2015

OHIO OSTEOPATHIC ASSOCIATION HOUSE OF DELEGATE MANUAL

FRIDAY, APRIL 24 TO SATURDAY, APRIL 25

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

Index

AGENDA AND SUPPORTING DOCUMENTS

PROFESSIONAL AFFAIRS REFERENCE COMMITTEE

PUBLIC AFFAIRS REFERENCE COMMITTEE

AD HOC REFERENCE COMMITTEE

APPENDIX

OHIO OSTEOPATHIC SYMPOSIUM
KEYNOTE ADDRESS

ON THE EDGE: THE ART OF HIGH-IMPACT LEADERSHIP
SATURDAY, APRIL 25, 11:00 AM, EASTON A/B

Imagine yourself on the highest mountain in the world. You have to deal with the physiological effects of extreme altitude, along with bone-chilling temperatures, battering winds, and a climbing team that's counting on all of its members to make smart decisions. There's simply no room for poor judgment – one mistake or misstep can result in an "unrecoverable error." In any situation where lives are on the line or the stakes are exceptionally high, there's no better training ground for leaders. Drawing on her experience as team captain of the first American Women's Everest Expedition, Alison Levine makes a compelling case that the leadership principles that apply in the world of extreme adventure also apply to today's rigorously competitive business environments.

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
Easton Ballroom C/D/E

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

Friday, April 24, 2015

BUSINESS SESSION 1

1:30 p.m. Delegate/Alternate Credentialing – John F. Ramey, DO, Chair

1:45 p.m. Welcome and Call to Order – Paul T. Scheatzle, DO, President

1:50 p.m. Invocation Charles G. Vonder Embse, DO
Osteopathic Pledge of Commitment – Dr. Scheatzle
Introduction of the Speaker/Vice Speaker – Dr. Scheatzle

2:00 p.m. Credentials Committee Report – Dr. Ramey, DO

2:05 p.m. Adoption of Standing Rules – Dr. Uslick, DO

2:10 p.m. Approval of Executive Director's Report of 2014 House Proceedings

2:15 p.m. Program Committee Report – Robert W. Hostoffer, Jr., DO, President-Elect

2:20 p.m. State of the State Report – Dr. Scheatzle

2:35 p.m. Report of the Advocates for the AOA and OOA – Janet Burns, AAOA President and Barbara C. Wills, AOOA President

2:50 p.m. **Professional Affairs Reference Committee – Magnolia**
Resolutions: 05, 10, 14, 15, 18, 19, 23, 24
Initial Members: Douglas W. Harley, DO, Chair (District VIII)
Darren J. Sommer, DO (District VI)
Jennifer L. Gwilym, DO (District III)
Edward E. Hosbach, DO (District II)
Robert W. Hostoffer, DO (District VII)

Public Affairs Reference Committee – Easton C/D/E
Resolutions: 01, 04, 07, 11, 16, 17, 21, 22, 25, 26
Initial Members: Cleanne Cass, DO, Chair (District III)
Peter A. Bell, DO (District VI)
Andre B. Bown, OMS II (OU-HCOM)
Michael E. Dietz, DO (District IV)
Luis L. Perez, DO (District V)

Ad Hoc Reference Committee – Lilac
Resolutions: 02, 03, 06, 08, 09, 12, 13, 20
Initial Members: Henry L. Wehrum DO, Chair (District VI)
Melinda E. Ford, DO (District IX)
Charles D. Milligan, DO (District VIII)
Lili A. Lustig, DO (District VII)
Aaron P. Hanshaw, DO (District III)

6:00 PM **Awards Reception and Recognition Ceremony, Regent Ballroom**

Saturday, April 25, 2015 – Easton A/B

7:00 a.m. Refreshment Break/ Poster Exhibition – Regent Ballroom *(Posters on Display until 3:00 pm)*

8:00 a.m. *Osteopathic Patient Centered Care in the 21st Century: Empathy, Mindfulness and Advanced Communications* – Leonard H. Calabrese, DO

9:00 a.m. AOA President's Update – Robert S. Juhasz, DO

10:00 a.m. *JO Watson, DO Lecture: Reaching the Summit – Leading the Medical Education Expedition* – Kenneth H. Johnson, DO

11:00 a.m. *Keynote Address: On the Edge: The Art of High Impact Leadership* – Alison Levine

12:00 Noon District Academy Caucus Meetings (Box Lunches will be served)
Akron-Canton – Gahanna Board Room
Columbus – Juniper B
Cleveland – Easton C/D/E
Dayton – Magnolia
Small Districts – Juniper C

