OHIO OSTEOPATHIC ASSOCIATION
Actions by the 2017 House of Delegates

Submitted by OOA Executive Director Jon F. Wills

The OOA House of Delegates met, April 22-23, during the Ohio Osteopathic Symposium. Delegates representing the OOA's ten districts debated 21 resolutions. Ten new policy statements were approved. Those resolutions covered a range of topics -- Physician Burnout, Conversion Therapy, Direct Primary Care, Cultural Competency, Health Insurance Coverage for Eating Disorders; OOA Strategic Vision; Maintaining Effective Therapies; Step Therapy; Increased OOA Promotion of Primary Care and OMT; and Increasing Student Involvement in the OOA. Five resolutions were forwarded to the AOA House of Delegates for consideration at the July meeting.

During the Symposium, Sean D. Stiltner, DO, of Piketon, was installed as OOA president. Other elected officers include: President-elect Jennifer J. Hauler, DO, of Dayton; Vice President Charles D. Milligan, DO, of Orville; and Treasurer Sandra Cook, DO. Immediate Past President Geraldine N. Urse, DO, of Columbus, 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 Mark S. Jeffries, 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. Henry L. Wehrum, DO, of Columbus, chaired the Ad Hoc Committee and the following served on the panel: Amber Richardson, DO, Lili A. Lustig, Charles D. Milligan, DO; Michael E. Dietz, DO, Melinda E. Ford, DO, and Carol Tatman. Sandra L. Cook, DO, of Cleveland, chaired the Constitution & Bylaws Committee. Committee members included Nicholas G. Espinoza, DO; Robert L. Hunter, DO; Ying H. Chen, DO; Jean S. Rettos, DO; John J. Vargo, DO; and David A. Bitonte, DO. The Professional Affairs Committee was led by Douglas W. Harley, DO with committee members, Roger L. Wohlwend, DO; Kimbra L. Joyce, DO; K. Ronald Routh, DO; Phillip A. Starr, III, DO; Hilary S. Haack, DO, and Cheryl Markino. Nicholas J. Hess, DO, led the Public Affairs Committee. Edward E. Hosbach, II, DO; Luis L. Perez, DO; Paige S. Gutheil Henderson, DO; Schield M. Wikas, DO; and Scott Wong, OMS I, and Jon F. Wills served on the committee. John F. Ramey, DO, of Sandusky, chaired the Credentials Committee. Delegates adopted ten new positions. The full text of those resolutions is printed here.

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, the Maslach Burnout Inventory (MBI), consisting of 22 items that measure all three burnout dimensions is the most frequently used, highly regarded questionnaire for burnout in medical research literature14; and

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

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

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

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

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

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

Explanatory Statement

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

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<u>Actions Taken Since the Resolution Passed</u>: This resolution was submitted for consideration at the 2017 American Osteopathic Association House of Delegates. The OOA delegation withdrew the resolution because the AOA is already working on physician wellness initiatives. As a result, an OU-HCOM student representative was added to the AOA Committee.

In Ohio, OOA has joined the Ohio Physician Wellness Coalition, which is coordinated by the Ohio Physicians Health Program. OPWC is dedicated to addressing physician burnout and providing physician wellness initiatives. Members of the OPWC include: Ohio State Medical Association, Ohio Osteopathic

Association, The Academy of Medicine of Cleveland and Northern Ohio, Ohio Psychiatric Physicians Association, Ohio Academy of Family Physicians, Ohio Hospital Association, Columbus Medical Association, Ohio Physicians Health Program, Ohio Chapter, American Academy of Pediatrics, and Ohio Chapter, American College of Emergency Physicians. Sandra L. Cook, DO, serves as the OOA Representative on the Physician Advisory Committee.

