2017

OHIO OSTEOPATHIC ASSOCIATION HOUSE OF DELEGATES MANUAL

FRIDAY, APRIL 21 TO
SATURDAY, APRIL 22

EASTON C/D/E
HILTON COLUMBUS AT EASTON
3900 CHAGRIN DRIVE, COLUMBUS OHIO

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Agenda and Supporting Documents

Professional Affairs Reference Committee

Public Affairs Reference Committee

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Constitution & Bylaws Reference Committee

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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.

AGENDA

Ohio Osteopathic Association
House of Delegates

John F. Uslick, DO, Speaker
David A. Bitonte, DO, Vice Speaker

FRIDAY, APRIL 21, 2017

10:30 am — J.O. Watson, DO Memorial Lecture, *Age of Champions,* Brian C. Clark, PhD – Easton A/B

11:30 am — Keynote Speaker *A Call to Healing,* Adrienne Boissy, MD, MA, Chief Experience Office, Cleveland Clinic – Easton A/B

12:30 pm — OOA President's Luncheon featuring American Osteopathic Association President Boyd R. Buser, DO, and installation of Sean D. Stiltner, DO, as OOA president – Regent Ballroom

2:00 pm — Delegate/Alternate Credentialing, John F. Ramey, DO, Chair – Outside Easton C/D/E

BUSINESS SESSION 1 – Easton Ballroom C/D/E

2:15 pm — Welcome and Call to Order – Geraldine N. Urse, DO, President
- Pledge of Allegiance – Dr. Urse
- Invocation – Charles G. Vonder Embse, DO
- Osteopathic Pledge of Commitment – Dr. Urse
- Introduction of the Speaker/Vice Speaker – Dr. Urse

2:20 pm — Opening Remarks – John F. Uslick, DO, Speaker

2:25 pm — Credentials Committee Report – Dr. Ramey

2:30 pm — Program Committee Report – Sean D. Stiltner, DO, President-Elect

2:40 pm — Routine Business – Dr. Uslick
- Appointment of Jon F. Wills as Secretary of the House
- Adoption of Standing Rules
- Approval of Executive Director's Report (2016 House Proceedings)

2:45 pm — Report of the Advocates for the AOA and OOA – Linda Kazan Garza, AAOA President; Becky Marx, AOOA Secretary

3:00 pm — State of the State Report – Dr. Urse

3:15 pm — Report of the State Medical Board of Ohio – Kim Anderson, Chief Legal Counsel

3:30 pm Assignment of Resolutions and Reference Committees – Dr. Uslick

3:45 pm Refreshment Break – Easton Lobby

3:45 pm Reference Committees

Ad Hoc Reference Committee – Lilac
Resolutions: 11-14-15-18-21
Initial Members: Henry L. Wehrum, DO, Chair (District VI)
Chelsea A. Nickolson, DO (District III)
Lili A. Lustig, DO (District VII)
Charles D. Milligan, DO (District VIII)
Michael E. Dietz, DO (District IV)
Melinda E. Ford, DO (District IX)

Constitution & Bylaws Reference Committee – New Albany Board Room
Resolutions: 1-2-3-4-6-7
Initial Members: Sandra L. Cook, DO, Chair (District VII)
Nicholas G. Espinoza, DO (District I)
Robert L. Hunter, DO (District III)
Ying H. Chen, DO (District VI)
Jean S. Rettos, DO (District IX)
John J. Vargo, DO (District X)

Professional Affairs Reference Committee – Magnolia
Resolutions: 9-10-12-17-20
Initial Members: Douglas W. Harley, DO, Chair (District VIII)
Roger L. Wohlwend, DO (District I)
Kimbra L. Joyce, DO (District III)
K. Ronald Routh, DO (District VI)
Phillip A. Starr III, DO (District VII)
Hilary S. Haack, DO (District IX)

Public Affairs Reference Committee – Easton C/D/E
Resolutions: 5-8-13-16-19
Initial Members: Nicholas J. Hess, DO, Chair (District III)
Edward E. Hosbach II, DO (District II)
Luis L. Perez, DO (District V)
Paige S. Gutheil Henderson, DO (District VI)
Schield M. Wikas, DO (District VIII)
Scott Wang, OMS I (OU-HCOM)

6:00 pm Awards Reception and Recognition Ceremony – Regent Ballroom

SATURDAY, APRIL 22, 2017

7:00 am *Poster Exhibition* – Regent Ballroom (posters on display until 1:00 pm)

8:00 am *Rapid Fire Orthopedics,* miscellaneous presenters

10:00 am Refreshment Break

10:30 am *Women's Health*, Jane T. Balbo, DO – Easton A/B

11:30 am *Emerging Research Poster Presentations*, Sonia M. Najjar, PhD – Easton A/B

12:00 Noon **District Academy Caucus Meetings** (box lunches will be served)
Akron-Canton – Easton C/D/E
Columbus – Juniper B
Cleveland – Lilac
Dayton – Magnolia
Small Districts – Juniper C

1:30 pm Ohio Women in Medicine Workshop: *An Osteopathic Approach to Professional Wellness* – Easton A/B

3:15 pm Refreshments – Easton Lobby

BUSINESS SESSION 2 – Easton C/D/E

3:30 pm Call to Order – Dr. Uslick

3:35 pm Report of the Credentials Committee – Dr. Ramey

3:40 pm OOPAC Report – Dr. Ramey, Chair

3:50 pm OOA/OOF Financial Reports – Charles D. Milligan, DO, Treasurer

4:00 pm Professional Affairs Reference Committee Report – Douglas W. Harley, DO, Chair

4:15 pm Public Affairs Reference Committee Report – Nicklaus J. Hess, DO, Chair

4:30 pm Ad Hoc Reference Committee Report – Henry L. Wehrum, DO, Chair

4:45 pm Constitution & Bylaws Reference Committee – Sandra L. Cook, DO, Chair

5:00 pm Introduction of 2017-2018 OOA President Sean D. Stiltner, DO, and recognition of Geraldine N. Urse, DO, outgoing president

5:15 pm Report of the OOA Nominating Committee – Dr. Ramey, Chair
Committee Members: Paul A. Martin, DO (Dayton); Christopher J. Loyke, DO, (Cleveland); Charles G. Vonder Embse, DO, (Columbus); M. Terrance Simon, DO, (Akron-Canton); Victor D. Angel, DO, (Cincinnati)

Nominees for OOA Officers
President-Elect .....Jennifer J. Hauler, DO
Vice President .....Charles D. Milligan, DO
Treasurer..... Sandra L. Cook, DO
Speaker of the House.....John F. Uslick, DO

Vice Speaker of the House..... David A. Bitonte, DO

Nominees for Ohio Osteopathic Foundation Board
Three-year term ending 2020.....Paul T. Scheatzle, DO
Three-year term expiring 2020.....Mark S. Jeffries, DO

Nominees for Ohio Delegation to the AOA House (to be distributed)

6:00 pm Adjournment

6:30 pm **Pass the Torch – Match and Mentor Celebration - Easton A/B (Spouses Welcome)**

OOA HOUSE OF DELEGATES

PASS THE TORCH
MATCH AND MENTOR CELEBRATION

AS DELEGATES FOR YOUR DISTRICT, PLEASE ATTEND THE RECEPTION
TO WELCOME SECOND YEAR OU-HCOM STUDENTS
WHO WILL BE COMING TO CORE SITES IN YOUR DISTRICT

AND

CELEBRATE WITH FOURTH YEAR STUDENTS WHO
WILL BE STARTING RESIDENCY PROGRAMS

SATURDAY APRIL 22

REGENT BALLROOM
6:30 PM – 8:30 PM

See You Next Year!

OHIO OSTEOPATHIC SYMPOSIUM

April 25 – 29, 2018

COLUMBUS HILTON AT EASTON
Columbus, Ohio

House Standing Rules

The rules governing this House of Delegates shall consist of the Ohio Osteopathic Association Constitution and Bylaws, Robert's Rules of Order "Newly Revised" and the following standing rules:

1. Roll call votes will be by academies and by voice ballot, not by written ballot.

2. Debate, by any one delegate, shall be limited to no more than two speeches on any one subject, no longer than five minutes per speech. The second speech should be after all others have had an opportunity to speak.

3. Nominations shall be presented by the nominating committee.

4. The agenda of the House of Delegates meeting shall be sent to all districts at least twenty-one (21) days before the convention.

5. All resolutions submitted by any district or any other business to require House of Delegates attention shall automatically be brought before the House of Delegates if each district has been notified at least twenty-one (21) days in advance of such resolutions. Emergency resolutions or business addressing issues which occur after the published deadlines my be considered by the House of Delegates provided such resolutions or business have been submitted in typewritten form to the OOA Executive Director, with sufficient copies for distribution to the delegates, prior to the commencement of the first session of the House of Delegates. The sponsor of the resolution may move that the House consider the resolution at this session and that the House judges that the matter could not have been submitted by the published deadline. Each proposed item shall be considered separately.

6. The order of the agenda shall be left to the discretion of the Speaker of the House or presiding official.

7. Persons addressing the House shall identify themselves by name and the district they represent, and shall state whether they are for or against a motion.

8. The district executive directors and/or secretaries shall be permitted to sit with their delegations during all but executive sessions without voice or vote.

9. The Speaker of the House may appoint five or more members to the following Reference Committees: Public Affairs, Ad Hoc, Professional Affairs, Constitution and Bylaws. The purpose of each committee is as follows:

    - Public Affairs: To consider matters relating to public and industrial health, such as medical care plans, health care for the aging, disaster medical care, physical fitness and sports medicine, mental health etc.

- Professional Affairs: To consider matters relating to osteopathic education, osteopathic colleges, osteopathic hospitals, internship and residency programs, certification, postgraduate training programs, student loans, research, membership, conventions, etc.

- Constitution and Bylaws: To consider the wording of all proposed amendments to the Constitution, Bylaws and the Code of Ethics.

- Ad Hoc: To consider resolutions not having a specific category

10. Reports and resolutions, unless otherwise provided for, shall be referred to an appropriate reference committee for study, investigation and report to the House.

11. The reference committee shall report their findings to the House at a specified time. The reports of the reference committees shall be given in respect to each item referred to them, and the House shall act upon each item separately or by consent calendar for collective action by the full house when deemed appropriate by the committee. Any seated delegate shall have the right to request the removal of any resolution from the consent calendar for separate consideration. The reference committees may recommend the action to be taken, but the vote of the House shall be the final decision in those matters, which are in its province, according to the rules of procedure.

12. The Speaker shall have the power to refer any resolution to a special committee or the House may recommend the appointment of a special committee.

13. The osteopathic student delegate shall be seated with the delegation from the academy within whose boundaries the osteopathic school is located.

14. Committee reports shall be limited to ten (10) minutes unless an amended report is to be read which has not been previously published. The House reference committees are excluded from this limit.

15. All resolutions passed by the House of Delegates shall be monitored by the OOA Board of Trustees for appropriate implementation.

16. The OOA Executive Director shall compile a written report on all actions proposed, initiated or completed in response to resolutions enacted during the annual session. Such report shall be included in the House of Delegates manual the year following enactment.

