Ohio Osteopathic Association encourages its members to continue to prescribe the drug products that are the most efficacious and cost effective for their patients. *(Original 1977*)

Photo IDs for Scheduled Drug Prescriptions (2016)

RESOLVED, that the Ohio Osteopathic Association encourages pharmacists through the Ohio Pharmacists Association, to request photo IDs from individuals who present a prescription or pick up the prescribed medication when the pharmacist has concerns about the identity of that individual. (Original 2006)

Physician Signatures, Reduction of Unnecessary (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to study the issue of physician signature burden, identify areas of potentially unnecessary signature requirements, and seek a reduction in same with the appropriate agencies and institutions doing business in the State of Ohio. *(Original 2001, amended and reaffirmed 2006)*

Pre-Authorized Medical Surgical Services, Denial of Payment (2017)

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

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

Prescriptions, Generic Substitution (2014)

RESOLVED that the Ohio Osteopathic Association opposes any mandatory generic substitution programs in Ohio that remove control of the patient's treatment program from the physician; and be it further

RESOLVED that the Ohio Osteopathic Association encourages its members to continue to prescribe the drug products that are the most efficacious and cost effective for their patients. *(Original 1977*)

Prescription Safety and Drug Diversion Tactics (2016)

RESOLVED that the Ohio Osteopathic Association (OOA) encourage colleges of osteopathic medicine to educate students about common diversionary tactics; and be it further,

RESOLVED, that the OOA periodically publish information and/or provide continuing medical education on best practices to eliminate medication errors and prevent drug diversion in physician practices. *(Original 2006)*

Preventive Health Services (2017)

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

Primary Care and Osteopathic Manipulative Medicine Research, Increased OOA Promotion of (2017)

WHEREAS, in 2016 of the approximately $12 billion given to medical schools by the NIH, only about $23 million (.19%) was granted to colleges of osteopathic medicine[1]; and

WHEREAS, 94% of allopathic medical schools received some type of NIH funding as compared to just 33.3% of osteopathic medical schools[1]; and

WHEREAS, "Schools of Osteopathic Medicine" ranked last among the 10 different types of educational institutions receiving NIH funding, in the fiscal year of 2016[1]; and

WHEREAS, in the 5-year period from 2006 to 2010, 28 colleges of osteopathic medicine combined to produce only 1843 publications[2] which is fewer than 15 publications per year per school, and more than a quarter of these publications had never been cited[3]; and

WHEREAS, a survey of the 2015-2016 osteopathic medical school graduates, reported that only 2% of their time during their clerkship years was devoted to research endeavors, and 47% of the students felt that an inadequate amount of time was devoted to learning research techniques[4]; and

WHEREAS, of the $12 billion awarded to medical schools only $370 million (3.08%) was dedicated to Family Medicine and Public Health & Preventative Medicine[5]; and

WHEREAS, from FY2006 until FY2012, only 2.64% (180 of 6809) of active research contracts and grants at osteopathic medical schools had a subject of "OMT/OPP + Other"[6]; and

WHEREAS, "the mission statements of a majority of colleges of osteopathic medicine (COMs) mention the goal of producing primary care physicians"[7]; and

WHEREAS, primary care research may be a niche for COMs to increase research activity and engagement due to their emphasis on a primary care focused education and location in underserved arease[7,8]; and

WHEREAS, creating research partnerships between COMs and primary care departments such as pediatricians, internal medicine, and family medicine is mutually beneficial for both advances in patient care and osteopathic research[8,9]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) promote the furthering of both primary care and osteopathic manipulative research and publications from within the colleges and schools of osteopathic medicine. *(Original 2017)*

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Professional Liability: Attorney Fees Limit for Medical Injury Awards (2014)

RESOLVED, that as advocates for Ohioans injured in the course of receiving medical care, the Ohio Osteopathic Association supports statutory changes that limit plaintiff attorney fees, thus providing a larger percentage of the damage award to the injured person. *(Original 2004)*

Professional Liability Insurance Company Ratings (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) urges Ohio hospitals to use flexible criteria to rate the adequacy of medical professional liability insurance (PLI) companies for medical staff insurance coverage. *(Original 2004)*

Professional Liability Insurance, Legislation and Tort Reform (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) work with members and staff of the Ohio General Assembly to study and develop all appropriate legislative means to improve the professional liability system in Ohio, including:

1. Pilot projects involving alternate dispute resolution procedures,
2. Limits on general damages such as pain and suffering and loss of consortium,
3. Adoption of a four-year statute of repose;
4. Jury consideration of collateral source payments when making awards,
5. Limitations on attorney contingency fees; and
6. Periodic payments of jury awards; and be if further

RESOLVED, that the OOA continue to work with Ohio Department of Insurance, hospitals and health profession groups to improve the professional liability market in
Ohio; and be it further,

RESOLVED, that the OOA keep its membership informed of all alternatives and proposals under study. *(Original 1975)*

Prompt Pay Statues (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to investigate and assist physicians in resolving problems associated with statutory prompt pay requirements in Ohio; and be it further,

RESOLVED, that the OOA encourages its members to file documented prompt pay complaints with the Ohio Department of Insurance (ODI) by completing a health insurance complaint form, which can be downloaded from the ODI website; and be it further;

RESOLVED, that the OOA supports revisions in the prompt pay statute to close any loopholes which allow licensed health insurance companies or government agencies to circumvent current prompt pay provisions of the Ohio Revised Code. *(Original 2000)*

Protection of the Doctor-Patient Relationship as Related to Proposed Gun Control Laws (2013)

WHEREAS, the tragic December 14, 2012, shootings at Sandy Hook Elementary School in Newtown, Connecticut, have initiated national discussion

regarding measures to reduce gun-related violence in the United States by the President, Congress, the media, state lawmakers, as well as health care professionals; and

WHEREAS, in 1974, the Supreme Court of California ruled on the Tarasoff case which held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient; and

WHEREAS, the Tarasoff case has been the adapted practice by many states and is generally already followed by many medical entities across the country; and

WHEREAS, any measures regarding the reporting of information about patients and gun ownership or use of guns must always be balanced with the inviolable trust established in the patient-doctor relationship as pledged by the Osteopathic Oath, and Oath of Hippocrates as well as federal law, specifically HIPAA; and

WHEREAS, the American Osteopathic Association, in its policy statement H301-A/05 states that in all matters of health care, the physician-patient relationship must be protected; now therefore, be it

RESOLVED that while the Ohio Osteopathic Association (OOA) supports measures that save the community at large from gun violence, the OOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns *except* in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the patient-doctor relationship; and be it further

RESOLVED that upon successful passage of this resolution, a copy be sent to the American Osteopathic Association for consideration at its annual House of Delegates meeting in July.

Quality Health Care, the role of Medical Staffs and Hospital Governing Bodies (2017)

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

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

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

Quality of Life Decisions (2017)

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

Reaffirmation of The DO Degree (2013)

RESOLVED, that the Ohio Osteopathic Association enthusiastically embraces the heritage and philosophy of Dr. Andrew Taylor Still by reaffirming the DO, Doctor of Osteopathic Medicine, degree as the recognized degree designation for all graduates of colleges of osteopathic medicine accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA). *(Original 2008)*

Reimbursement Formulas for Government Sponsored Healthcare Programs (2017)

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

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

Safe Prescriptions and Drug Diversion Tactics (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages colleges of osteopathic medicine to educate students about common diversionary tactics used to obtain scheduled drugs; and, be it further

RESOLVED, that the OOA periodically publish information and/or provide continuing medical education on best practices in order to reduce medication errors and prevent drug diversion in physician practices. (Original 2006)

School Bus Safety Devices (2017)

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

School Health Policies and Childhood Obesity (2016)

RESOLVED, that the Ohio Osteopathic Association (OOA) supports programs that advocate physical fitness in private and public schools for Ohio's youths; and be it further

RESOLVED, that the OOA support healthier food and drinks in public and private schools; and be it further

RESOLVED, that the Ohio Osteopathic Association continues to encourage its physician members to educate and caution their patients, school superintendents, and members of school boards across Ohio about the health consequences of consuming carbonated soft drinks and urge them to eliminate the sale of these products on school property; and be it further

RESOLVED, that the Ohio Osteopathic Association continue to support school health initiatives and campaigns to prevent childhood obesity. *(Two separate policy statements* Obesity in Children *and* Carbonated Soft Drinks in Schools *were combined; original resolutions 2001)*

School Multiple Allergen Exposure Emergency Plan (2017)