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

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

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

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

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

WHEREAS, the practice of "Conversion Therapy" or "Reparative Therapy" does not include counseling or therapy for an individual seeking to transition or transitioning from one gender to another gender; that provides acceptance, support, and understanding of an individual; or the facilitation of an individual's coping, social support, and identity exploration and development; including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity 4; and

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

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

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

RESOLVED, that the OOA supports potential legislation, regulations, or policies that oppose the practice of

"Conversion Therapy," "Reparative Therapy," or other techniques aimed at changing a person's sexual orientation or gender identity, by licensed medical and mental health professionals; and be it further,

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

Explanatory Statement:

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

References:

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Relevant AOA and OOA Policies

H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES The American Osteopathic Association (AOA) recognizes the need of same-sex households to have the same access to health insurance and health care as opposite-sex households and supports measures to eliminate discrimination against same-sex households in health insurance and health care. The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for same-sex marriages and civil unions and the children of those families. 2014

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

H439-A/16 LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING PROTECTION LAWS The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) individuals from discriminating

practices and harassment and reaffirms equal rights and protections for all patient populations as stated in AOA policy H506-A14. 2016 Corresponding OOA Policy (2016): Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws

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

Relevant legislative Efforts in Ohio and Nationwide

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

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

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

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

<u>Actions Taken Since This Resolution Passed:</u> This resolution was submitted for consideration at the 2017 American Osteopathic Association House of Delegates. Resolution H629, originated out of Ohio University Heritage College of Osteopathic Medicine and was written by students Rashmi Singh, OMS-III & Margaret Watt, OMS-III. Scott Wong, Ph.D., OMS-II advocated in support of the resolution at OOA House of Delegates, April 23-24th 2017, and at the AOA House, July 21-22 2017. The Ohio Osteopathic Association, the Michigan Osteopathic Association, & the Student Osteopathic Medical Association submitted the resolution to the AOA. The AOA House amended Resolution Number 629 on the floor to emphasize that conversion therapy violates AOA ethical standards:

H629-A/17 LGBTQ+ CONVERSION THERAPY OR REPARATIVE THERAPY – OPPOSITION TO THE PRACTICE OF: The American Osteopathic Association (AOA) affirms that individuals who identify as lesbian, gay, bisexual, transgender, questioning, identifying as queer, or other than heterosexual (LGBTQ+) are not inherently suffering from a mental disorder.

The AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity.

The AOA 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.

The AOA opposes the use of Sexual Orientation Change Efforts (SOCE), which is based on the assumption that homosexuality is a mental disorder that should be changed and that any effort by an osteopathic physician to participate in any SOCE activity is considered unethical. 2017

In Ohio, OOA has been in contact with Equality Ohio to communicate the profession's stand on conversion therapy. Ohio SB 126 (Conversion Therapy) has been introduced by Sen. Charletta Tavares in the Ohio Senate. OOA has communicated our support to the sponsor, although hearings on the bill have not been scheduled. Equality Ohio is also seeking to have the Medical Board and other professional licensing boards enact position statements opposing the use of conversion therapy.

Direct Primary Care

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

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

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

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

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

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

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

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

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

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<u>Actions Taken Since this Resolution Passed:</u> This resolution was submitted for consideration at the 2017 American Osteopathic Association House of Delegates, where it approved as follows:

H628-A/17 DIRECT PRIMARY CARE The American Osteopathic Association (AOA) supports the direct primary care model of practice and specify that it is not insurance and supports patients' 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 a physician's ability to dispense prescription medications from their office in accordance with applicable federal and state laws. The AOA supports mechanisms allowing Medicaid and Medicare patients access to direct primary care services while preserving physician autonomy. 2017

Cultural Competency Dialogue on Eliminating Healthcare Disparities, Longitudinal Approach to (2017)

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

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

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

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

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

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

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

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

WHEREAS, the dialogue on health disparities should include historical and institutional implications, environmental factors, cultural considerations, and the production of symptoms or gene methylation by the influence of socioeconomic forces, in order to present knowledge about diseases and bodies in combination with expert analysis of social systems to help put notions of structural stigma at the center of conceptualizations of illness and health[3]; and

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

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

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

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

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

References

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***Actions Taken Since This Resolution Passed*: This resolution was submitted to the AOA House of Delegates where it passed as follows:**

H215-A/17 CULTURAL COMPETENCY DIALOGUE ON ELIMINATING HEALTH CARE DISPARITIES – LONGITUDINAL APPROACH TO The American Osteopathic Association encourages osteopathic medical institutions to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician's role in eliminating racial health care disparities in medical treatment as part of a longitudinal curriculum throughout undergraduate medical education years one thru four. 2017