BUSINESS SESSION TWO – Easton C/D/E

3:30 p.m. Call to Order – Dr. Uslick

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

3:40 pm OOPAC Report – Robert L. Hunter, DO, Chair

3:50 p.m. OOA Financial Reports – Sean D. Stiltner, DO, Treasurer

4:00 p.m. Plenary Session on the CORE, the ACGME Unified Accreditation, and Resolution 2015-05

4:30 p.m. Report of the Professional Affairs Reference Committee – Douglas W. Harley, DO, Chair

4:45 p.m. Report of the Public Affairs Reference Committee – Jennifer J. Hauler, DO, Chair

5:00 p.m. Report of the Ad Hoc Reference Committee – Henry L. Wehrum, DO, Chair

5:15 p.m. Report of the Medical Board of the State of Ohio – Anita M. Steinbergh, DO, Osteopathic Member; and A.J. Groeber, Executive Director

5:35 p.m. Introduction of Robert W. Hostoffer, Jr., DO, OOA 2015-16 OOA President, and recognition of Paul T. Scheatzle, DO, outgoing president

5:40 p.m. Report of the OOA Nominating Committee: Dr. Ramey, Chair

(Members: Paul A. Martin, DO, Dayton; Christopher J. Loyke, DO, Cleveland; Charles G. Vonder Embse, DO, Columbus; M. Terrance Simon, DO, Akron-Canton; and Victor D. Angel, DO, Cincinnati)

Nominees for OOA Officers

President-Elect ..... Geraldine N. Urse, DO
Vice President ..... Sean D. Stiltner, DO
Treasurer.....Jennifer J. Hauler, DO
Speaker of the House.....John F. Uslick, DO
Vice Speaker of the House..... David A. Bitonte, DO

Nominees for the Ohio Osteopathic Foundation Board

Three-year Term expiring 2018.....Gilbert S. Bucholz, DO
Unexpired Term ending 2017 (vacant)..... _____, DO
Three-year Term expiring 2018.....M. Terrance Simon, DO

Ohio Delegation to the AOA House (To be distributed)

5:45 p.m. Adjournment

6:30 p.m. **Mentor and Match Celebration Reception and Ohio Mentoring Hall of Fame Inductions – Easton A/B (Spouses Welcome) - Meet students who are coming to CORE sites in your district**

2016
OHIO OSTEOPATHIC SYMPOSIUM

COLUMBUS HILTON AT EASTON

Columbus, Ohio

April 20 – 24, 2016

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.
3. Nominating speeches will be limited to two minutes and seconding speeches will be limited to two minutes.
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 resolutions or business shall be read by the presiding officer 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.
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.

Report on Actions Taken by the 2014 House of Delegates

Submitted by Jon F. Wills,
Executive Director

The 2014 OOA House of Delegates adopted the resolutions listed below. Any activity that occurred during the year related to a specific resolution is noted in italics under the resolution.

NEW RESOLUTIONS APPROVED BY THE 2014 HOUSE OF DELEGATES

Thirty-three Ohio DOs served as voting members at the AOA House of Delegates, July 18-20, 2014. George Thomas, DO, of Cleveland, chaired the Ohio delegation and Paul A. Martin, DO, was vice-chair. Delegates considered more than 200 policy positions, including nine submitted by the OOA. OOA President Paul T. Scheatzle, DO, served as chair of the Ad Hoc Committee, and the following Ohioans served on Reference Committees: John F. Uslick, DO (Constitution and Bylaws); Jennifer L. Gwilym, DO (Educational Affairs); Peter A. Bell, DO (Professional Affairs); Christopher J. Loyke, DO (Public Affairs); and Robert L. Hunter, DO (Special Reference Committee on Single Accreditation System).

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

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

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

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

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

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

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

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

Action Taken. *This resolution was amended and approved by the AOA. It received considerable attention in the news media, and Jennifer J. Hauler, DO, and Cleanne Cass, DO, of Dayton, were interviewed and quoted about this resolution in an article published by Modern Healthcare.*

E-Cigarettes, Prohibit the Sale of to Minors (2014)

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

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

products; (1)"; and

WHEREAS, "It is not known if e-cigarettes may lead young people to try other tobacco products including conventional cigarettes, which are known to cause disease and lead to premature death; (1)"; now therefore be it

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

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

Action Taken. *This resolution was submitted to the AOA House of Delegates, where the principles therein were combined with several other resolutions submitted by other states. The new policy statement was subsequently approved by the House.*