17. All resolutions passed by the OOA House of Delegates which pertain to policy, shall be reviewed by the OOA Resolutions Committee and resubmitted to the House of Delegates no later than five years after the enactment date.

OHIO OSTEOPATHIC ASSOCIATION
Actions by the 2016 House of Delegates

Submitted by OOA Executive Director Jon F. Wills and
Cheryl Markino, Director of Communications

The OOA House of Delegates met, April 22-23, during the Ohio Osteopathic Symposium. The physician-delegates representing the OOA's ten districts debated 22 resolutions. Nine new policy statements were approved. Those resolutions covered a range of topics including law enforcement response to mental health crises; patient involvement in cancer clinical trials; LGBTQ patients; food and housing insecurity; human trafficking; eugenic selection with preimplantation genetic diagnosis; CME credits; and TRICARE health insurance. Six resolutions were forwarded to the AOA House of Delegates for consideration at the July meeting.

During the Symposium, Geraldine N. Urse, DO, of Columbus, was installed as OOA president. Other elected officers include: President-elect Sean D. Stiltner, DO, of Piketon; Vice President Jennifer J. Hauler, DO, of Dayton; and Treasurer Charles D. Milligan, DO, of Orville. Immediate Past President Robert W. Hostoffer, Jr, DO, of Cleveland, remains on the Executive Committee. Speaker of the House John F. Uslick, DO, of Canton, and Vice Speaker David A. Bitonte, DO, MBA, MPH, presided over the meeting. Both were re-elected to another term. The House also elected E. Lee Foster, DO; Sharon L. George, DO; and Paul T. Scheatzle, DO, to the Ohio Osteopathic Foundation Board of Trustees and voted for a full slate of physicians to represent Ohio at the AOA House of Delegates in July.

NEW POLICY STATEMENTS ADOPTED

Four reference committees met on the first day of the House session to evaluate each resolution and conduct a five-year review of existing policies. Committee chairs then provided a report the following day to the entire House. Peter A. Bell, DO, of Columbus, chaired the Ad Hoc Committee and the following served on the panel: Nicole J. Barylski-Danner, DO; Douglas W. Harley, DO; Nicklaus J. Hess, DO; and Christopher J. Loyke, DO. Sandra L. Cook, DO, of Cleveland, chaired the Constitution & Bylaws Committee. Committee members included David A. Bitonte, DO (ex officio); Charles D. Hanshaw, DO; Adele M. Lipari, DO; Daniel K. Madsen, DO; and Marc S. Ucchino, DO. The Public Affairs Committee was led by Jennifer J. Hauler, DO, of Dayton, with committee members: Ying Chen, DO; William F. Emlich, Jr., DO; Luis L. Perez, DO; Mark J. Tereletsky, DO; Alyssa Ritchie, OMSI; and Cheryl Markino. Charles D. Milligan, DO, of Orville, led the Professional Affairs Committee. John C. Baker, DO; James A. Schoen, DO; Henry L. Wehrum, DO; John J. Wolf, DO; and Carol Tatman served on the committee. John F. Ramey, DO, of Sandusky, chaired the Credentials Committee. Delegates adopted nine new positions. The full text of those resolutions is printed here.

Improving Outcomes of Law Enforcement Responses to Mental Health Crises through the Crisis Intervention Team Model

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.

Explore Incentives to Increase Patient Involvement in Cancer Clinical Trials

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.

Addressing Food and Housing Insecurity for Patients

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.

Human Trafficking Education for Health Care Workers

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.

Eugenic Selection with Preimplantation Genetic Diagnosis

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.

TRICARE Health Insurance for our Military

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.

Providing CME Credits for Physicians Pursuing Further Education

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.

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws

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.

Expanding Gender Identity Options on Physician Intake Forms to be More Inclusive of LGBTQ Patients

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).

EXISTING POSITION STATEMENTS AMENDED AND/OR REAFFIRMED

According to the Standing Rules of the OOA House of Delegates "all resolutions passed by the OOA House of Delegtates which pertain to policy shall be reviewed by the OOA Resolutoons Committee and resubmitted to the House of Delegates no later than five years after the enactment date." The following actions were taken as a result of the ive year review rule.

Diagnostic, Therapeutic, and Reimbursement

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 2001)*

Drug Enforcement Administration Numbers

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)*

Home Health Care, Physician Reimbursement

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

Hospital Medical Staff Discrimination

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)*

OOA Physician Placement Information Service

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

Photo IDs for Scheduled Drug Prescriptions

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)*

Third Party Payers, Osteopathic Representation

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

Safe Prescriptions and Drug Diversion Tactics

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages colleges of osteopathic medicine to educate students about common drug diversion 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)*

Health Literacy and Cultural Competency

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)*.

Ohio Automated Rx Reporting System (OARRS)

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

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)*

Childhood Obesity and School Health Policies

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)*

Physician Signatures, Reduction of Unnecessary

RESOLVED, that the Ohio Osteopathic Association (OOA) supports continuous evaluation of physician signature requirements imposed by agencies, institutions and private businesses, to eliminate non-essential validation mandates and reduce administrative burdens on physician offices *(Original 2001)*

EXISTING POSITION STATEMENTS AMENDED BY SUBSTITUTION AND APPROVED

Pain Management Education

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)*

Medicare Three-Day Qualifying Policy for Skilled Nursing Facility Care

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)*

EXISTING POSITION STATEMENTS DELETED

The House of Delegates approved the Resolutions recommendations to delete the following resolutions:

- **AOA Resolution 29 (AOA Approval of ACGME Residency in an Option-1 Specialty) Repeal**
- **Terminally Ill Patient Access to Pain Medications** (Rules implementing HB 93 and subsequent legislation addressing pain management exclude terminally ill patients.)
- **Prescriptions for Over-the-Counter Medications** (Some of the language in the policy statement was incorporated into another resolution on the same topic by the Ad Hoc Reference Committee and the alternate resolution was approved by the American Osteopathic Association in lieu of the Ohio resolution, which was redundant.)

RESOLUTIONS DEFEATED, REFERRED, OR WITHDRAWN

One resolution, **Harassment of Physicians**, was disapproved. After significant debate and adopting amendments, one resolution, **Remove Federal Ban on Funding Gun Research**, was re-referred.

Respectfully submitted by,
Jon F. Wills
Executive Director

Professional Affairs Reference Committee

Purpose: To consider matters relating to osteopathic education, osteopathic colleges, osteopathic hospitals, internship and residency programs, certification, postgraduate training programs student loans, research, clinical practice, etc.

Resolutions: 9, 10, 12, 17, & 20

Members:

Douglas W. Harley, DO, Chair (District VIII)
Roger L. Wohlwend, DO (District I)
Kimbra L. Joyce, DO (District III)
K. Ronald Routh, DO (District VI)
Phillip A. Starr III, DO (District VII)
Hilary S. Haack, DO (District IX)
Cheryl Markino (Staff)

Magnolia Room

RES. NO.
2017-09

SUBJECT: Medicaid Support of GME Funding

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMMENDED AS FOLLOWS AND APPROVED:

Medicaid Support of GME Funding

(Delete Current Policy Statement)

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

(Substitute Resolution)

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 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, 95 percent of the entering class at 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)

ACTION TAKEN: _____

DATE: _____

***Explanatory Note**: This resolution was originally approved in 1997 and has been updated to address recommendations from a 2015 study committee formed by the Ohio General Assembly. Section 327.320 of the 2016-2017 state operating budget (Am. Sub. H.B. 64) established a "Graduate Medical Education Study Committee" to study Medicaid payments to hospitals for the costs of graduate medical education (GME). The committee was disbanded after it submitted a report to the Governor and Ohio General Assembly by December 31, 2015. The following individuals served on the committee, as appointed by the Ohio General Assembly:*

- *Mike Anderson, Ohio Children's Hospital Association (appointed per statute)*
- *John Carey, Ohio Board of Regents (appointed per statute)*
- *Charles Cataline, Ohio Hospital Association (appointed per statute)*
- *Dan Clinchot, Ohio State University (appointed by House)*
- *Chris Cooper, University of Toledo (appointed by Senate)*
- *Andrew Filak, University of Cincinnati (appointed by Senate)*
- *Jay Gershen, Northeast Ohio Medical University (appointed by House)*
- *David Hopkins, Wright State University (appointed by House)*
- ***Kenneth Johnson, Ohio University (appointed by Senate)***
- *John McCarthy, Ohio Department of Medicaid (appointed per statute)*
- ***Roderick McDavis, Ohio University (appointed by House)***
- *Greg Moody (Chair), Office of Health Transformation (appointed per statute)*
- *Brent Mulgrew, Ohio State Medical Association (appointed per statute)*
- *Andy Thomas, Ohio State University (appointed by Senate)*
- ***Jon Wills, Ohio Osteopathic Association (appointed per statute)***

To see an entire copy of the report go to:
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=WvonZuMotws%3d&tabid=162

Medicaid Direct GME Formula Proposal
Draft for Discussion at Medicaid GME Study Commission
November 30, 2015

This is a proposal to change the formula for a substantial portion of the Medicaid Direct GME (DGME) add-on payment under Ohio Medicaid. This proposal is presented as a discussion draft for the Medicaid GME Study Commission that was appointed in the Fall of 2015 to advise the legislature on this issue. The current formula was designed in 1987 and has not been updated since that time.

The principles discussed at the first meeting of the Medicaid GME Study Commission included the following:

- **Most importantly, the proposal should provide incentives to teaching hospitals to produce physicians for the State of Ohio in primary and other "underserved" specialties**
- The proposal must be budget neutral
- The proposal should continue to pay the DGME payments as an add-on to patient care payments in order to preserve Federal draw-down funds for this purpose under the Medicaid program
- The proposal should take into account the current number of trainees at any given institution
- The proposal should provide greater "fairness" in the DGME dollars paid to Ohio teaching hospitals on a per resident basis
- The proposal should be based on data that can easily be collected through the Medicaid Cost Report either through currently collected data or through a new addendum to the cost report that Medicaid can create

The amount of funding for DGME under the Ohio Medicaid program for CY2014 was $100 million. With Medicaid expansion in Ohio, that number will most likely continue to grow over time since the DGME payment is an add-on to the DRG payment for each Medicaid discharge for a teaching hospital. **This proposal would initially move one fourth of the total Direct GME payments to the new payment methodology – for the purposes of this example, $25 million is used to represent one quarter of the total current Direct GME payments**. This percentage could increase over a period of five years to a 50/50 split between the current CMI-adjusted Direct GME formula and the newly proposed formula.

Although additional work needs done on details and data collection, the newly proposed formula would be structured as follows:

- **Step 1: Weighting GME positions based on specialty of program**

In order to incentivize teaching institutions to create more training positions in primary care and "underserved" specialties, the proposal would provide increased weights for primary care

(e.g., family medicine, pediatrics, OB/GYN, internal medicine) and underserved specialties (e.g., psychiatry, child/adolescent psychiatry, geriatrics, general surgery). Other specialty residency and fellowship programs would receive lower weights. The relative weights would be determined by a standing GME advisory body created by the legislature.