In Ohio, OOA continues to educate legislators about what the osteopathic profession is doing to ensure medical students are culturally competent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Explanatory Statement

The goal of this resolution is for the Student Osteopathic Medical Association and the American Osteopathic Association to support health benefit plans that cover diagnosis and treatment of Eating Disorders on the basis of the medical necessities of an individual patient as judged by their healthcare provider - as opposed to predetermined biometric benchmarks. Some states have passed bills in support of this, for example Missouri 2015 Senate Bill 145; however, it is not a uniform ruling across the United States.

References:

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2. Swanson S, Crow S, Grange D et al. Prevalence and Correlates of Eating Disorders in Adolescents. *Archive of General Psychiatry* 2011; 68: 714-23. DOI: 10.1001/archgenpsychiatry.2011.22.
3. Fotios C Papadopoulos, Anders Ekbom, Lena Brandt, Lisa Ekselius. Excess mortality, causes of death and prognostic factors in anorexia nervosa. *The British Journal of Psychiatry* 2009, 194 (1) 10-17; DOI: 10.1192/bjp.bp.108.054742
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5. The Society of Adolescent Health and Medicine. Position Paper of the Society for Adolescent Health and Medicine: Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. *Journal of Adolescent Health* 2015; 56: 121-5. DOI: 10.1016/j.jadohealth.2014.10.259
6. Grange D, Ross C & Lock. Predictors and Moderators of Outcome in Family-Based Treatment for Adolescent Bulimia Nervosa. *Journal of American Academy of Child Adolescent Psychiatry* 2008; 47: 464-70. DOI: 10.1097/CHI.0b013e3181640816

<u>Actions Taken Since this Resolution Passed</u>: This resolution was submitted for consideration at the 2017 American Osteopathic Association House of Delegates, where it was approved as follows:

H440-A/17 EATING DISORDERS – HEALTH INSURANCE COVERAGE FOR RESIDENTIAL TREATMENT AND INPATIENT TREATMENT OF: ***The American Osteopathic Association (AOA) 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. The AOA 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. The AOA supports continued care for individuals suffering from eating disorders staying in residential and inpatient facilities, regardless of insurance criteria requiring termination of treatment. 2017***

Strategic Vision for Osteopathic Medicine in Ohio (2017)

WHEREAS, in, January 2016, the Ohio Osteopathic Association (OOA), in cooperation with the Osteopathic Heritage Foundations, Ohio University Heritage College of Osteopathic Medicine, and Centers for Osteopathic Research and Education, launched a major planning initiative to set the future direction for the association and for osteopathic medicine in Ohio, facilitated by Cavanaugh, Hagan, Pierson, & Mintz, a consulting firm based in Washington, DC; and

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

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

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

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

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

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

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

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

GOALS

1. Provide high quality and convenient continuing medical education programs that support physicians in achieving the quadruple aim: better outcomes, lower cost, improved patient experience and improved physician experience and well-being.

2. Advocate on behalf of the osteopathic profession to create the enabling environment to improve the health of the people of Ohio and achieve the quadruple aim (e.g. policy, regulation, funding representation in the American Osteopathic Association);

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

Actions Taken Since This Resolution Passed. The OOA has completed the Executive Search for a successor to Jon F. Wills. Matt Harney was selected as the new executive director by the Ohio Osteopathic Transformation Committee, February 1, 2018. His contract was approved by the OOA Board of Trustees, on February 25, 2018.

Effective Therapies for Patients, Maintaining (2017)

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

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

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

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

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

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

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

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

Actions Taken Since this Resolution Passed: This topic is closely related to the Step Therapy resolution, which follows. For complete details of actions taken, see the next resolution.