Marijuana's Impact on Patients (2014)

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

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

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

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

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

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

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

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

WHEREAS, repeated use of THC over an extended time can lead to harmful effects including recurrent failure to fulfill major role responsibilities, persistent social problems, and legal issues. More severe manifestations of cannabis use disorder are characterized by behavioral and physiologic symptoms: including using larger amounts of cannabis over longer periods of time, unsuccessful efforts to limit use, tolerance to

cannabis's effects, and possibly physiologic withdrawal (3). Long term psychological effects may include the development of schizophrenia in susceptible individuals (2); and

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

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

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

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

Action Taken: *See the note for the following resolution.*

Marijuana Use by Osteopathic Physicians and Students (2014)

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

WHEREAS, in the November 2012 general election, the states of Colorado and Washington legalized the use of small amounts of marijuana for most adults in each state (2,3); and

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

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

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

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

WHEREAS, federal law recognizes marijuana as a dangerous drug and prohibits its illegal distribution and sale under the Controlled Substances Act (CSA) and the United States Department of Justice has claimed it will continue to enforce the CSA with help of federal prosecutors (4); now therefore be it
RESOLVED, that the Ohio Osteopathic Association recognizes the dangers of recreational use of marijuana among practicing physicians, osteopathic physicians in training, and osteopathic medical students and encourages the American Osteopathic Association to enact a policy statement against the recreational use of

marijuana by practicing osteopathic physicians in response to its legalization in states like Colorado and Washington; and be it further

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

Action Taken: *The two marijuana resolutions were submitted to the AOA House of Delegates, received considerable debate, were amended and approved. Dr. Scheatlze was* interviewed by The DO (http://bit.ly/1mIU1rl). For complete details, read the article on line.

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

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

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

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

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

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

Action Taken. *This resolution was submitted to the AOA House of Delegates where it was amended and approved. This resolution received strong support from the Student Osteopathic Medical Association (SOMA) and the Student Government Association (SGA). Please see the following story which is posted on the AOA website: http://www.osteopathic.org/inside-aoa/events/annual-business-meeting/HOD-news/Pages/7-19-14-resolution-calls-for-emr-system-access-for-students.aspx A reporter for Politico took a particular interest in this topic and quoted me in an article he wrote for the on-line addition.*

Ohio Chronic Non-Malignant Pain Management (2014)

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

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

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

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

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

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

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

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

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

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

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

Action Taken. *The OOA continues to work with GCOAT and the Ohio General Assembly on prescription drug abuse issues.*

Ohio KePRO, Inc. (2014)

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

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

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

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

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

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

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

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

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

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

AIM: Healthy People, Healthy Communities: Improving the Health Status of Communities
Goal 1: Promote Effective Prevention and Treatment of Chronic Disease
Task B.1: Improving Cardiac Health and Reducing Cardiac Healthcare Disparities
Task B.2: Reducing Disparities in Diabetes Care: Everyone with Diabetes Counts (EDC)
Task B.3: Using Immunization Information Systems to Improve Prevention Coordination
Task B.4: Improving Prevention Coordination through Meaningful Use of HIT and Collaborating with Regional Extension Centers
AIM: Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible, Safe Care
Goal 2: Make Care Safer by Reducing Harm Caused in the Delivery of Care
Task C.1: Reducing Healthcare-Associated Infections
Task C.2: Reducing Healthcare-Acquired Conditions in Nursing Homes
Goal 3: Promote Effective Communication and Coordination of Care
Task C.3: Coordination of Care
AIM: Better Care at Lower Cost
Goal 4: Make Care More Affordable
Task D.1: Quality Improvement through Physician Value-Based Modifier and the Physician Feedback Reporting Program
Task D.2: QIN-QIO proposed Projects that Advance Efforts for Better Care at Lower Cost
Other Technical Assistance Projects
Task E.1: Quality Improvement Initiatives

Update: *Effective August 1, the Quality Improvement Organization (QIO) scope of work was divided between two newly designated QIOs in each state. In Ohio and 23 other states, KEPRO is now handling all Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs), managing all beneficiary complaints and quality of care reviews. Quality improvement initiatives formerly handled by KEPRO will be assumed by Health Services Advisory Group (HSAG), headquartered in Arizona. The new Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) will be responsible for working with providers on initiatives to improve patient safety, reduce harm, and enhance clinical care and transparency at local, regional, and national levels. HSAG also has a state contract with Medicaid and maintains an office in Columbus.*

Postponing ICD 10 (2014)