- **Step 2: Determine the number of actual trainees in each specialty at each teaching hospital**

Each teaching hospital would submit an annual report to the Department of Medicaid as an appendix to the annual Medicaid Cost Report which would outline each training position that rotates at that institution or is financially covered by that institution in the case of outpatient rotations. Rules for which positions could be counted would follow Federal Medicare rules so that positions where an institution covers "all or substantially all" of the costs associated with the trainees training could be counted by that institution.

- **Step 3: Determine the total number of "Weighted Positions" at each teaching hospital**

Using the weight for each specialty from Step 1, a total number of weighted positions for each teaching hospital would be calculated.

- **Step 4: Determine the proportion of "Weighted Positions" at each teaching hospital as a percentage of all "Weighted Positons" in Ohio**

Once all Cost Reports are submitted, the Department of Medicaid would determine the total number of weight positions for the state of Ohio. A proportionate percentage of all weighted positions in the state would then be calculated for each teaching hospital.

- **Step 5: Determine the estimated annual "Weighted Position Funding" for each teaching hospital**

In Year 1 of the new formula, the "Estimated Weighted Position Funding" for each teaching hospital would be total funding for "weighted position" (in this example, we are using $25 million) multiplied by the percentage of all weighted positions in the state for that teaching hospital from Step 4. For example, if a hospital had 5% of all of the weighted positions and the total funding pool is $25 million, the estimated annual "Weighted Position Funding" for that teaching hospital would be $1.25 million.

- **Step 6: Determine the "Weighted Position Add-on Payment per Discharge" for each teaching hospital**

The "Estimated Weighted Position Funding" from Step 5 would be divided by the total number of Medicaid discharges for the previous fiscal year to determine the "Weighted Position Add-on Payment per Discharge" for each teaching hospital. For example, if the total estimated funding for the year from Step 5 is $1.25 million and the hospital had 5,000 Medicaid discharges in the

previous fiscal year, the "Weighted Position Add-on Payment per Discharge" would be $250 per discharge for that teaching hospital. In order to reflect difference in the complexity of patients seen by a teaching hospital as well as the share of uninsured and Medicaid patients seen, the add-on payment should also modified by the average case mix index (CMI) for Medicaid patients and whether the hospital is a high DSH/"deemed" DSH facility based on those definitions.

- **Step 7: Actual annual reimbursement for each teaching hospital**

The actual total reimbursement received by any teaching hospital for the "Weighted Position Add-on Payment" for a given year would then be determined by the total number of Medicaid discharges from the hospital in the following fiscal year. For example, if the hospital being used in this example had 5,500 Medicaid discharges in the following year, the hospital would receive a total of $1.375 million; if the hospital had 4,500 Medicaid discharges the following year, the hospital would receive only $1.125 million.

- **Step 8: Impact on current Medicaid Direct GME Funding add-on payments**

In year 1, Medicaid Direct GME Funding add-on payments would be calculated as they have been in the past, but they would simply multiplied by 0.75 to compensate for the fact that 25% of the funding for Direct GME will be paid under this new formula. In future years, if the ratio of Direct GME payments between the old formula and the proposed new formula were to change, this percentage would change accordingly.

Other issues to be discussed:

- Estimates of current weighted positions at each teaching hospital (see attached) are difficult to determine because this information is not currently submitted to the Department of Medicaid.
    - The best estimates come from the NRMP, AOA and San Francisco match programs which can tell us how many positions are "offered" at each GME sponsor.
    - However, some sponsors are not teaching hospitals and it is unclear at which hospitals those trainees rotate.
    - Also, many teaching hospitals send some trainees to other inpatient facilities to train (i.e., Children's hospitals or other hospitals in the local area), so the estimates for those teaching hospitals with a count of positions may be over or under-estimates.
- The newly proposed formula is not case mix index (CMI) adjusted like the current DME and IME formulas. As noted in Step 6, additional weighting based on average CMI should be applied to the add-on payment.
- As noted in Step 6, the newly proposed formula should include an additional weighting factor for teaching institutions that are high or "deemed" DSH hospitals who take on a larger than usual proportion of uninsured or Medicaid patients.

Discussion Concepts Submitted by the Ohio Osteopathic Association for Ohio Medicaid Direct GME Payment Redesign November 2015

Current Conditions-create an imbalanced response with the least impact potential and greatest harm to stakeholders						
Decision-making	Allocation	Recipient	Reporting	Utilization	Outcome	
Ohio Medicaid direct GME funds re-allocated to: 1) Reward desired medical education choices and 2) Fund health transformation efforts aligned to state policy and 3) Respect existing conditions and the impact of change	$100 million	Teaching hospital with GME (primarily academic health centers and larger community-based facilities)	IRIS	$ Invested primarily in hospital-based GME programs	Produce physicians across a broad range of specialties who provide needed care to Ohioans	
Target Conditions-create a balanced response with the greatest impact potential and least harm to stakeholders						
	Allocation	Recipient	Reporting	Utilization	Outcome	Comments/Impact
	$60 million	Teaching hospitals with GME programs	IRIS report	$ Invested in hospital-based GME programs	Continue to produce physicians across a broad range of specialties who provide needed care to Ohioans (particularly those recognized as vulnerable populations)	Utilize a five year phase-in period intended to minimize impact upon hospital budgets

Notes	Will require the creation of a floor and ceiling payment structure Must allow for an updated cost report and ongoing reviews and adjustments Will continue to favor higher payment to the larger academic health centers	Teaching facilities will have the ability to access funds regardless of the type of GME programs offered, although the absence of programs in high need fields should have an impact upon payment	The existing reporting structure should be utilized, but the inclusion of simple outcome criteria could be recommended in order to reward for performance The outcome criteria could follow existing Medicare performance metrics	Maintain current configuration of training programs		Some hospitals will see a decrease in Ohio Medicaid direct GME payment Some hospitals will see an increase in Ohio Medicaid direct GME payment Some hospitals will see no change in Ohio Medicaid direct GME payment
	Allocation	Recipient	Reporting	Utilization	Outcome	Comments/Impact
	$30 million	Medical Schools	# Of graduates entering high need fields in Ohio submitted annually	$ Invested in clinical learning environment, innovative programming, and role modeling by desirable faculty	Investment by the medical schools into clinical learning environment (inclusive of GME) results in an increased number of graduates entering high need fields	Five year phase-in period intended to allow for meaningful changes in medical school-hospital and medical school-physician relationships
Notes		While this payment may initially favor certain schools, it must be assumed all of Ohio's medical	Simple reporting structure aligned to policy Per graduate	1. Strengthen medical school-hospital relationships 2. Strengthen		Medical schools have the ability to invest directly in the clinical learning environment,

		schools can achieve the desired outcome and a balanced payment will result The possibility of an equal number of graduates from each Ohio medical school entering a high need field must be considered	payment based upon entry into high need fields High need fields must be published and updated by Ohio Medicaid with advance notice and input from community of interest	clinical learning environment associated with high need fields 3. Support role model in high needs fields		creating an opportunity to promote high need fields to students Some funds lost by hospitals in the re-allocations process are potentially re-gained through these relationships
	Allocation	**Recipient**	**Reporting**	**Utilization**	**Outcome**	**Comments/Impact**
	$10 million	Newly graduated physicians entering high need fields and practicing in Ohio (DO and MD)	# Of students precepted # Of Medicaid patients treated Location of practice (high need preferred)	$ Invested in new graduates for teaching and quality care of Medicaid patients	Investment by the State into new graduates results in an increased number of graduates entering high need fields	
Notes		The enhanced payment must align to the five year phase-in period and be calculated to account for an increasing number of new physicians receiving the enhanced payment over time	Simple reporting structure aligned to policy Formula: # of teaching weeks x # of Medicaid patients treated x enhanced payment = annual payment	1. Increase teaching in high need fields through role models 2. Increase payment to new graduates for five years in high need fields 3. Promote quality care using of		New graduates entering high need fields are supported during a vulnerable period in practice (funds can be directed toward loan repayment) New graduates are encouraged to

			or # of teaching weeks x enhanced payment = annual payment High need fields must be published and updated by Ohio Medicaid with advance notice and input from community of interest	Medicaid patients using established metrics		become active with teaching A teaching pool with needed and desirable competencies is created Needed services are provided to Ohio Medicaid patients
Summary						
	$100 million program expense maintains budget neutrality	No single solution is applied to a complex problem Funds are now allocated to multiple recipients Funds are linked to teaching and patient care	Simple new formulas and use of existing data is intended to minimize burden upon end users	Available funds are spread across involved stakeholders and conditions are created for low risk, high reward investments toward stated goals	The likelihood of achieving State health transformation goals is increased Can be studied to promote best practices and treated as an experiment rather than a solution	New system is adaptable as change occurs and is designed for the intended outcome

RES. NO.
2017-10

SUBJECT: Physician-Patient Relationships

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

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

RESOLVED that the Ohio Osteopathic Association opposes any government 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)*

ACTION TAKEN: _____

DATE: _____

RES. NO
2017-12

SUBJECT: AOA Category 1-B Continuing Medical Education (CME) Credit for Preceptoring Physician Assistant Students (PAs)

SUBMITTED BY: Columbus Osteopathic Association

REFERRED TO:

WHEREAS, the osteopathic profession has had a long-standing relationship with physician assistants (PAs), dating back to the 1970's; and

WHEREAS, the American Osteopathic Association (AOA) and the American Academy of Physician Assistants, issued a Joint Statement in 2013, stating: "Osteopathic physicians and PAs share common goals of providing physician-led, team-based, patient-centered care that is focused on improving the health of patients and communities;" and

WHEREAS, the AOA is represented on the governing board of the National Commission on Certification of Physician Assistants, and osteopathic licensing boards regulate PAs in seven states; and

WHEREAS, the Ohio Osteopathic Association (OOA) has served as a liaison organization in an advisory capacity with the Ohio Association of Physician Assistants for more than 30 years; and

WHEREAS, many osteopathic colleges have co-located osteopathic medicine and physician assistants schools and colleges, including the Heritage College of Osteopathic Medicine and the Physician Assistants program on the Ohio University campus in Dublin; and

WHEREAS, physician assistant students complete twelve months of clinical studies under direct supervision of osteopathic physicians in general medical and specialty rotations to improve medical knowledge through learning and honing diagnostic skills, developing broader differential diagnoses, ordering and interpreting pertinent laboratory testing, developing treatment modalities, and learning procedures to enhance the quality of medical care, and

WHEREAS, many professional hours are dedicated to training these PAs in the clinical settings to adequately train these future medical providers, and

WHEREAS, these clinical rotations are conducted in a similar fashion for medical students and residents; and

WHEREAS, there is currently inadequate remuneration for the physician's time to train the PAs and a shortage of quality training sites due to this inadequate remuneration; and

WHEREAS, AOA Category 1-B CME credit is awarded to physicians who train medical students and residents, for up to 60 hours per cycle, this is not the case with training PAs who are an integral and vital group of medical practitioners; now, therefore be it

RESOLVED, that OOA supports awarding AOA Category 1-B Continuing Medical Education credits to osteopathic physicians who precept Physician Assistant students commensurate with hours of clinical education, for up to 60 hours in a CME cycle; and be it further,

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-17

SUBJECT: Prevention and Maintenance of Burnout in Medical Students and Residents

SUBMITTED BY: Marietta (IX) District Academy of Osteopathic Medicine

REFERRED TO:

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

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

WHEREAS, between 22 and 60 percent of practicing specialists and general practitioners have experienced burnout; 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); 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 Inventory; 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 retirement; and

WHEREAS, burnout is associated with errors, 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 study 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 symptoms, and suicidal thought level was high amongst medical students, and in the first postgraduate year, mental distress was the most important predictor; and

WHEREAS, 15 percent of year one students demonstrated lifetime prevalence of mental health problems, 31 percent of students began exhibiting mental health problems without seeking help at term two, and 14 percent 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 stress; 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 literature; 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 implicated; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports 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 Maslach Burnout Inventory; 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.