Step Therapy and Fail First Medication Policies

WHEREAS, insurance companies are increasingly implementing "Step Therapy" or "Fail First" policies that are designed to control costs through price-negotiated drug formularies but that sometimes block patients' access to medications and risk delay of effective treatment; and
WHEREAS, these policies require patients to take other potentially ineffective medications first and fail on these medications before insurers will pay for the physician's original prescriptions; and

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

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

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

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

1. Require that an insurer's process for requesting a step therapy override is transparent and readily available to the provider and patient;

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

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

<u>Actions Taken Since this Resolution Passed</u>. OOA is one of the key stakeholders leading this initiative. OOA has designed a web site for physician advocacy on the bill, has participated in interested party meetings, met with individual legislators, and has participated in two Step Therapy Days at the Statehouse. SB 56 and HB 72 seek to minimize barriers to treatment by improving the step therapy process. SB 56 is sponsored by State Senators Peggy Lehner (R-Kettering) and Charleta Tavares (D-Columbus). HB 72 is sponsored by State Representatives Terry Johnson (R-McDermott) and Nickie Antonio (D-Lakewood). Draft 4 of SB 56 was accepted by the Senate Health, Human Services and Medicaid Committee, March12, 2018. Draft 2, of companion bill HB 72 was accepted, March 21, 2018, by the House Health Committee. Testimony is anticipated when the House Health Committee meets, April 11, 2018. Although the legislation is opposed by the Ohio Association of Health Plans, the Chamber of Commerce and other business association have taken a more moderate stand.

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

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

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

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

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

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

RESOLVED, that Article V, Section 1 (B) of the Ohio Osteopathic Association (OOA) Constitution be amended to read, "The Ohio University Heritage College of Osteopathic Medicine shall be entitled to two delegates and four alternate delegates to the OOA House of Delegates. Three shall be from years one and two, one from each campus with one voting delegate. The other three will be from years three and four with one voting delegate. They will not diminish the total seated delegates from any district and will be seated together; and, be it further

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

References

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

Actions Taken Since this Resolution Passed: ***This resolution requires an amendment to the OOA Bylaws. See Resolution 2018-01. The Board of Trustees is recommending that a voting student delegate from each OU-HCOM campus be seated with the District in which the campus is located. OOA Executive Committee continues to discuss student involvement, and Charles Milligan, DO, has been appointed to chair the OOA Task Force on Student Involvement.***

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

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

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

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

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

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

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

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

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

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

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

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

References

1. US Department of Health & Human Services (2016) *NIH Research Portfolio Online Reporting Tools* (RePORT). Retrieved from https://report.nih.gov/award/index.cfm.
2. American Association of Colleges of Osteopathic Medicine website. *What is Osteopathic Medicine?* Retrieved from http://www.aacom.org/about/osteomed/pages/default.aspx.
3. Suminski RR, Hendrix D, May LE, Wasserman JA, Guillory VJ. Bibliometric measures and National Institutes of Health funding at colleges of osteopathic medicine, 2006-2010. (2012). *Journal of the American Osteopathic Association*, 112(11):716-724.
4. American Association of Colleges of Osteopathic Medicine. (2017). *AACOM 2015-2016 Academic Year Survey of Graduating Seniors Summary Report*. Retrieved from http://www.aacom.org/docs/default-source/data-and-trends/2015-16-graduating-seniors-summary.pdf?sfvrsn=10.
5. Blue Ridge Institute for Medical Research. (2017). *Table 1: total NIH Awards to all Departments of a Given Discipline*. Retrieved from http://www.brimr.org/NIH_Awards/2016/NIH_Awards_2016.htm
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7. Cummings, M.(2016). Osteopathic Students' Graduate Medical Education Aspirations Versus Realities: The Relationship of Osteopathic Medicine and Primary Care. *Journal of Academic Medicine*, 91(1):36-41.
8. Cardarelli R, Seater M, Palmarozzi E. (2007). Overcoming obstacles to implementing a primary care research framework. *Journal of Osteopathic Medicine and Primary Care*, 1-4.
9. Naik AD et al. (2014) Building a primary care/research partnership: lessons learned from a telehealth intervention for diabetes and depression. *Journal of Family Practice*, 32 (2): 216-223