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

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

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

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

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

WHEREAS, the Workgroup for Electronic Data Interchange (WEDI) conducted a survey of providers, vendors and health plans in December 2013 which indicated that significant disruption from a lack of ICD-10 preparedness could result unless progress occurs very quickly and also found: Only 25 percent of vendors surveyed say they are ready for ICD-10, and one-fifth of the vendors indicate they are halfway or less than halfway complete with product development; and

WHEREAS, about 40 percent of health plans have not yet completed an impact assessment regarding ICD-10. The majority of providers said they will not complete impact assessments, business changes or external testing until well into 2014. Only about 50 percent of providers will begin external testing in the first half of 2014; and

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

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

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

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

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

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

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

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

Action Taken. *This resolution was submitted to the AOA House where it was amended and approved.*

EXISTING POLICY OOA POLICY STATEMENTS REAFFIRMED OR AMENDED AND AFFIRMED:

Advocates for the OOA (2014)

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

Cell Phone Usage While Driving (2014)

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

Chicken Pox Vaccine for School Entry (2014)

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

Update. *OOA supported HB 536 (Smith, Antonio) to require chicken pox vaccinations in child care centers. The Governor signed the provision into law in December. Prior to that time, Ohio was the only state in the nation that did not have a vaccination requirement for child care centers.*

Childhood Obesity, Dangers of (2014)

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the *Ohio Obesity Prevention Plan* and ongoing initiatives by the Ohio Department of Health to combat the epidemic of childhood obesity across Ohio. *(Original 2004)*

Collective Bargaining By Physicians (2014)

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

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

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

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

RESOLVED, that the Ohio Osteopathic Association House of Delegates charge the Association's Board of Trustees with the responsibility to take whatever action is required to guarantee that the OOA continues to be the body that certifies continuing medical education credits for registration of licensure for all osteopathic physicians and surgeons in the state of Ohio. *(Original 1979)*

Dietary Supplements Hazardous to Health (2014)

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

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

Electronic Prescribing of Controlled Substances (2014)

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

Update. *The electronic prescribing of controlled substances (EPCS) is now legal in many states. This functionality provides prescribers with a way to manage treatments for patients with pain electronically and also deters creation of fraudulent prescriptions, which is a major concern in combating opioid misuse and abuse. While the technology may, in many instances, be in place to support EPCS, workflow challenges and additional modifications may need to occur to meet the requirements of Drug Enforcement Agency regulations (75 FR 16236). However, as Stage 3 Meaningful Use would not begin until January of 2017 and would not be required until January of 2018, it is possible that significant progress in the availability of products enabling the electronic prescribing of controlled substances may occur. Therefore, CMS is proposing that providers who practice in a state where controlled substances may be electronically prescribed who wish to include these prescriptions in the numerator and denominator may do so under the definition of "permissible prescriptions" for their practice. If a provider chooses to include such prescriptions, they must do so uniformly across all patients and across all allowable schedules for the duration of the EHR reporting period. The OOA is working with CliniSync and the Ohio State Board of Pharmacy to provide current guidance to OOA members. Visit the CliniSync Booth for information.*

Extended Care Facilities (2014)

RESOLVED, that the Ohio Osteopathic Association continue to work with the Ohio Department of Health to increase physician involvement in development of appropriate policies and procedures governing extended care facilities. *(Original 1994, reconfirmed 2009)*

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

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

Financial Aid for Ohio Medical Students (2014)

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

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

Update: *Luis Perez, DO, Sandusky, was reappointed this year by Governor Kasich as OOA's representative on the OPLR Advisory Committee.*

Health Care Reform, OOA Position Statement (2014)

RESOLVED that the Ohio Osteopathic Association continues to endorse and/or support introduction of legislation, which is consistent with the following statement and propose modification or defeat of any initiatives, which are not substantially consistent with these principles: *(View the remainder on line at www.ooanet.org)*

Health Planning (2014)

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

Jury Duty For Physicians (2014)

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

Lead Poisoning (2014)

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

Licensure Examination For Osteopathic Physicians (2014)

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

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

Managed Care (2014)

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

Update: OOA is supporting SB 129 (Garner, Cafaro) to require greater transparency regarding prior authorization (PA) requirements and ensure that, once a PA has been approved, the insurer will not retroactively deny coverage for the approved service.