ACTION TAKEN: _____

DATE: _____

Explanatory Note: *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.*

References:

1. Informed Health Online [Internet]. Cologne, Germany: Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. Depression: What is burnout syndrome? 2012 Dec 5 [Updated 2013 Jan 17].

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RES. NO.
2017-20

SUBJECT: Opposition to the Practice of LGBTQ "Conversion Therapy" or "Reparative Therapy" by Licensed Physicians and Other Medical and Mental Health Care

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, contemporary science recognizes that being lesbian, gay, bisexual, or transgender (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; 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,"; 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; 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. 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; and

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: American Medical Association; American Academy of Pediatrics; American Academy of Child and Adolescent Psychiatry; American Psychiatric Association; American College of Physicians; 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, 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.

ACTION TAKEN: _____

DATE: _____

Explanatory Note: *"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."*

References:

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RELEVANT AOA AND OOA POLICY:

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

Public Affairs Reference Committee

Purpose: To consider matters relating to public and industrial health, such as medical care plans, health care for the aging, disaster medical care, physical fitness and sports medicine, mental health, etc.

Resolutions: 5, 8, 13, 16, & 19

Members:

Nicholas J. Hess, DO, Chair (District III)
Edward E. Hosbach II, DO (District II)
Luis L. Perez, DO (District V)
Paige S. Gutheil Henderson, DO (District VI)
Schield M. Wikas, DO (District VIII)
Scott Wang, OMS I (OU-HCOM)
Jon Wills (Staff)

Easton C/D/E

RES. NO.
2017-05

SUBJECT: School Allergen Exposure Emergency Plans

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

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

School Multiple Allergen Exposure Emergency Plans (2012)

RESOLVED, that the Ohio Osteopathic Association (OOA) 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 ~~work with the Ohio Department of Health and the Ohio Department of Education to investigate the feasibility of changing~~ 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 Ohio Osteopathic Association 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)*

ACTION TAKEN: _____

DATE: _____

3313.7110 Procurement of epinephrine autoinjectors for public schools.

(A) The board of education of each city, local, exempted village, or joint vocational school district may procure epinephrine autoinjectors for each school operated by the district to have on the school premises for use in emergency situations identified under division (C) (5) of this section by doing one of the following:

(1) Having a licensed health professional authorized to prescribe drugs, acting in accordance with section 4723.483. 4730.432. or 4731.96 of the Revised Code, personally furnish the epinephrine autoinjectors to the school or school district or issue a prescription for them in the name of the school or district;

(2) Having the district's superintendent obtain a prescriber-issued protocol that includes definitive orders for epinephrine autoinjectors and the dosages of epinephrine to be administered through them.

A district board that elects to procure epinephrine autoinjectors under this section is encouraged to maintain, at all times, at least two epinephrine injectors at each school operated by the district.

(B) A district board that elects to procure epinephrine autoinjectors under this section shall require the district's superintendent to adopt a policy governing their maintenance and use. Before adopting the policy, the superintendent shall consult with a licensed health professional authorized to prescribe drugs.

(C) - The policy also adopted under division (B) of this section shall do all of the following:

(1) Identify the one or more locations in each school operated by the district in which an epinephrine autoinjector must be stored;

(2) Specify the conditions under which an epinephrine autoinjector must be stored, replaced, and disposed;

(3) Specify the individuals employed by or under contract with the district board, in addition to a school nurse licensed under section 3319.221 of the Revised Code or an athletic trainer licensed under Chapter 4755. of the Revised Code, who may access and use an epinephrine autoinjector to provide a dosage of epinephrine to an individual in an emergency situation identified under division (C)(5) of this section;

(4) Specify any training that employees or contractors specified under division (C)(3) of this section, other than a school nurse or athletic trainer, must complete before being authorized to access and use an epinephrine autoinjector;

(5) Identify the emergency situations, including when an individual exhibits signs and symptoms of anaphylaxis, in which a school nurse, athletic trainer, or other employees or contractors specified under division (C)(3) of this section may access and use an epinephrine autoinjector;

(6) Specify that assistance from an emergency medical service provider must be requested immediately after an epinephrine autoinjector is used;

(7) Specify the individuals, in addition to students, school employees or contractors, and school visitors, to whom a dosage of epinephrine may be administered through an epinephrine autoinjector in an emergency situation specified under division (C)(5) of this section.

(D)

(1) The following are not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or using an epinephrine autoinjector under this section, unless the act or omission constitutes willful or wanton misconduct;

(a) A school or school district;

(b) A member of a district board of education;

(c) A district or school employee or contractor;

(d) A licensed health professional authorized to prescribe drugs who personally furnishes or prescribes epinephrine autoinjectors. consults with a superintendent, or issues a protocol pursuant to this section.

(2) This section does not eliminate, limit, or reduce any other immunity or defense that a school or school district, member of a district board of education, district or school employee or contractor, or licensed health professional may be entitled to under Chapter 2744. or any other provision of the Revised Code or under the common law of this state.

(E) A school district board of education may accept donations of epinephrine autoinjectors from a wholesale distributor of dangerous drugs or a manufacturer of dangerous drugs, as defined in section 4729.01 of the Revised Code, and may accept donations of money from any person to purchase epinephrine autoinjectors.

(F) A district board that elects to procure epinephrine autoinjectors under this section shall report to the department of education each procurement and occurrence in which an epinephrine autoinjector is used from a school's supply of epinephrine autoinjectors.

(G) As used in this section, "licensed health professional authorized to prescribe drugs" and "prescriber" have the same meanings as in section 4729.01 of the Revised Code.

Amended by 131st General Assembly File No. TBD, HB 200, §1, eff. 9/8/2016.

Added by 130th General Assembly File No. TBD, HB 296, §1, eff. 4/21/2014.

SUBJECT: School Allergen Exposure Emergency Plans

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE DELETED

~~WHEREAS, food allergy is a potentially serious immune response to eating specific foods or food additives, and eight types of food account for over 90 percent of allergic reactions in affected individuals, including milk, eggs, peanuts, tree nuts, fish, shellfish, soy, and wheat; and~~

~~WHEREAS, in 2007, the reported food allergy rate among all children younger than 18 years was 18 percent higher than in 1997. During the 10-year period 1997 to 2006, food allergy rates increased significantly among both preschool-aged and older children; and~~

~~WHEREAS, recent data show hospitalizations with diagnoses related to food allergies have increased among children; and~~

~~WHEREAS, the Ohio Osteopathic Association realizes that the Division of Child Development and Early Education at the Department of Health and Human Services requires all lunches served in pre-kindergarten programs — including in-home day care centers — to meet USDA guidelines; and~~

~~WHEREAS, a preschooler at West Hoke Elementary School, in North Carolina, on January 26, 2012, was forced to purchase a school lunch (including chicken nuggets, fried potatoes, applesauce, and milk), over a packed home lunch because a state inspector interpreted the toddler's lunch her mother packed (a turkey and cheese sandwich, potato chips, banana, and apple juice) was not nutritious based on the USDA guidelines; and~~

~~WHEREAS, children with food allergies may pack school lunches to prevent allergic reactions to lunches provided by schools; and~~

~~WHEREAS, the Centers for Disease Control and Prevention, preeminent Children's Hospitals, and the American Osteopathic Association all support an all-inclusive approach to the treatment of childhood nutrition and wellness, including educational programs in the community and within schools, better access to healthier foods, and more physical activity within schools; now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association advocates a holistic approach with respect to childhood nutrition and wellness without mandates that force potentially food allergic children to purchase school lunches; and, be it further~~

~~RESOLVED, that upon successful passage of this resolution, a copy be submitted to the American Osteopathic Association for consideration and discussion at its 2012 House of Delegates meeting.~~

ACTION TAKEN: _____

Date: _____

Explanatory Note: *The intent of this resolution is being added to Res. No. 2017-04.*

RES. NO
2017-13

SUBJECT: Direct Primary Care

SUBMITTED BY: Marietta District Academy (IX) of Osteopathic Medicine

REFERRED TO:

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 provides patients with extensive benefits such as substantial savings in health care costs, improved patient access to care, increased time spent with their physician, improved preventive health care, and fewer emergency department visits; and

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

WHEREAS, that within the Affordable Care Act health insurance exchange rules, the US 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) make every effort to support the direct primary care model of practice and 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; 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 2017 AOA House of Delegates.

ACTION TAKEN: _____

DATE: _____

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 Primary Care:

An Alternative Practice Model to the Fee-For-Service Framework

Legal Concerns: The regulations governing the development of a Direct Primary Care practice varies from state to state. Contact your State Academy of Family Physicians and legal counsel in order to assure compliance with local insurance regulations.

What is direct primary care?

Direct primary care (DPC) is a subset model of the retainer-based practice framework for primary care practices. There is not a single DPC practice model; rather the model represents a broad array of practice arrangements that share a common set of characteristics. Perhaps the defining characteristic of DPC practices is that they offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. DPC practices are distinguished from other retainer-based care models, such as concierge care, by lower retainer fees, which cover at least a portion of primary care services provided in the DPC practice.

What is the retainer fee?

The practice retainer fee is a set recurring charge billed directly to patients to cover the comprehensive and coordinated primary care services provided by the DPC physicians and practice staff under the terms of a practice retainer or membership contract. The value of the practice retainer fees is most commonly based on the breadth of primary care services covered under the retainer contract.

The intent of the retainer fee structure in the DPC model is to ensure that family physicians are appropriately paid for the entire range of value-added services they provide for their patients. In the current fee-for-service (FFS) payment system, nearly 50% of a family physician's workday is spent outside of face-to face visits, often in conducting vital follow-up or helping to coordinate care for patients as they communicate with other clinical providers. Under FFS, these critical non-face-to-face services often go uncompensated. Under a DPC retainer fee, the practice can ensure that family physicians are appropriately compensated for providing comprehensive care, and not just the care provided during an office visit.

How does direct primary care differ from traditional primary care?

The opportunity to spend more time interacting with patients and providing ongoing follow-up services is at the heart of the patient-centered care provided in DPC practice settings. The regular and recurring revenue generated by the practice retainer fees allows physicians participating in DPC practices to overcome some of the pressures associated with the traditional FFS payment system. Because DPC physicians are no longer generating revenue solely on the basis of how many patients they see per day, many report that they have significantly more time to spend with patients in face-to-face visits. Additionally, many DPC physicians provide a larger array of non face-to-face services, such as tele-visits or e-visits, for their patients, to ensure primary care services can be accessed in a manner most convenient for patients and their families.

What is the difference between DPC practice models?