***Actions Taken Since This Resolution Passed:* OOA continues to be leader in promoting scholarly research. Thanks to a generous gift from OOA Past President Robert W. Hostoffer, Jr., DO, the Ohio Osteopathic Foundation has produced and is sponsoring three on-line courses, which are available for free, continuing medical education through the American Osteopathic Association web site. For complete information see http://ooanet.org/aws/OOSA/pt/sp/scholar7**

EXISTING POSITION AMENDED BY SUBSTITUTION

Medicaid Support of GME Funding (2017)

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

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

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

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

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

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

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

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

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

RESOLVED, that OOA supports increased funding and incentives for primary care residencies in rural and underserved areas and Medicaid reimbursement policies that encourage physicians to continue to practice and precept medical students in those areas after completion of residency training. *(Original 1997, Substitute Resolution 2017)*

Actions Taken Since This Resolution Passed: The OOA is coordinating the Ohio Coalition of Primary Care Physicians (OCPCP). The Council of Medical School Deans, led by Kenneth H. Johnson, DO, and the OCPCP have appointed a new joint study committee headed by Ted Wymyslo, Chief Medical Office of the Ohio Association of Community Health Centers. The Ohio Primary Care Physician Workforce Collaborative was subsequently created to devise a strategy for enhancing the primary care workforce for the state of Ohio. The major focus will initially be on GME, as there has been little change in the number of primary care residency slots in Ohio in the last decade, despite significant growth in the number of medical student training positions during that same time. There is agreement among all national agencies that predict health workforce needs that there is and will continue to be a significant shortage of primary care physicians in Ohio, with the only question being just how great the deficit will be. There is no current statewide plan in Ohio to address this shortage. Dr. Wymsylo is therefore starting by convening a small group of leaders from various organizations who have an interest in beginning a conversation about how to best address this need. Douglas Harley, DO, of Akron, is the OOA representative along with OU-HCOM Executive Dean Johnson. The focus will only be on physician shortage, as there is no predicted shortage of primary care nurse practitioners or physician assistants at the present time.

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 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." The following actions were taken as a result of the five-year review rule.

Antibiotics for Medical Treatment, Preservation of (2017)

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

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 healthcare 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)*

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)*

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)*

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)*

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)*

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)*

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)

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)*

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

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

Managed Care Plans, 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)*

Medicare Mandatory Assignment (2012)

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

Nursing Facilities, Tiered (2012)

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)*

OOA Smoking Policy (2012)

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)*

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

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

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

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

Physicians Exclusive Right to Practice Medicine (2012)

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

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

Physician-Patient Relationships (2017)

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

Physician Placement in Rural Areas (2017)

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

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

Physician Fines by Third Party Payers (2012)

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)*

Pre-Authorized Medical Surgical Services, Denial of Payment (2012)

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

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

Preventive Health Services (2012)

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)*

Quality Health Care, the role of Medical Staffs and Hospital Governing Bodies (2012)

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

RESOLVED, that the OOA encourages hospital medical staffs to maintain independence in exercising medical judgments to control patient care and establish professional standards accountable to the hospital governing body, but not surrendering authority; and be it further
RESOLVED, that the OOA encourages hospital medical staffs and hospital governing bodies to respect the rights and obligations of each body and together be advocates to insure that quality health care is not compromised. *(Originally passed in 1987, amended by substitution in 1992, amended and affirmed in 1997, reaffirmed in 2002)*

Quality of Life Decisions (2012)

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)*

Reimbursement Formulas for Government Sponsored Healthcare Programs (2012)

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

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

School Bus Safety Devices (2012)

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)*

Telemedicine (2012)

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)*

Third Party Payers, DO Medical Consultants (2012)

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

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

EXISTING POSITION STATEMENTS DELETED

The House of Delegates deleting the following resolutions:

- The original resolution supporting creation of the Western Reserve Academy, since the OOA Constitution and bylaws were amended to reflect the change.
- The existing policy on School Allergens was deleted and a new policy adopted in its place.

RESOLUTIONS DEFEATED, REFERRED, OR WITHDRAWN

One resolution, **AOA Category 1-B CME Credit for Preceptoring Physician Assistant Students (PAs)**, was disapproved.

Respectfully submitted by,
Jon F. Wills
Executive Director Emeritus