RESOLVED, that the Ohio Osteopathic Association urges all school districts in Ohio to adopt comprehensive allergen exposure emergency plans to protect students from food allergies and environmental allergies such as bee stings, mold, dust, and fragrances; and be if further

RESOLVED, that the OOA commends State Reps. Terry Johnson, DO and Mike Duffey for sponsoring House Bill 296 in 2014 which changed Ohio law to allow schools to maintain stocks of epi-pens to use on any student suspected of having an allergic reaction (anaphylaxis); and be it further,

RESOLVED, that the OOA encourages its members to assist school districts in developing these plans and help educate parents and school employees on how to use epi-pens in emergency situations according to requirements outlined in Section 3313.7110 of the Ohio Revised Code; and be it further

RESOLVED, that the OOA advocates a holistic approach with respect to childhood nutrition and wellness without mandates that force potentially food allergic children to purchase school lunches. *(Original 2007)*

Silent Preferred Provider Organizations (2015)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to oppose "Silent Preferred Provider Organizations (PPOs)," that give undisclosed patients access to discounted rates without the physician's legal authorization, when health insuring corporations (HICs) buy or sell physician contracts with discounted fees schedules to other HICs and self insured employer health plans; and, be it, further

RESOLVED, that the OOA disclose the names of HICs which appear to breach provider contracts to the Ohio Department of Insurance and OOA members, and, be it, further,

RESOLVED, that the OOA continue to advocate for prohibitions against such practices at the state and national levels *(Original 2000)*

SNF, Providing Exceptions for the Medicare Three-Day Qualifying Policy for (2016)

WHEREAS, the current Medicare guidelines require a 3 day (3-night) stay at a hospital in order to qualify for care at a skilled nursing facility; and

WHEREAS, there are some patients whose medical clearance/care can be achieved in an overnight stay or observation care; and

WHEREAS, there is an incredible amount of wasted resources and increased healthcare cost as delineated by the current criteria; and

WHEREAS, advances in medicine and better overall healthcare has reduced this need; and

WHEREAS, it is more prudent to participate in preventative or proactive care (such as with sub-acute patients that could benefit from skilled nursing care prior to requiring a full admission); now, therefore, be it

RESOLVED, that the OOA petition the Centers for Medicare & Medicaid Services and insurance agencies with similar rules to develop exception guidelines to these rules that will facilitate care to be given to

appropriate patients in a less intense setting, without having to fulfill the three-day rule; and, be it further

RESOLVED, that the OOA forward this resolution to the AOA House of Delegates for its consideration. *(Original 2011)*

Social Media Guidelines (2013)

WHEREAS, a 2012 survey shows that about one in four physicians use social media daily or multiple times a day to scan or explore medical information, and 14 percent use social media each day to contribute new information; and

WHEREAS, social media use offers valuable and real-time health information to help guide patients and consumers; and

WHEREAS, social media allows health care consumers the ability to tap into health experts that they can trust; and

WHEREAS, social media establishes a relationship with the community; and

WHEREAS, with the growing benefits of social media in medicine, there are some unclear dangers of social media use in our profession; and
WHEREAS, other professional organizations currently have professionalism in the use of social media policies, therefore be it

RESOLVED, that the OOA encourages the AOA to explore and define a "Professionalism in Social Media" policy; and, be it further

RESOLVED, that the OOA supports the use of appropriate social media by osteopathic physicians as a method to promote our profession and practices; and, be it further

RESOLVED, that a copy of this resolution be submitted to the 2013 AOA House of Delegates for national consideration. *(Original 2013)*

Step Therapy and Fail First Medication Policies (2017)

WHEREAS, insurance companies are increasingly implementing "Step Therapy" or "Fail First" policies that are designed to control costs through price-negotiated drug formularies but that sometimes block patients' access to medications and risk delay of effective treatment; and

WHEREAS, these policies require patients to take other potentially ineffective medications first and fail on these medications before insurers will pay for the physician's original prescriptions; and

WHEREAS, there is little oversight and few regulations to ensure that step therapy procedures are evidence-based, consistent and protect patient safety and timely access to the medications they need; and

WHEREAS, eleven states (CA, CT, IL, IN, KY, LA, MD, MO, MS, WA, WV) have now enacted laws to reform the Step Therapy or Fail First procedures in those states; and