The variance between DPC practices is often found in the breadth of primary care services covered by their retainer contract fee structure. Some DPC practices have retainer fees that cover the entirety of primary care services, including care management and care coordination, as well as services involving external organizations such as off-site diagnostic facilities. This means that patients do not have to pay out of pocket for any services delivered to them through their DPC practice beyond the monthly retainer fee. Other DPC practices cover a far more limited scope of services and collect service fees from patients at the time of care to cover costs occurred in the visits. This is because these DPC practices continue to participate in traditional FFS contracts with third party insurance carriers but utilize the retainer fees to supplement their contracts. Typically, these retainer fee structures only cover services that would otherwise go unreimbursed under those insurance network contracts.

Why would I want to consider practicing in a DPC practice?

One of the most appealing aspects of the DPC model for family physicians is that the retainer fee payment structure can greatly simplify the business of operating a family practice. DPC practices report significantly reduced operating rates when compared with traditional primary care practices. This is primarily because DPC practices do not need to maintain staff dedicated to organizing, reviewing, filing, and managing payment claims to third-party payers. Further, because many DPC practices do not participate in contracts with private insurance carriers, they avoid the economic pressures of diminishing contract service rates. DPC practices that choose to continue participating in insurance carrier contracts can act in a far more proactive manner and participate in insurance contracts that are economically beneficial for the practice and its patients.

Additionally, many family physicians practicing in DPC settings report that the opportunity to spend more time with patients has resulted in improved professional satisfaction. This anecdotal evidence is bolstered by the evaluations and assessments that draw a connection between physicians' satisfaction and the duration of patient visits. Further, the simplification of practice administration and billing processes has resulted in an improved work-life balance for DPC physicians.

How will transforming into a DPC practice affect my patients?

The core result of the DPC practice model is that physicians and patients have the opportunity to spend more time interacting. The consequence of spending more time with each patient, however, is that family physicians practicing in a DPC setting typically have much smaller patient panels than they would in the traditional FFS system. Generally, DPC physicians have a panel of between 600 and 800 patients. In typical FFS settings, the patient panels tend to range from between 2,000 and 2,500 per family physician. This often results in patients losing access to their personal physicians if they elect to not participate in the DPC contract or if their physicians cannot take on new DPC contract patients.

Patients who do receive personal care in the DPC practice will find their primary care services significantly altered when compared with care received in traditional practice settings (e.g, increased time spent with their family physicians). There are a number of reported outcomes of increasing visit time, including improved patient experience of care , and improved clinical outcomes as patients become more engaged in managing their own health care.

DPC patients will also find it much easier to access their physicians and the DPC practice offices. This facilitates care that is timely and convenient. A number of DPC practices offer non-face-to-face visit options, such as e-visits, to empower patients to access care in a manner that best fits their needs. Additionally, many DPC practices also have expanded their operating hours while opening scheduling for same-day visits. Finally, some DPC practices provide patients a means to contact their physicians, or an on-call physician from the practice, 24 hours a day.

How will transforming into a DPC practice affect my current insurance contracts?

Physician owners and practice administrators of a DPC practice can choose whether to continue to participate in insurance carrier contracts. Many DPC practices elect to forgo insurance payment contracts and operate solely off of their patients' retainer fees and/or patient fees collected at the time of service. An immediate consequence of terminating an insurance carrier contract is that the practice will automatically be deemed as out-of-network. This may not have a significant impact on the practice, but it does affect patients who continue to receive health insurance coverage, either through an employer-sponsored plan or an individual market plan. The primary result is that insured patients who choose to receive care through a DPC practice may pay more out of pocket for primary care services.

Some DPC practices, however, do choose to continue participating in a smaller number of insurance plan contracts. The process for determining which insurance plans to continue accepting varies among DPC practices. Factors to consider in the determination process include:

- concentration of patients across contracted insurance carriers (i.e., payer mix);
- favorable contract payment rates for primary care services;
- timeliness of the plan's ability to process and pay out on a standing claim; and
- value-added practice support services that are deemed advantageous to the DPC practice.

If a DPC practice chooses to continue participating in a set of insurance plan contracts, the DPC practice providers must make clear to patients what medical services and procedures are covered by the insurance carrier contract. Many insurance carriers will not pay for services determined to be covered by the DPC retainer fee contract.

Can a DPC practice treat patients with insurance coverage?

Patients who receive health care insurance coverage, either through employers or individual insurance plans, can receive primary care in a DPC practice. This is true even if the DPC practice does not participate in any insurance contract. The reality is, however, that receiving care in a DPC setting can increase the responsibility of patients to manage their health care-related finances. Insured patients can typically receive reimbursement from insurance carriers for care received in a DPC practice via the claims process. The process typically requires the patient to submit an itemized bill for review and approval by the insurance carrier.

It is up to DPC practice owners and administrators to determine how much support the practice will provide to patients in managing claims. Some DPC practices provide fully itemized bills at each visit that can be submitted to insurance carriers. Others will submit itemized bills to insurance carriers as a non-participating practice on behalf of patients but elect to forgo managing the patient's ongoing claims-review process.

What about Medicare?

Direct primary care practices can continue to see Medicare beneficiaries, as long as the practice's retainer fee does not cover services already covered under Medicare. DPC practices seeking to include Medicare beneficiaries in their patient populations should contact a health care attorney familiar with retainer-based practice models to review the DPC retainer contract to ensure there is no conflict with Medicare's regulation of concierge care delivery.

How do I begin exploring the DPC model for my practice?

There are a few simple steps that any primary care practice can take to investigate the DPC model.

1. The first practical step is to conduct a practice evaluation to determine whether the practice would benefit from transforming into a DPC practice. As part of the evaluation process, practice administrators and physicians should, at the very least, address:
   - whether the practice physicians would be interested in spending more time with patients and would be willing to see fewer patients as a consequence;
   - current and ongoing practice management and operational cost trends;
   - current insurance carrier contracts in order to determine which, if any, could be carried over if the practice decides to undertake the DPC transformation. **Here** is a guide for how to begin evaluating your insurance carrier contracts from the *Journal of Family Practice Management;* and
   - receptivity of the practice's patient base to determine whether there is enough consumer interest to ensure a stable patient panel for the participating physicians.
2. The next step is to review the services of health care consultants or health care attorneys familiar with the DPC or other retainer-based models of care. These resources can provide insight about local and state regulations governing the practice of retainer-based medicine and whether current insurance carrier contracts may be amendable to complementary services covered under a retainer fee. If you cannot find an appropriate consultant or attorney, contact your state AFP chapter for references, or check the **AAFP's Buyer's Guide** resource listing.
3. Contact national DPC/concierge franchise operators to explore opportunities to establish a DPC practice under a franchise contract. The leading national franchise chains provide new DPC practices with proven business models and a corresponding body of practice resources (manuals, practice tools, and well-established operating guidelines), marketing material, and legal support staff. Typically, these franchise operators charge a percentage of a practice's retainer fee, as they are collected across a multiyear contract. In considering the resources provided by any franchise operator, practice leaders must weigh whether the diminished practice revenue is worth reduced administrative burden and support in undertaking the actual practice transformation process.

Informing patients about the DPC model

Perhaps the most important step for practices seeking to become DPC practices is that they keep the existing patient population well informed of the ongoing transformation. Practice leaders and staff must be as transparent as possible throughout the process, particularly because it is very likely that the practice will be unable to transition its entire patient base into the new DPC retainer contract framework.

Patients who choose to participate in the new practice delivery model must be made aware of what is entailed in the DPC practice arrangement: what services are covered under the retainer fee; how much patients are expected to pay, on an ongoing basis and at the time of visits; and what level of support the practice will provide for patients in managing their own claims.

Physicians and practice administrators in a new DPC practice should work even more diligently on behalf of patients who choose not to participate in the retainer contract and/or those who could not participate in the retainer contract due to patient panel constraints. The DPC practice should work to ensure that these patients find new primary care physicians. This is particularly true for high-risk patients. These efforts are critically important, because physicians bear an ethical mandate to not abandon patients **(AMA Code of Medical Ethics – Retainer Practices)** and could be subject to legal challenges if it is determined that they have violated this ethical guideline. **Here** is a recent article from the *Journal of Family Practice* outlining practical guidelines for ethically ending a patient relationship.

Direct Primary Care Resources:

The Direct Primary Care Coalition

The American Academy of Private Physicians

The American Medical Association's resources for "Cash-based Practices"

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

04/2014

acofp American College of Osteopathic Family Physicians

Direct Primary Care

Transform your practice.

Transforming a practice into a DPC takes time and resources, so many organizations are working to help doctors transition and market their practices. The Direct Primary Care Practice Model is one of the fastest growing models of primary care. Patients or their employers pay doctors directly – hence the name Direct Primary Care – versus working through insurance companies. Also patients have more direct access to doctors through same day appointments, more time with physicians and greater access to procedures, diagnostics and medications.

HOW DOES DPC BENEFIT PRIMARY CARE DOCTORS?

In a DPC model, patients pay what's called a periodic fee, which is usually on a monthly basis, but some physicians employ monthly, quarterly or yearly plans.

For that fee, patients have access to a full range of comprehensive primary care. The fee is designed to pay physicians for the range of duties that are involved with taking care of patients.

The fee-for-service system only pays physicians for seeing the patient in the office, while DPC physicians are free to spend larger amounts of time with the patients in a variety of settings from telephone visits and electronic visits – forms of patient care that's faster and more convenient for established patients.

WHAT DOES DPC DO FOR PATIENTS?

By using DPC physicians, patients end up paying less than if they use primary care insurance. In addition to the DPC retainer, patients typically buy what is called "wrap-around coverage" that takes care of emergency and hospital care.

Under the DPC model, patients are given more individualize care through ongoing follow ups and spend more time with their doctors who now have a small set number of patients.

HOW DOES DPC DIFFER FROM CONCIERGE MEDICINE?

Concierge medicine typically charges higher retainer fees for services than DPC. These types of practices also take insurance that covers primary services as the concierge fee is for services like same day appointment and 24-hours access to doctors that aren't covered in typical insurance plans. DPC retainer fees cover primary care services, so many DPC practices don't take any insurance, so physician overhead is less.

HOW DOES IT AFFECT INSURANCE COVERAGE FOR PATIENTS?

Physicians in DPC practices can treat patients who have insurance coverage through employer or individual plans. Privately insured patients may receive reimbursement for care through the claims process that they handle themselves instead of physicians' office, but this is rarely necessary due to the low cost.

HOW DO I TRANSFORM MY PRACTICE INTO A DPC?

The first step in transforming a practice to a DPC is to conduct a practice evaluation to determine whether a practice should take the next step. In that evaluation, physicians should ask how important it is for them to spend more time with patients, how it may affect practice management and operating costs and how current patient population may respond to the new model.

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| membership@acofp.org

RES. NO.
2017-16

SUBJECT: Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

SUBMITTED BY: Marietta (IX) District Academy of Osteopathic Medicine

REFERRED TO:

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

WHEREAS, the AMA emphasizes that the profession can increase awareness of racial and ethnic disparities in health care, 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; and

WHEREAS, a needs assessment for medical student cultural competency training revealed that "...many of the participating students—38.8 percent 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 percent) are uncomfortable with and unsure about how to approach culture-related issues arising in patient care"; and

WHEREAS, cultural competency is seen by ACGME as an important factor of patient care, professionalism, and interpersonal and communication skills; 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; 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 health care disparities; 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; 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; and

WHEREAS, to assist medical schools in their efforts to integrate cultural competency content into their curricula, the AAMC, supported by a Commonwealth Fund grant, has developed the Tool for Assessing Cultural Competence Training (TACCT); 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; 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"; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association encourages all osteopathic medical institutions in the US 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 a first step approach to integration into a longitudinal curriculum throughout UME years 1-4; 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.