Managed Care Plans, Termination Clauses (2014)

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

Mandatory Assignment (2014)

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

RESOLVED, that the Ohio Osteopathic Association continues to oppose any legislation that: (a) prohibits private physicians from billing their private patients; (b) mandates physicians to accept assignment of insurance claims; and (c) requires any third party payer to reimburse the healthcare facility instead of the physician unless authorized by the physician. *(Original 1984)*

Medical Malpractice Tort Changes (2014)

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

Ohio's Indoor Smoking Ban (2014)

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

OOA Professional Liability Insurance (2014)

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

Ohio State Medical Board, State Funding (2014)

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

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

Osteopathic Unity (2014)

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

Prescriptions, Generic Substitution (2014)

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

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

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

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

Professional Liability Insurance Company Ratings (2014)

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

Professional Liability Insurance, Legislation and Tort Reform (2014)

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

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

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

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

Update. *The OOA continues to participate in Court Watch with the Ohio Hospital Association and the Ohio State Medical Board. The three associations have recently filed an amicus brief in Griffith v. Aultman. This decision will maintain the current definition of what constitutes a medical record. The three associations are coordinating with our national organizations and requesting permission from the court to make an appearance in the Woessner damage cap matter before the 6th District Court of Appeals. This case could strike down Ohio's current caps for medical claims.*

Substance Abuse, Position Statement (2014)

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

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

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

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

Update. *OOA continues to be actively involved with the Governors Cabinet Opiate Action Team initiatives to educate patients and physicians about prescription drug abuse and current practices.*

Substance Abuse Insurance Coverage (2014)

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

Uncompensated Care, Tax Credits For Providers (2014)

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

Update. *OOA is advocating for tax credits as part of biennial budget discussions.*

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: 05, 10, 14, 15, 18, 19, 23, 24

Members:

Douglas E. Harley, DO, Chair (District VIII)
Jennifer L. Gwilym, DO (District IX)
Edward P. Hosbach, DO (District II)
Robert W. Hostoffer, DO (District VII)
Darren J. Sommer, DO (District XI)
Jon F. Wills, OOA Staff

Magnolia Room

RES. NO.
2015-05

SUBJECT: Centers Of Osteopathic Research And Education (2010)

SUBMITED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2010 BE AMENDED BY SUBSTITUTION AND APPROVED:

~~RESOLVED, that the Ohio Osteopathic Association supports the Ohio University College of Osteopathic Medicine/Ohio Osteopathic Hospital Association CORE structure that encompasses traditional osteopathic medical school curriculum, continuum curriculum, internship, residency and continuing medical education programs through its Osteopathic Postdoctoral Training Institution (OPTI) consortium.~~ *(Original 1990)*

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

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

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

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

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

- Maintaining elements and characteristics of the CORE which have served to advance osteopathic medical education in our predominantly community-based training facilities;
- Understanding change created by the alignment of community-based training facilities with academic health centers and health systems;
- Recognizing how an education network creates strength in numbers with a commitment to a common goal;

- Seeking osteopathic recognition of current programs in the new single accreditation system, thereby allowing opportunity for further development of osteopathic knowledge and skills by residents as well as promoting a strong future for osteopathic medicine;
- Involving leaders and resources from across the nation and throughout the state; and
- Developing a meaningful and viable business model for both undergraduate and graduate medical education that recognizes the diversity of needs across members, recognizes the changing landscape of undergraduate and graduate medical education and is completed on a timeline that reflects understanding of the change created by the new graduate medical education accreditation environment; now, therefore be it

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

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

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

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

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-10

SUBJECT: Leadership Development

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, it is important to develop a sustaining source of osteopathic physicians to provide leadership for the osteopathic profession; and~~

~~WHEREAS, our national osteopathic leaders rise from the ranks of our state osteopathic associations; and~~

~~WHEREAS, our state leaders rise from the ranks of our local academies; and~~

~~WHEREAS, the membership of our local academies determine by democratic process the members of their executive committee; and~~

~~WHEREAS, moving through the chairs of the executive committee serves as training experience; and~~

~~WHEREAS, moving through local chairs should provide a pathway to state leadership; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association (OOA)~~ develop a~~ continue to offer periodic ~~statewide program for the active inclusion of executive members of all academies in Ohio directly into the affairs of the OOA~~; leadership development programs for OOA district officers and executive directors; and, be it further,

RESOLVED, that the OOA encourages all OOA District academy presidents and presidents-elects ~~be encouraged~~ to participate in other training and leadership development programs ~~by the OOA~~ offered by hospitals, local civic organizations and national osteopathic specialty affiliates.~~; and, be it further~~