WHEREAS, SB 56 (Lehner, Tavares) and HB 72 (Johnson, Antonio) have been recently introduced in the Ohio General Assembly to reform Step Therapy procedures used by third party payors in Ohio; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association supports legislation to reform Step Therapy (Fail First) procedures used by third party payers in Ohio to:

1. Require that an insurer's process for requesting a step therapy override is transparent and readily available to the provider and patient;
2. Allow automatic exceptions to step therapy requirements when (a) the required prescription is contraindicated or will likely cause an adverse reaction; (b) the required prescription drug is expected to be ineffective; (c) the patient has previously tried the required drug or a drug in the same pharmacologic class and the drug was ineffective or caused an adverse event; (d) the required prescription drug is not in the best interests of the patient based on medical appropriateness; and/or (e) the patient is already stable on a prescription drug for the medical condition under consideration; and

3. Ensure that step therapy programs are based on clinical guidelines developed by independent experts. *(Original 2017)*

Strategic Vision for Osteopathic Medicine in Ohio (2017)

WHEREAS, in, January 2016, the Ohio Osteopathic Association (OOA), in cooperation with the Osteopathic Heritage Foundations, Ohio University Heritage College of Osteopathic Medicine, and Centers for Osteopathic Research and Education, launched a major planning initiative to set the future direction for the association

and for osteopathic medicine in Ohio, facilitated by Cavanaugh, Hagan, Pierson, & Mintz, a consulting firm based in Washington, DC; and

WHEREAS, the process began with interviews with ten key thought leaders, conducted in February 2016, to identify major issues, opportunities and challenges facing osteopathic medicine and osteopathic medical education; and

WHEREAS, the interview process was followed by an online survey that provided an opportunity for input from a broad cross-section of the osteopathic medical community in Ohio, including osteopathic physicians (OOA members and non-members), medical educators, residents, students and hospital executives, with almost 400 respondents participating; and

WHEREAS, to obtain more qualitative feedback on the opportunities and challenges facing osteopathic medicine in Ohio, and the OOA's role in responding to these issues, a series of focus groups were conducted with OOA board members, osteopathic medical students and representatives of the graduate medical education community during the 2016 Ohio Osteopathic Symposium in Columbus; and

WHEREAS, the information collected from interviews, survey and focus groups was used to frame and inform the planning discussions at the May 2016 OOA Strategy Summit; and

WHEREAS, in October 2016, the OOA Board of Trustees reviewed the Report from the Ohio Osteopathic Strategy Summit and supporting documents and approved a new vision, mission statement, and set of goals for the Ohio Osteopathic Association; now, therefore, be it

RESOLVED, that the 2017 Ohio Osteopathic House of Delegates, hereby accepts the report of the Ohio Osteopathic Strategy Summit and adopts the following vision, mission and goals for the Ohio Osteopathic Association:

VISION: Improved health for the people of Ohio by delivering on the promise of osteopathic medicine.

MISSION: Support Ohio's osteopathic physicians in delivering principle centered medicine and achieving the quadruple aim through the practice off osteopathic medicine.

GOALS

1. Provide high quality and convenient continuing medical education programs that support physicians in achieving the quadruple aim: better outcomes, lower cost, improved patient experience and improved physician experience and well-being.
2. Advocate on behalf of the osteopathic profession to create the enabling environment to improve the health of the people of Ohio and achieve the quadruple aim (e.g. policy, regulation, funding representation in the American Osteopathic Association);

3. Serve as the unifying platform for osteopathic medicine in Ohio supporting cross-site connections and learning, linking policy, practice and education, and promoting osteopathic identify. *(Original 2017, replacing the previous plan and goals)*

Student Involvement in the Ohio Osteopathic Association, Increasing (2017)

WHEREAS, as the first state osteopathic association in the nation to add a voting student representative to its Board of Trustees and to seat a student delegate in its House of Delegates, the Ohio Osteopathic Association (OOA) has a long history of supporting student involvement in the osteopathic profession1; and

WHEREAS, to encourage participation in the OOA during medical school and after, the OOA provides all students enrolled in the Ohio University Heritage College of Osteopathic Medicine (OUHCOM) dues-free membership in the OOA; and

WHEREAS, with the recent openings of the Dublin and Cleveland campuses of OUHCOM, by 2018 there will be more than 900 students enrolled at OUHCOM during a given school year, representing an increase of over 70 percent since 2014; and