ACTION TAKEN: _____

DATE: _____

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RES. NO.
2017-19

SUBJECT: Health Insurance Coverage for Residential Treatment and Inpatient Treatment of Eating Disorders

SUBMITTED BY: Marietta (IX) District Academy of Osteopathic Medicine

REFERRED TO:

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

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

WHEREAS, the estimated prevalence of adolescents and children with eating disorders of inpatient psychiatric admissions is 13.3 percent; and

WHEREAS, research studies have shown a 24 percent drop out rate of hospitalizations among patients suffering with eating disorders; 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 as physical illness; and

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

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

WHEREAS, research evaluating effective treatment of eating disorders have found competing events; for example, termination of insurance coverage competes with patient outcome; 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.

ACTION TAKEN: _____

DATE: _____

Explanatory Note: *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. The authors of this resolution would like to see progress to move forward with this nationally.*

Missouri 2015 Senate Bill 145
Requires health benefit plans cover diagnosis and treatment of eating disorders
Summary: requires health insurance to provide coverage for the diagnosis and treatment of eating disorders. The act further requires that the provided coverage include a broad array of specialist services as prescribed as necessary by the patient's treatment team. Coverage under this act is limited to medically necessary treatment and the treatment plan must include all elements necessary for a health benefit plan to pay claims. Under the act medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with the eating disorder and shall not be based solely on weight. Coverage may be subject to other general exclusions and limitations of the contract or benefit plan not in conflict with the act.

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Ad Hoc Reference Committee

Purpose: To consider resolutions not having a specific category.

Resolutions: 11, 14, 15, 18, & 21

Members:

Henry L. Wehrum, DO, Chair (District VI)
Chelsea A. Nickolson, DO (District III)
Lili A. Lustig, DO (District VII)
Charles D. Milligan, DO (District VIII)
Michael E. Dietz, DO (District IV)
Melinda E. Ford, DO (District IX)
Carol Tatman (Staff)

Lilac Room

RES. NO.
2017-11

SUBJECT: A Strategic Vision for Osteopathic Medicine in Ohio

SUBMITTED BY: OOA Executive Committee

REFERRED TO:

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 health systems and osteopathic physicians in delivering principle centered medicine and achieving the quadruple aim through the practice of 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 identity.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-14

SUBJECT: Maintaining Effective Therapies for Patients

SUBMITTED BY: District VIII (Akron-Canton) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, there is a national trend for insurance companies to discontinue covering 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 health care 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 makes the insurance plan 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 Ohioans from medical plans demanding that their enrollees discontinue/change medications that have been safe and effective based on a change in formulary only.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-15

SUBJECT: Step Therapy and Fail First Medication Policies

SUBMITTED BY: OOA Health Policy Committee

REFERRED TO:

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 delay 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.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-18

SUBJECT: Increased AOA Promotion of Primary Care and Osteopathic Manipulative Medicine Research

SUBMITTED BY: Marietta (IX) District Academy of Osteopathic Medicine

REFERRED TO:

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

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

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

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

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

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

WHEREAS, the mission statements of a majority of colleges of osteopathic medicine (COMs) mention the goal of producing primary care physicians; 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 areas; 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; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) promote the furthering of both primary care and osteopathic manipulative research and publications out of the colleges of osteopathic medicine schools; and, be it further

RESOLVED, that the OOA create more opportunities and implement support for osteopathic medical students participating in research.

ACTION TAKEN: _____

DATE: _____

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SUBJECT: Increasing Student Involvement in the Ohio Osteopathic Association

SUBMITTED BY: Marietta (IX) District Academy of Osteopathic Medicine

REFERRED TO:

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 profession; 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 four delegates and four alternate delegates to the OOA House of Delegates. Of the student delegates and alternate delegates, two delegates shall be selected by the student council of the college, two delegates shall be determined by the executive dean of the college from students in the third- and fourth-year classes, and the alternate delegates shall be determined by the executive dean of the college."; 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 official modes for student involvement in the OOA. The task force shall be co-chaired by the OOA president and the president-national representative of the OUHCOM student government association and be comprised of physicians appointed by the OOA president and students appointed by the OUHCOM executive dean. The task force shall submit a report of its conclusions, and any related resolutions, to the following year's House of Delegates.

ACTION TAKEN: _____

DATE: _____

References

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

Constitution & Bylaws Reference Committee

Purpose: To consider the wording of all proposed amendments to the constitution, bylaws, the code of ethics, and existing policy statements as assigned.

Resolutions: 1, 2, 3, 4, 6, & 7

Members:

Sandra L. Cook, DO, Chair (District VII)
Nicholas G. Espinoza, DO (District I)
Robert L. Hunter, DO (District III)
Ying H. Chen, DO (District VI)
Jean S. Rettos, DO (District IX)
John J. Vargo, DO (District X)
Jon Wills (Staff)

New Albany Board Room

RES. NO.
2017-01

SUBJECT: Reaffirmation of Existing Policy Statements

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENTS BE REAFFFIRMED ACCORDING TO THE FIVE YEAR POLICY REVIEW RULE:

1 - Continuing Medical Education, State-Mandated, Subject Specific

RESOLVED that the Ohio Osteopathic Association (OOA) continues to oppose any legislation that would mandate subject-specific Continuing Medical Education (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 Health Policy Committee and staff 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 health care issues requiring legislative action; and be it further;

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

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

RESOLVED that the Ohio Osteopathic Association (OOA) continues to support 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)*

3 - Direct Payment by Insurers

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

4 - Disability Coverage for Physicians Who Are HIV Positive

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

5 - Driving Under the Influence of Alcohol and Other Mind-Altering Substances

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

6 - Emergency Department Utilization

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

7 - Immunization Initiatives

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

8 - Information Technology Adoption and Interchange

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)*

9 - Managed Care Plans, Standardized Reporting Formats

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)*

10 - Medicare Mandatory Assignment

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

11 - Nursing Facilities, Tiered

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

12 - OOA Smoking Policy

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

environment with such policy to be enforced by the OOA Executive Director. *(Original 1987)*

13 - Physicians Exclusive Right to Practice Medicine

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

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

14 - Physician Fines by Third Party Payers

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)*

15 - Pre-Authorized Medical Surgical Services, Denial of Payment

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to support legislation that would prohibit any health care 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*

16 - Preventive Health Services

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

17 - Quality Health Care, the Role of Medical Staffs and Hospital Governing Bodies

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

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

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

18 - Quality of Life Decisions

RESOLVED, that the Ohio Osteopathic Association and its members continue to participate in ongoing

debates, decisions and legislative issues concerning quality of life, dignity of death, and individual patient decisions and rights. *(Original 1992)*

19 - Reimbursement Formulas for Government Sponsored Health Care Programs

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

RESOLVED, if payment for services cannot be at acceptable, usual, customary and reasonable levels, that the OOA 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)*

20 - School Bus Safety Devices

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

21 - Telemedicine

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 State Medical Board of Ohio and other Ohio physician organizations to develop laws and 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)*

22 - Third Party Payers, DO Medical Consultants

RESOLVED that the Ohio Osteopathic Association continues to urge all third party insurers doing business in Ohio to hire osteopathic physicians (DOs) as medical consultants to review services provided by osteopathic physicians 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)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-02

SUBJECT: Antibiotics for Medical Treatment, Preservation of

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AS FOLLOWS AND AFFIRMED:

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)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-03

SUBJECT: Managed Care Plans, Quality Improvement and Utilization Review

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT BE AMENDED AS FOLLOWS AND AFFIRMED:

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-04

SUBJECT: Osteopathic Practice and Principles Through the Continuum of Osteopathic Education

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

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

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

RESOLVED, that ~~this process of establishing clear and demonstrable osteopathic components for each clinical rotation should extend into all accredited osteopathic residency programs and incorporated into the curricular standards of the osteopathic postdoctoral training institution (OPTI) programs~~ 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 ~~American Osteopathic Association in implementing such standards through the Bureau of Professional Education and the OPTI Task Force., as directed by Resolution 306, passed by the American Osteopathic Association House of Delegates in 1997.~~ transition to the ACGME Single Accreditation System *(Original 1997, amended and affirmed 2002, reaffirmed 2007)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-06

SUBJECT: Tobacco Control

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

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

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 in private homes and vehicles when children are present;
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 ~~the position statements of Tobacco Free Ohio and the Ohio Tobacco Control Resource Group~~ 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.

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2017-07

SUBJECT: Western Reserve Academy of Osteopathic Medicine

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING RESOLUION APPROVED IN 2012 BE DELETED FROM THE POLICY MANUAL:

~~WHEREAS, the 2011 Ohio Osteopathic Association House of Delegates approved a three-year Strategic Plan, which in part called for creation of an Ad Hoc Committee to reduce the number of OOA districts; and~~

~~WHEREAS, the OOA Board of Trustees has appointed a strategic committee of the OOA Board focused on governance and redistricting; and~~

~~WHEREAS, the Board Governance Committee has discussed preliminary strategies for redistricting, but believes that any changes in OOA Districts must be accomplished methodically and in consultation with the membership in each district; and~~

~~WHEREAS, the leadership of the Warren and Youngstown academies held a meeting on April 4, 2012, and recommended the creation of a new district in Northeast Ohio to be known as the Western Reserve Academy of Osteopathic Medicine; and~~

~~WHEREAS, the OOA Board of Trustees approved the recommendations of the Warren-Youngstown Academy leadership work by poll vote; and~~

~~WHEREAS, Article I, Section 1, of the OOA Bylaws gives the OOA Board of Trustees the authority to divide the state into districts; and~~

~~WHEREAS, Article I, Section 2, requires any redistricting involving more than one county to be also approved by the OOA House of Delegates; now, therefore be it~~

~~RESOLVED, that the OOA House of Delegation approve Phase I of the OOA Board of Trustees' Strategic Redistricting Plan by creating a new district to be known as the Western Reserve Academy of Osteopathic Medicine, by combining the geographical area formerly comprising the Warren and Youngstown academies, which includes Trumbull, Mahoning, Columbiana, Carroll, Jefferson, and Harrison Counties. *(Original 2012)*~~

ACTION TAKEN: _____

DATE: _____

***Explanatory Note**: The formation of the Western Reserve Academy of Osteopathic Medicine has been completed with required amendments to the OOA Constitution and Bylaws enacted.*

APPENDIX

EXECUTIVE COMMITTEE 2016-17

President	Geraldine N. Urse, DO
President-Elect	Sean D. Stiltner, DO
Vice President	Jennifer J. Hauler, DO
Treasurer	Charles D. Milligan, DO
Immediate Past President	Robert W. Hostoffer, Jr., DO
Executive Director	Mr. Jon F. Wills