~~RESOLVED, that the OOA present a copy of this resolution to the American Osteopathic Association along with a request for similar programs at the national level, and for a resolution to this effect to be submitted to the 2010 House of Delegates.~~ *(Original 2010)*

ACTION TAKEN: _____

DATE: _____

SUBJECT: Osteopathic Identity

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, there are two types of complete physicians in the United States who are fully qualified and licensed to prescribe medication and perform surgery; and~~

~~WHEREAS, DOs represent 11 percent of the total physicians practicing in Ohio and 26 percent of the state's family physicians; and~~

~~WHEREAS, nationwide, approximately 65 percent of practicing osteopathic physicians specialize in primary care areas, such as pediatrics, family practice, obstetrics and gynecology, and internal medicine; and~~

~~WHEREAS, a mission of the OOA and its district academies is to advance the public awareness of the philosophy and practice of osteopathic medicine; and~~

~~WHEREAS, the 2009 OOA House of Delegates approved a resolution to petition the American Osteopathic Association to work with medical equipment manufacturers that have pre-programmed text such as "Ordering MD" changed to "Ordering Medical Professional;" and~~

~~WHEREAS, the term "MD" is often erroneously used as a synonym for "physician" or "doctor" in many circumstances (i.e. media, physician correspondence, conversation); now, therefore, be it~~

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

~~RESOLVED, that the Ohio Osteopathic Association develop provide a sample educational letter for members to use and/or other item(s) (example of such items: "This form is discriminatory in its current format. Please change it to read "MD/DO signature" or "physician signature" and I will be happy to sign it. Thank you.) for the purpose of presenting a unified message to promote osteopathic identity; and, be it further~~

RESOLVED, that the OOA post ~~this educational~~ a sample letter and supporting information ~~be available~~ on the OOA website for members ~~and OOA staff to easily obtain and~~ to download, adapt and distribute ~~in appropriate circumstances~~ to correct

instances where osteopathic physicians are incorrectly identified as MDs or required to sign forms that have a preprinted "MD."

ACTION TAKEN: _____

DATE: _____

SAMPLE LETTERS TO CORRECT
OSTEOPATHIC IDENTIFY ISSUES

Dear _____:

I recently noticed that (you, your office, hospital, department, pharmacy, company, etc.) incorrectly identified me as an MD on a (letter, preprinted form, name badge, etc.). I would appreciate it very much, if you would correct this misrepresentation of my degree and properly identify me as a DO in the future.

As you may know, there are two types of physicians who are licensed as unlimited practitioners in all 50 states: DOs and MDs. The Ohio Revised Code specifically defines a "physician" as "a person authorized under Chapter 4731 of the Ohio Revised Code to practice medicine and surgery or osteopathic medicine and surgery."

D.O. is the abbreviation for Doctor of Osteopathy or Doctor of Osteopathic Medicine, and DOs are commonly referred to as osteopathic physicians. Osteopathic medicine is a complete system of medical care with a philosophy that combines the needs of the patient with the current practice of medicine, surgery and obstetrics, and emphasizes the interrelationships between structure and function, and the appreciation of the body's ability to heal itself.

I am proud of my osteopathic heritage and wish to be correctly identified as a DO. I appreciate your cooperation in making sure this oversight is corrected in the future.

Sincerely,

Dear _____:

I recently noticed that your (company, pharmacy, school, office, etc.) is using a preprinted "MD" as a synonym for the word, "physician" on (name, title or number of a form, etc.)

As you may know, there are two types of physicians who are licensed as unlimited practitioners in all 50 states: DOs and MDs. The Ohio Revised Code specifically defines a "physician" as "a person authorized under Chapter 4731 of the Ohio Revised Code to practice medicine and surgery or osteopathic medicine and surgery."

D.O. stands for Doctor of Osteopathy or Doctor of Osteopathic Medicine, and physicians who earn the DO degree are commonly referred to as osteopathic physicians. Osteopathic medicine is a complete system of medical care with a philosophy that combines the needs of the patient with the current practice of medicine, surgery and obstetrics, and emphasizes the interrelationships between structure and function, and the appreciation of the body's ability to heal itself.

The pre-printed MD which appears on your (form, contract, etc.) is inadvertently discriminatory against me. I would appreciate a reply indicating that you will update the form by omitting the preprinted "MD" and substituting the word "Physician" at your next printing.