WHEREAS, student representation in the OOA House of Delegates has not been restructured to take into account the large increase in the number of student members in the OOA; and

WHEREAS, increasing participation by students in the OOA likely will lead to increased participation in the OOA when the students become physicians, thereby strengthening the OOA's future outlook; now, therefore be it

RESOLVED, that Article V, Section 1 (B) of the Ohio Osteopathic Association (OOA) Constitution be amended to read, "The Ohio University Heritage College of Osteopathic Medicine shall be entitled to two

delegates and four alternate delegates to the OOA House of Delegates. Three shall be from years one and two, one from each campus with one voting delegate. The other three will be from years three and four with one voting delegate. They will not diminish the toal seated delegates from any district and will be seated together; and, be it further

RESOLVED, that the OOA shall establish a task force on student involvement that will meet periodically to examine the current structure, processes, and activities of the OOA with the goal of determining additional modes for student involvement in the OOA. *(Original 2017)*

References

Ohio Osteopathic Association student membership website. Accessed on March 18, 2017 at http://www.ooanet.org/aws/OOSA/pt/sp/students.

Student Loans, Interest Deductions (2014)

RESOLVED, that the Ohio Osteopathic Association continues to support state and federal legislation that would make student loan interest payments tax deductible. *(Original 1989)*

Substance Abuse Insurance Coverage (2014)

RESOLVED, that the Ohio Osteopathic Association supports mandated offering of coverage for in- hospital and ambulatory treatment of substance abuse as part of all health benefits plans or policies offered in Ohio. *(Original 1977)*

Substance Abuse, Position Statement (2014)

RESOLVED, that the Ohio Osteopathic Association pledges its full support in cooperating with the pharmaceutical industry, law enforcement officials, and government agencies to stop prescription drug abuse that is a threat to the health and well-being of the American public; and be it further

RESOLVED, that the Ohio Osteopathic Association reaffirm its position that members should prescribe controlled substances in compliance with state and federal laws and regulations; and be it further,

RESOLVED, that the Ohio Osteopathic Association support the crusade to reduce substance abuse by advocating intelligent enforcement of existing state and federal laws which govern handling of all dangerous substances; and be it further,

RESOLVED, that the Ohio Osteopathic Association pledge its full support of existing and future programs which promote proper use of prescription drugs and other substances among young and old alike in an effort to reduce or eliminate substance abuse. *(Original 1972)*

Suicide Prevention and Screening (2013)

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to encourage and promote the professional use of suicide prevention screening programs like the "Columbia Teen Screen," "American Foundation for Suicide Prevention College Screening Project" and the "College Response"; and, be it further,

RESOLVED, that the OOA work closely with the Advocates for the Ohio Osteopathic Association to promote these screening programs along with the Yellow Ribbon Suicide Prevention Program to Ohio's schools, colleges and universities; and be it further

RESOLVED, that the OOA encourages AOA Category 1-A continuing medical education programs to include education about suicide prevention and screening. *(Original 2008)*

Tanning Facilities (2015)

WHEREAS, the hazardous effects of ultraviolet radiation include skin cancer formation, premature aging of the skin, cataract formation, impairment of the immune system, photosensitizing reaction with various drugs, initiation and/or aggravation of certain systemic diseases; and

WHEREAS, tanning parlor rays penetrate deeper and do more harm than natural sunlight; and

WHEREAS, people receive 80 percent of their dangerous lifetime exposure to ultraviolet radiation (tanning rays) before the age of 20 and numerous studies have established that skin cancer is closely associated with excessive ultraviolet (UV) light exposure before the age of 18; and

WHEREAS, State Reps. Tery Johnson, DO and Mike Stinziano introduced HB 131 in the 130th Ohio General Assembly to address the danger of exposure to UV rays in tanning parlors, particularly for children under the age of 18; and

WHEREAS, HB 131, effective June 23, 2015, was signed into law by Governor Kasich and establishes consent requirements, which vary depending on the age of the individual and must be satisfied before a tanning

facility operator or employee may allow an individual to use sun lamp tanning services; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) commends Reps. Johnson and Stinziano for sponsoring HB 131, and be it further,

RESOLVED, that the OOA urges its members to continue to educate their patients about the harmful effects of UV light and the correlation between the use of indoor tanning equipment and the incidence of skin cancer. *(Original 2010)*

Taser Safety (In memory of Kevin Piskura) (2013)