BOARD OF TRUSTEES 2016-17

DISTRICT		TERM EXPIRES
NW OHIO-I	Nicholas G. Espinoza, DO	2017
LIMA-II	Wayne A. Feister, DO	2017
DAYTON-III	Nicklaus J. Hess, DO	2017
CINCINNATI-IV	Michael E. Dietz, DO	2017
SANDUSKY-V	Gilbert S. Bucholz, DO	2019
COLUMBUS-VI	Henry L. Wehrum, DO	2019
CLEVELAND-VII	John J. Wolf, DO	2019
AKRON/CANTON-VIII	Douglas W. Harley, DO	2018
MARIETTA-IX	Jennifer L. Gwilym, DO	2019
WESTERN RESERVE-X	John C. Baker, DO	2019
RESIDENT	Ryan K. Martin, DO	*
OU-COM STUDENT	Alyssa Ritchie, OMS II	2017

***Individual serves until a successor is appointed.**

NEW TRUSTEES 2017-18

Northwest	Nicholas G. Espinoza, DO, DO	2020
Lima	Wayne A. Feister, DO	2020
Dayton	Nicklaus J. Hess, DO	2020
Cincinnati	Michael E. Dietz, DO	2020
Cleveland	Katherine H. Eilenfeld, DO	2019
Sandusky	Luis L. Perez, DO	2019
Resident	Ryan K. Martin, DO	*
OU-COM Student Rep.	Scott Wang, OMS I	2018

2016-17 DISTRICT PRESIDENTS AND SECRETARIES

DISTRICT	PRESIDENT	SECRETARIES
I	Nicholas J. Pfleghaar, DO	John T. Rooney, DO
II	John C. Biery, DO	Lawrence J. Kuk, Jr., DO
III	Ruth M. Thomson, DO	H. Brent Bamberger, DO
IV	Michael E. Dietz, DO	Scott A. Kotzin, DO
V	Nicole J. Barylski-Danner, DO	James E. Preston, DO
VI	Alex S. Tsai, DO	Carrie A. Lembach, DO
VII	John J. Wolf, Jr., DO, DO	Katie Pestak, DO
VIII	Mark J. Tereletsky, DO	David A. Bitonte, DO
IX	Melinda E. Ford, DO	Timothy D. Law, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2017-18 DISTRICTS PRESIDENTS AND SECRETARIES

DISTRICT	PRESIDENT	SECRETARIES
I	Nicholas J. Pfleghaar, DO	John T. Rooney, DO
II	John C. Biery, DO	Lawrence J. Kuk, Jr.
III	Christine B. Weller, DO	Jeffrey S. Rogers, DO
IV	Michael E. Deitz, DO	Scott A. Kotzin, DO
V	Nicole J. Barylski-Danner, DO	John F. Ramey, DO
VI	Adele M. Lipari, DO	Jeffrey A, Madachy, DO
VII	Christopher J. Loyke, DO, DO	Katherine H. Eilenfeld, DO
VIII	Mark J. Tereletsky, DO	David A. Bitonte, DO
IX	Melinda E. Ford, DO	Timothy D. Law, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2017 OOA DELEGATES AND ALTERNATES

Academy	Voting Members	Delegates/ Votes	Delegates	Alternates
Northwest Ohio	70	5/14	Nicholas G. Espinoza, DO, Chair Roberta J. Guibord, DO Jennifer L. Pfleghaar, DO Nicholas J. Pfleghaar, DO Roger L. Wohlwend, DO	All Northwest Ohio Members
Lima	28	2/6	John C. Biery, DO, Chair Edward E. Hosbach, DO	All Lima Members
Dayton	195	13/39	Ruth M. Thomson, DO, Chair Barbara A. Bennett, DO Cleanne Cass, DO Jennifer J. Hauler, DO Nicklaus J. Hess, DO Robert L. Hunter, DO Mark S. Jeffries, DO Kimbra L. Joyce, DO Gordon J. Katz, DO Paul A. Martin, DO Chelsea A. Nickolson, DO Jessica L. Tyler, DO Christine B. Weller, DO	All Dayton Members
Cincinnati	36	2/7	Sean D. Stiltner, DO, Chair Michael E. Dietz, DO	All Cincinnati Members
Sandusky	50	3/10	John F. Ramey, DO, Chair Gilbert S. Bucholz, DO Luis L. Perez, DO	All Sandusky Members
Columbus	229	15/46	Adele M. Lipari, DO, Chair Peter A. Bell, DO David L. Bowman, DO William J. Burke, DO Ying H. Chen, DO John A. Cocumelli, DO Mark W. Garwood, DO Paige S. Gutheil Henderson, DO Ronald K. Routh, DO Albert M. Salomon, DO Gary L. Saltus, DO Eugene F. Trell, DO Geraldine N. Urse, DO Charles G. Vonder Embse, DO Henry L. Wehrum, DO	All Columbus Members Tejal R. Patel, DO Maury L. Witkoff, DO
Cleveland	122	8/24	John J. Wolf, Jr., DO, Chair Sandra L. Cook, DO Robert W. Hostoffer, Jr., DO Lawrence K. Lief, DO Christopher J. Loyke, DO Lili A. Lustig, DO Phillip A. Starr, III, DO George Thomas, DO	All Cleveland Members
Akron/Canton	147	10/29	Douglas W. Harley, DO, Chair	All Akron-Canton Members

			David A. Bitonte, DO Charles D. Milligan, DO Eugene D. Pogorelec, DO Christine M. Samsa, DO Nathan P. Samsa, DO M. Terrance Simon, DO Mark J. Tereletsky, DO John F. Uslick, DO Schield M. Wikas. DO	
Marietta	107	7/21	Melinda E. Ford, DO, Chair Hilary S. Haack, DO Militza Lozada, DO Jean S. Rettos, DO Anthony L. Randich, DO Edward W. Schreck, DO	All Marietta Members
Western Reserve	78	5/16	Sharon L. George, DO, Chair John C. Baker, DO E. Lee Foster, DO John J. Vargo, DO Robert M. Waite, DO	All Western Reserve Members
OU-COM	1	1/1	Scott Wang, OMS I	Nate Ogletree, OMS I

House of Delegates

Authority/Responsibilities from Constitution and Bylaws:

1. Is the policy-making body of the Association. *(Constitution, Article VI)*

2. Is composed of one delegate for each 15 (or major fraction thereof) of OOA regular members within each district. *(Constitution, Article VI)*

3. Delegates and alternates must be regular members in good standing of the OOA and district and shall serve for 12 months. *(Bylaws, Article V, Section 1 (a))*

4. Each delegate shall receive at least one vote. In addition, each district receives one vote for each five members, which may be cast by one delegate or divided among the delegation as decided by the delegation in caucus; votes shall be proportionate to delegates registered by the Credentials Committee. *(Bylaws, Article V, Section 3)*

5. Determines the time and place of the annual session, which may be changed by the Board of Trustees should necessity warrant. *(Constitution, Article X)*

6. May confer honorary memberships by a two-thirds vote and on approval by the Board of Trustees. *(Bylaws, Article II, Section 5)*

7. Must concur in levying assessments, which may not exceed the amount of annual dues. *(Bylaws, Article IV, Section 1; Fees and Dues Administrative Guide)*

8. Shall convene annually preceding the annual convention or upon call by the president. *(Bylaws, Article V, Section 5)*

9. Shall hold special meetings upon the call of the President or upon written request by three district academies, provided the request has been passed by a majority of the academy membership at a regular or special meeting of the district. Must be given two weeks' notice and the object of the meeting must be stated. *(Bylaws, Article V, Section 5)*

10. Must have a quorum of one-third the voting members to transact business. *(Bylaws, Article V, Section 6)*

11. Is governed by Roberts Rules of Order Newly Revised, the order of business, and any special rules adopted at the beginning of the sessions unless suspended by a two-thirds vote. *(Bylaws, Article V, Section 7)*

12. Nominates and elects OOA officers. *(Bylaws, Article VI, Section 1)*

13. Nominates and elects delegates and alternates to the AOA House. *(Bylaws, Article VI, Section 4)*

14. Must refer all resolutions, motions, etc. involving the appropriation of funds to the Executive Committee and Board of Trustees without discussion. A negative recommendation from the

Board/Executive Committee may be overruled by a three-fourths vote by the House. *(Bylaws, Article VIII, Section 2)*

15. May amend the Constitution by two-thirds vote, provided the amendment has been presented to the Board of Trustees and filed with the Executive Director at a previous meeting of the Board. The amendment must be published in the Buckeye Osteopathic Physician no less than one month nor more than three months prior to the meeting where it will be considered. *(Constitution, Section X)*

16. May amend the Bylaws by two-thirds vote, but the amendment must be deposited to the OOA Executive Director at least 90 days in advance of the meeting. The Board may revise the amendment to ensure conformity. The amendment must be circulated to the membership by written communication at least one month prior to the session. *(Bylaws, Article XII)*

Authority Given by the Ohio Osteopathic Foundation Code of Regulations

1. Shall elect six trustees of the Ohio Osteopathic Foundation Board to three-year terms. *(OOF Code of Regulations, Article IV, Section 1 (c))*

Nominating Committee

The Speaker OOA shall appoint a nominating committee, and the charge of this committee shall be to interview/review potential candidates for OOA officers and recommend candidates for each office. The committee shall operate under the following guidelines (Resolution 98-13):

1. The nominating committee shall consist of six (6) members, one member each from districts III (Dayton), VI (Columbus), VII (Cleveland), VIII (Akron-Canton) and two (2) that are selected from the I (Toledo), II (Lima), IV (Cincinnati), V (Sandusky), IX (Marietta) and Western Reserve, X districts collectively.

2. Each of the six committee members will be selected by their respective academies and their names shall be presented to the Speaker of the OOA House of Delegates for appointment.

3. This committee shall meet at least twice annually after its appointment.

4. This committee will conduct interviews with candidates for each of the following offices: president-elect, vice president, and treasurer.

5. A slate of candidates shall be presented to the OOA president and executive director thirty (30) days in advance of the OOA annual meeting. The slate with a brief description of each candidate's qualifications shall be printed in the House of Delegates Manual and the names of these candidates shall be placed in nomination by the Chairman of the Nominating Committee during the annual OOA meeting. Additional nominations may be made from the floor of the OOA House of Delegates. The slate shall include candidates for Speaker, Vice Speaker and OOF Trustees to be elected by the House.

6. Candidates for OOA officers shall obtain endorsements from and be presented through district academies. Every effort shall be made to continue the current rotational system in the selection of these candidates to ensure that different regions of the state are represented on the OOA Executive Committee.

7. Current members of the nominating committee shall not be candidates for OOA office and shall not be incoming officers of the OOA.

8. The Chairman of this committee will be elected by the committee members annually.

9. The committee shall also present a slate of nominees to serve as delegates and alternates to the AOA House of Delegates in consultation with the Chairman and vice-chairman of the Ohio Delegation. Names shall be placed in nomination by the Nominating Committee Chairman and additional nominations may be made from the floor of the OOA House of Delegates.

10. In the event that any duly appointed nominating committee member resigns or is unable to serve following his/her appointment, the academy(ies) which that member represent(s) shall select a replacement. Committee members are expected to serve on a long-term basis, and once appointed shall continue to serve until the respective academy selects and presents a successor to the Speaker of the House for appointment.