CC: Ohio Osteopathic Association

RES. NO.
2015-15

SUBJECT: Specialty Hospitals and Economic and Exclusionary Credentialing (2010)

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

~~Specialty Hospitals and Economic and Exclusionary Credentialing~~

RESOLVED, THAT THE OOA WHITE PAPER POSITION STATEMENT, ENTITLED "HOSPITALS AND ECONOMIC AND EXCLUSIONARY CREDITIALING," ORIGINALLY APPROVED IN 2006 AND REVISED AND AFFIRMED IN 2010; BE AMENDED BY SUBSTITUTION AS FOLLOWS AND THE ORIGINAL WHITE PAPER FILED IN THE OOA ARCHIVES FOR HISTORICAL REFERENCE.

Hospital – Physician Relationships And Medical Staff Credentialing

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

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

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

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

RESOLVED, OOA supports hospital ownership information disclosure to patients and

supports the patients' right to choose where they receive medical care; and, be it further

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

Explanatory Note: As noted on the CMS Web Site: A physician-owned hospital is now generally prohibited from expanding facility capacity. Therefore, the circumstances that led to this resolution are being deleted from the statement.

Specialty Hospitals and Economic and Exclusionary Credentialing
(To be maintained in the OOA archives.)

Issue Identification

Hospital-physician relations are being strained in many parts of the United States due to changing competitive forces in healthcare. Many of these forces were driven by government, business, and managed care organization policies that were designed to stimulate competition in the healthcare marketplace. For example, physicians felt threatened in Cleveland, Ohio, when the University Hospitals Health System (UHHS) suggested imposing "exclusive credentialing" on members of their medical staffs. The proposal would have required all physicians in the UHHS hospital system to drop privileges at competing institutions and refer their patients solely to UHHS physicians and facilities. Cleveland physicians rejected these suggestions and demanded the right to continue to refer patients outside the system, in cases where other specialists and facilities better met the needs of their patients. Recently, the boards of community hospitals throughout Ohio have felt threatened by a movement to create for-profit, specialty niche healthcare facilities, known as centers of excellence by some and called "boutique" hospitals by others. Although specialty hospitals have operated in other parts of Ohio and in other states for some time, the New Albany Surgical Hospital in the central Ohio area sparked a public debate, pitting physicians against hospitals.

Columbus-area hospitals have operated for more than 100 years without a tax levy to support charity care. During this time the hospitals have stated they serve the entire community. Their philosophy has been to provide a single standard of care for all citizens. They have delivered this care to those who can pay as well as those who cannot. In 2001, they accumulated more than $201 million in charity care, uncompensated services, and bad debt as they served the central Ohio community. This includes $85 million from OhioHealth hospitals, the parent system of Doctors Hospital, the only osteopathic teaching institution in central Ohio. Ohio's hospitals have also been experiencing decreases in funding for the Hospital Care Assurance Program; this money is used to serve indigent patients and cuts could result in an even higher level of uncompensated care for Ohio's hospitals.

In 2002, a group of orthopedic surgeons (MDs and DOs) who practiced in the Columbus not-for-profit hospitals began construction on a facility in New Albany, Ohio, to serve a number of their patients. The Columbus area hospital boards believed that physicians would "cherry pick" the best-paying patients and leave the less able to pay and complex

patients to be served at the not-for-profit hospitals. As a result, the board members of the Columbus area hospitals threatened to restrict medical staff privileges for physicians who invest in for-profit hospitals and/or limited-service hospitals. This has been referred to by the physicians as "economic credentialing," and most recently by the hospital boards as a "conflict of interest."

Ironically, many Ohio hospitals were founded through a collaboration of physicians with the local community. Dollars came from private and public sources (physicians, local businesses, tax dollars, religious organizations, philanthropists). Because of the need to advance quality healthcare, physicians and hospitals have continued to pool their financial resources. In addition, many new innovations and services have been supported solely by physicians in order to enhance patient access (surgical centers, outpatient healthcare centers, radiology centers, urgent care centers).

Legislative Background

There are currently no state or local laws that restrict physicians from practicing in or having ownership in for-profit hospitals. However, there is a question concerning the authority of hospitals to restrict the right of physicians to practice in the not-for-profit hospitals. There may be a restraint of trade or question of collusion when hospitals act together in this manner.