RESOLVED, the Ohio Osteopathic Association (OOA) encourages state and federal agencies to develop guidelines for post-taser immediate emergency care to be included in taser certification and annual recertification for all law enforcement professionals who might use a taser. *(Original 2008)*

Telemedicine (2017)

RESOLVED, that the Ohio Osteopathic Association continues to support affordable and uniform medical licensure requirements to enable physicians to practice medicine and surgery by utilizing telemedicine technologies: and be it further

RESOLVED that the OOA work with the Ohio State Medical Board and other Ohio physician organizations to develop rules that encourage innovation and access to physician services through telemedicine while ensuring quality and promoting effective physician-patient relationships. *(Originally passed in 1997, amended and affirmed in 2002)*

Third Party Payers, DO Medical Consultants (2017)

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

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

Third Party Payers, Osteopathic Representation (2016)

RESOLVED, that the Ohio Osteopathic Association continue to encourage all third party payers to appoint medical policy panels which include osteopathic representation. *(Original 1991)*

Third Party Reimbursement for Physician Services (2015)

RESOLVED, that the Ohio Osteopathic Association work with all third party payers and the Ohio Department of Insurance to ensure appropriate reimbursement to physicians for services they are qualified to render irrespective of their specialty designation *(Original 1990)*

Tobacco Control (2017)

RESOLVED, that the Ohio Osteopathic Association:

1. Encourages elimination of federal and state subsidies
   for the tobacco industry;
2. Supports increased taxation on tobacco products at both the state and federal levels, and urges that any revenue from such taxes be earmarked for smoking reduction programs and research involving tobacco-related diseases;
3. Encourages municipal, state and federal governmental agencies and lawmakers to enact clean indoor acts, a total ban on tobacco product advertising, and elimination of free distribution of cigarettes in the United States;
4. Urges schools to incorporate recognized tobacco use prevention courses in their health education curriculum.
5. Aggressively supports state and national efforts to eliminate smoking from all health care facilities, long-term care facilities and public buildings;
6. Supports raising the legal minimum age for smoking to age 21;
7. Encourages adults to avoid smoking anywhere children frequent and/or are present, including private homes and vehicles;
8. Opposes the availability of cigarette vending machines in general and supports state and federal legislation that would further limit access to these machines by minors; and
9. Supports programs and initiatives of the Tobacco Free Ohio Alliance, an association of Ohio agencies, organizations, groups and individuals

who work to prevent the use of tobacco products and to educate Ohioans about the harmful effects of tobacco use and secondhand smoke exposure on all citizens. *(Original Policy 1997)*

Transformation of Ohio DO Primary Care Practices into Medical Homes (2015)

WHEREAS, the Comprehensive Primary Care initiative (CPCi) is a four-year, multi-payer CMS pilot program designed to foster collaboration between public and private health care payers to strengthen primary care; and

WHEREAS, CMS is collaborating with nine commercial and state health insurance plans in Cincinnati/Dayton/Kentucky to offer population-based care management fees and shared savings opportunities to 75 participating primary care practices to support the provision of five "Comprehensive" primary care functions; and

WHEREASE, these core functions include (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care across the Medical Neighborhood; and

WHEREAS, Ohio has been awarded a $75 million State Innovation Model (SIM) grant by CMS to test payment reform based on episodes of care and patient centered medical homes; and

WHEREAS, Governor Kasich's Office for Health Transformation has set a goal of placing 80 to 90 percent of Ohio's population in some value–based payment model within five years using the CPC and PCMH models; and

WHEREAS, the Kasich Administration has asked CliniSync/Ohio Health Information Partnership to lead a broad-based coalition of Ohio provider organizations in applying for an Ohio Practice Transformation Network (OPTN) grant from CMS in the amount of $28.6 million to assist 6,400 clinicians with practice transformation; and

WHEREAS, the OPTN grant will complement Ohio's State Innovation Model (SIM) grant, which builds on episodes of care and the Patient-Centered Primary Care Home models as well as CMS' Comprehensive Primary Care Initiative (CPCi) in Dayton and Cincinnati; and

WHEREAS, the grant, if awarded to CliniSync, will fund "boots on the ground" to help practices adapt to payment reform models by assisting with quality metrics focused on diabetes, COPD, asthma and heart failure; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association continues to strongly encourage its members to seek assistance to transform-their practices into patient centered medical homes; and, be it further

RESOLVED, that the OOA work with the State of Ohio, CliniSync/Ohio Health Information Partnership and other physician organizations, to assist physicians in preparing their practices to be ready for new payment methods; and, be it further

RESOLVED, that the OOA continues to advocate for enhanced primary care reimbursement at the state and federal levels so primary care physicians can achieve an appropriate return on investment (ROI) for practice transformation.