House Officers and Committees

Speaker Of The House

1. Elected annually by the House of Delegates (Constitution, Article VII)
2. Presides over the House of Delegates (Bylaws, Article X, Section 9)
3. Appoints Nominating Committee in accordance with resolution no 98-13.
4. Appoints Reference Committees. (Standing Rule No. 9)
5. Assigns resolutions to Reference Committees (Standing Rules Nos. 10 and 12)
6. May attend OOA Board of Trustees and Executive Committee meetings, without vote and shall serve as Parliamentarian (Bylaws, Article X, Section 9)
7. With the assistance of the Constitution and Bylaws Committee, reviews all proposed amendments to ensure proper format.
8. Determines whether a registered parliamentarian should be employed or not prior to the annual session.
9. May editorially correct resolutions prior to the printing in the manual upon notification to the originator of the resolution.
10. Serves as chairperson of the Committee on Standing Rules.
11. May sit ex officio in any reference committee meeting.

Vice Speaker

1. Elected annually by the House of Delegates (Constitution, Article VII)
2. Presides as Speaker of the House in the absence of the Speaker or at the Speaker's request (Bylaws, Article X, Section 9)
3. May sit ex officio in any reference committee meeting (Bylaws, Article X, Section 10)
4. Performs such other duties as assigned by the Speaker (Bylaws, Article X, Section 10)

Secretary

1. Appointed by the President (Bylaws, Article X, Section 1)
2. Handles all correspondence concerning the House of Delegates (Bylaws, Article X Section 1)

3. Makes sure that all deadlines are met with proper notice
4. Prepares the House of Delegates Manual
5. With the Executive Director, determines and certifies the number of delegates and alternates to the districts.
6. Maintains accurate minutes of the proceedings
7. Sends certifications to AOA delegates and alternates and prepares resolutions and forms for referral to the AOA.
8. Consults with the Speaker of the House prior to the annual session

Credentials Committee

1. Shall consist of at least two members appointed by the President (Bylaws, Article V, Section 4)
2. Receives and validates the credentials of delegates/alternates
3. Maintains a continuous roll call
4. Determines the presence of a quorum
5. Monitors voting and election procedures
6. Makes recommendations on the eligibility of delegates and alternates to a seat in the House when a seat is contested

Committee on Standing Rules

1. Shall consist of the Speaker of the House, the vice speaker of the House, the OOA President, and the Executive Director
2. Shall periodically review the standing rules of the House and recommend amendments 30 days prior to the House
3. Shall present such rules to the House for adoption

Program Committee

1. Shall consist of the President-Elect (Chairman), President, Executive Director and Immediate Past President
2. Shall review previous agendas and approve proposed agendas in consultation with the Executive Director

3. Shall present the agenda for approval at the House

Resolutions Committee

1. Shall consist of the Speaker, Vice Speaker, Secretary of the House and Executive Director
2. Shall review existing OOA policies no later than five years after each policy is passed for reconsideration by the full house
3. Shall recommend that such policies be reaffirmed, amended, substituted or deleted based on any subsequent action that has occurred during the five year period.
4. Shall review all new resolutions prior to the House to determine whether existing policies already exist at the state or AOA levels or whether the proposed resolution conflicts with existing policies. Such findings shall be reported to the appropriate reference committee.
5. Shall editorially correct any resolutions following the House, so they can be submitted to the AOA House of Delegates in the proper format

Referral of Business to Reference Committees

1. The Speaker of the House shall assign resolutions and other business to reference committees as part of the published agenda. The House, at its discretion, may refer a resolution to a different reference committee and accept new resolutions for assignment as defined in the Standing Rules.
2. The Speaker of the House may refer other items of business to a reference committee during the course of business.

Reference Committees

1. Shall consist of duly elected delegates or seated alternates
2. Shall consist of at least five members from five different academies appointed by the Speaker.
3. Committee members shall serve a one-year term, commencing with the annual meeting
4. Individual members should:
   a. Review resolutions prior to the House of Delegates
   b. Research issues involving resolutions
   c. Listen to testimony and maintain objectivity
   d. Notify the Speaker of the House in the event s/he cannot attend the meeting and recommend a replacement from his/her academy

Reference Committee Duties and Responsibilities

1. The primary responsibility of a reference committee is to recommend to the House an appropriate course of action on matters that have been placed before it. This duty should be accomplished by: evaluating all resolutions received by the committee, basing recommendations

on the best information and advice that is available, and making decisions in the best interests of the public and the profession.

2. Reference committees should NOT attempt to prevent the House from taking action on any matter that has been presented, nor should they automatically accept the opinions of their own committee members or the opinions of those who have testified without deliberation.

3. The reference committee fulfills its duty after thoughtful deliberation by advising the House to approve, disapprove, amend, postpone, or replace by a substitute resolution, any resolution that has been placed before it.

4. Reference committees must act within the standing rules of the House and within the framework of the Constitution and Bylaws. The reference committees may not only recommend action on resolutions before them but may also propose resolutions on their own initiative. They may call upon officers or members of the staff when they desire to gain information. They may make an explanation of the committee's decision before recommending to the House that a resolution be approved, disapproved, amended, postponed or replaced by a substitute resolution.

Reference Committee Hearings and Duties of the Chair

1. Reference committee hearings are conducted to receive and evaluate opinions so that the committee may present well-informed recommendations to the House.

2. Opinions are received during the open hearing that is conducted by the reference committee. During actual deliberations of the committee, the committee and its staff will meet in executive session.

3. All members of the OOA have the right to attend reference committee hearings and participate in the discussion, whether or not they are members of the House of Delegates.

4. The chair of the reference committee should carry out the usual duties of a chair in maintaining order, facilitating the transaction of business and in ruling on length and pertinence of discussion during both the public and executive sessions.

5. The chair should not permit the making of motions or the taking of formal votes at an open hearing, since the objective of the hearing is to receive information and opinions and not to make decisions of any sort that would bind the reference committee in its subsequent deliberations. The final motions should be held in executive session.

6. The chair, with consent of the committee, may impose reasonable time limits on discussion and debate to ensure all can be heard.

Reference Committee Reports

7. Reference committee reports are nothing more than comments and recommendations regarding resolutions and business assigned to the reference committee.

8. All reference committee reports are submitted in the standardized form described below.

9. Reference committees should ensure that resolutions are worded with the utmost clarity and only contain a single topic. Resolutions containing more than one topic must be divided so that the House can vote intelligently on each unrelated issue individually.

10. Each reference committee Chair shall review and approve the reference committee report prior to publication. The chairs should coordinate this activity with their reference committee secretaries.

11. Each reference committees report shall be presented to the House of Delegates by the chair and/or the vice chair of the respective committee.

Reference Committee Written Reports and Presentation to the House

1. Recommendations by reference committees shall be incorporated into a written report and the recommended action for each resolution shall be stated in the following format for oral presentation during the House: "I present for consideration Resolution ___ ; (followed by one of the following options):

   - the Committee recommends it be approved and I so move"; or,
   - the Committee recommends it be amended as follows and approved ("old material crossed out", and "new material underlined"), and I so move." (*All proposed amendments should be shown by line number.)* or,
   - the Committee recommends that it be amended by substitution as follows and approved (*include substitute resolution in entirety if not already included in the manual as a five-year review of an existing policy that is being substituted*)
   - the Committee recommends it be disapproved. "To start debate, I move the Resolution be approved". *(Important note: All motions pertaining to resolutions are presented in the positive. When conducting the vote to disapprove a resolution, the Speaker of the House will instruct the House with the following statement: "If you agree with the recommendation of the Committee, you will vote "nay", against the Resolution.")*

2. All reference committee reports must be approved by the chairs of reference committees prior to publication. The chair should make arrangements with staff to edit, correct and approve reports with secretarial staff assigned to the committee.

3. A resolution or motion, once presented to the House, may be withdrawn only by permission of the Delegates.

House of Delegates Code of Leadership

The mission of the AOA, as established by the AOA Board of Trustees and the AOA House of Delegates, is to serve the membership by advancing the philosophy and practice of osteopathic medicine and by promoting excellence in education, research, and the delivery of quality cost-effective healthcare in a distinct, unified profession.

The mission of the Ohio Osteopathic Association (OOA) as established by the OOA Board of Trustees is to partner with our members in order to create, provide and promote programs, services and initiatives that prepare osteopathic physicians (DOs) to thrive now and in the future; to educate the public; and to promote legislative and regulatory initiatives that allow DOs to continue to provide excellent and comprehensive health care. The OOA Constitution further defines the purpose of the state association to include the following:

- To promote the public health of the people of Ohio;
- To cooperate with all public health agencies;
- To maintain high standards at all osteopathic institutions within the state;
- To maintain and elevate osteopathic medical education and postgraduate training programs in the prevention and treatment of disease;
- To encourage research and investigation especially that pertaining to the principles of the osteopathic school of medicine;
- To maintain the highest standards of ethical conduct in all phases of osteopathic medicine and surgery; and
- To promote such other activities as are consistent with the above purposes.

As a Delegate to the Ohio Osteopathic Association's House of Delegates, I am fully committed to the American Osteopathic Association and the Ohio Osteopathic Association and their missions. I recognize that serving as a representative of an OOA District Academy carries additional responsibilities and obligations to support the activities of the American Osteopathic Association and the Ohio Osteopathic Association. As a leader, my decisions and actions must be guided by what is best for osteopathic medicine and the American Osteopathic Association and Ohio Osteopathic Association. To this end, I pledge to honor and promote the American Osteopathic Association and the Ohio Osteopathic Association and their missions by following three guiding principles:

I. I will maintain and strengthen the **Vision** of the AOA and OOA as defined by the OOA and AOA Boards of Trustees and the AOA and OOA House of Delegates, as demonstrated by…
   - Defining with other Delegates the mission of the Associations and participating in strategic planning to review the purposes, programs, priorities, funding needs, and targets of achievement.
   - Being a role model by participating in osteopathic philanthropy, encouraging DO colleagues to do the same, and by encouraging my spouse to participate in the Auxiliaries.
   - Publicly promoting the Associations' policies within the osteopathic family and to the public.

II. I will conduct myself with the highest level of **Integrity** to honor the AOA and the OOA and to support the highest ideals of the osteopathic profession for which they stand, as demonstrated by…

- Accepting the bylaws of the Associations and understanding that I am morally and ethically responsible for the health and vitality of the Associations.

- Leading the way by being an enthusiastic booster and a positive advocate for the Associations, and extend that enthusiasm to the Associations' affiliates and auxiliary groups.
- Accepting that every Delegate is making a statement of faith about every other Delegate, we trust each other to carry out this Code to the best of our ability.

III. I will be **Competent** in my actions and decisions for the AOA and OOA, as demonstrated by…

- Fulfilling my financial responsibilities by reviewing and approving the OOA's annual budget.
- Making myself available to attend the OOA House of Delegates' annual meeting, serving on committees as assigned, and being prepared for the annual meeting by reading the agenda and other materials.

Understanding that the House of Delegates is the legislative body of the OOA, exercising the delegated powers of the divisional societies in the affairs of the AOA and performing all other duties as described in the OOA Bylaws.