RESOLVED, that the Ohio Osteopathic Association encourage its members to study the medical home model and assist its primary care physician members in transforming their practices into medical homes; and, be it further,

RESOLVED, that the OOA work with primary care physicians through the Ohio Health Information Partnership, to assist practices in purchasing and implementing electronic medical records, which is an important part of obtaining medical home certification under the National Committee on Quality Assurance; and, be it further,

RESOLVED, that the OOA encourage members to achieve "meaningful use" of EHRs, and to participate in the American Osteopathic Association's Clinical Assessment Program (CAP) or other recognized quality reporting programs, in order to submit patient data to the Centers of Medicare & Medicaid Services (CMS); and, be it further

RESOLVED, that the OOA encourage the Ohio University College of Osteopathic Medicine and CORE Residency Programs to become leaders in the development and implementation of medical home models in the state of Ohio. *(Original 2015)*

TRICARE Health Insurance for our Military (2016)

WHEREAS, TRICARE is the Department of Defense's choice health insurance program connecting civilian health care providers with Active Duty, National Guard,

and Reserve Service Members, retirees and their families worldwide; and

WHEREAS, TRICARE is a network of health care providers who support and supply quality health care coverage for more than 155,000 Ohio Service Member and Family beneficiaries; and

WHEREAS, as a major component of the Military Health System, TRICARE brings together the health care resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies and suppliers to provide access to high-quality health care services; and

WHEREAS, the 17,000 men and women of the Ohio National Guard need support from all medical specialties, although those who practice family medicine, internal medicine, orthopedic surgery, obstetrics, gynecology, pediatrics, psychiatry, physical medicine and rehabilitation, radiology, ophthalmology, gastroenterology are in particularly high demand; and

WHEREAS, almost 28,000 Ohio providers accept TRICARE beneficiaries, as network providers, and nearly 17,290 more "participate" by filing claims and accepting assignment of TRICARE payments; and

WHEREAS, services can be provided as a contracted network or as a "participating" non-contract provider, with reimbursement rates that mirror Medicare and clean claims usually paid within 5.4 days; and

WHEREAS, Congress' efforts to provide an option for health care to members of the National Guard has been somewhat thwarted due to bureaucratic and structural reasons, not the least of which is the lack of geographically dispersed providers., with large percentages of National Guard members living hours from providers who accept reimbursement through TRICARE; and

WHEREAS, most recently, health care and military leaders in Ohio and across the nation are calling for modernization and simplification of the TRICARE program to better serve America's troops and their families; and

WHEREAS, unlike Active Duty service members who are always on military status and therefore covered by TRICARE for their health care, National Guard members change military statuses whenever they conduct training, mobilize, deploy and reintegrate after mobilization; and

WHEREAS, National Guard members may move from private insurance coverage to TRICARE and back again, depending on their activation status, and if health care providers do not continue to provide care for the members and their families through these status/benefit coverage changes, then continuity of care is compromised; now, therefore, be it

RESOLVED, the Ohio Osteopathic Association supports member participation in TRICARE plans to provide care for all armed service members, active or reserve, and their families. *(Original 2016)*

Uncompensated Care, Tax Credits for Providers (2014)

RESOLVED that the Ohio Osteopathic Association support business tax credits and /or tax deductions for uncompensated medical services provided to indigent patients in order to encourage physicians to provide such care *(Original 1989)*

Universal Credentialing (2015)

RESOLVED, that the Ohio Osteopathic Association supports universal credentialing by healthcare facilities and health insurance plans. (Original 2005)

Wireless Enhanced 911 Services for the State of Ohio (2013)

RESOLVED, the Ohio Osteopathic Association endorses state legislation to expedite implementation of Phase I, Phase II, and Phase III wireless enhanced 9-1-1 services to ensure that emergency call centers in all Ohio counties can identify wireless telephone numbers, use global positioning to locate call positions, and receive text messages from wireless phones*. (Original 2008)*