Several bills were introduced in the Ohio General Assembly to address the concerns of not-for-profit hospitals in regard to the specialty hospital issue. In the spring of 2003 Federal legislation (Stark III) was also pending to place certain restrictions on physicians referring patients to the physician-owned, for-profit hospitals. In the fall of 2003, the Medicare Modernization Act was passed. It placed a federal moratorium on the construction of any new facilities for 18 months (January 2004-June 2005) with a study to determine the effect of new facilities on the non- profit hospital community. In March 2005, MEDPAC recommended that the federal government extend the moratorium until January 2007. (For more information go to www.medpac.gov)

On May 11, 2005, Senator Chuck Grassley (R-IA), chair of the Senate Finance Committee, and ranking member Max Baucus (D-MT) introduced legislation (S. 1002) that would restrict development of a new physician-owned specialty or "boutique" hospitals. Physicians would be barred from referring Medicare or Medicaid patients to specialty hospitals in which they have an ownership interest if the facilities were in operation or under development after November 18, 2003.

The Patient Protection and Affordable Care Act signed into law by President Obama, March 23, 2010, essentially prohibits future physician investment and caps existing physician investment in hospitals as of the bill's signing. According to Molly Sandvig, Executive Director of Physician Hospitals of America (PHA), the legislation virtually destroys over 60 hospitals that are currently under development and leaves little room for the future growth of the industry

The Ohio Osteopathic Association believes that state and federal legislators must be careful not to disrupt current or future financial ventures by not-for-profit hospitals. With

hospital operating margins dropping from the 5 to 6 percent range of the early 1990s to the low of -1 to 1 percent in the 2000s, any investor— including the physician—is generally welcome. In addition, there are no longer any state laws that require a hospital to justify the need for medical services or justify the addition of new facilities to an existing institution. This change occurred in 1995 when Ohio's Certificate of Need law experienced a sunset provision. Free market forces were to determine the future of Ohio's healthcare needs.

The position of OhioHealth and other hospital systems in Columbus is to restrict medical staff privileges for physicians who invest in for-profit limited service hospitals. The Ohio Hospital Association has instructed its staff to develop a plan for state action similar to that being undertaken by the American Hospital Association. It would include a conflict-of-interest prohibition on self-referrals by physicians who are investors in inpatient hospitals.

Impact of Proposed Legislation

Proposed legislation could have significant impact on physicians, hospitals, patients and taxpayers. It could bring about increased costs for all hospitals, loss of income to physicians who are denied privileges to practice in the not-for-profit hospitals, increased cost to patients, and a possible increase in taxes to the residents of Columbus and other communities to support indigent hospital care. Additionally, legislation designed to discourage new healthcare delivery models and facilities could re-concentrate physicians and most healthcare services into traditional not-for-profit hospital campuses. While this might appear cost efficient, many of our existing not-for-profit hospitals have neither size nor scope of facilities to meet the entire community's needs. New innovations to fill this gap have come through physician and local businessman ventures. This relationship could be threatened.

Osteopathic Hospitals and the Osteopathic Profession

- The osteopathic profession faced a long history of discrimination by allopathic hospitals and the medical establishment, which led to the creation of osteopathic hospitals.
- The freedom to establish hospitals was vital to the profession's survival by providing surgical and clinical facilities for osteopathic specialists, and training opportunities for osteopathic students, interns, and residents.
- The American Osteopathic Association (AOA) simultaneously established a Healthcare Facilities Accreditation Program (HFAP) for hospitals and other healthcare facilities. The AOA has been delegated authority by the federal government to accredit hospitals through "deemed status." State and federal governments recognize the HFAP program as an alternative to the Joint Committee on the Accreditation of Healthcare Organizations (JCAHO) hospital accreditation system.
- Ohio's free-standing osteopathic hospitals had a long tradition of providing care to the underserved and received a significant share of Hospital Care Assurance Program dollars in the past.
- Osteopathic physicians have traditionally provided a disproportionate share of

medical services under the Ohio Medicaid program, and many DOs practice in inner cities and rural areas of need.

- The Ohio Osteopathic Association (OOA) and the Ohio Osteopathic Hospital Association (OOHA) supported voluntary planning for healthcare facilities beginning in the 1960s and participated in early regional hospital planning agencies. Voluntary health planning activities led to the creation of the mandatory hospital Certificate of Need (CON) program administered by the State through the Ohio Department of Health.
- In 1976 and subsequent years, the OOA petitioned for and obtained separate consideration under the state CON program in order to ensure that the needs of osteopathic physicians and their patients were adequately addressed. "Separate consideration" provisions were added to national health planning legislation and Ohio Department of Health regulations. Physicians and hospitals eventually viewed CON as bureaucratic and a detriment to healthcare, and the hospital community supported the restoration of a free-market system with the approval of the Ohio General Assembly in 1995.
- With the growth of managed care in Ohio, the business community and the state and federal governments encouraged the consolidation of hospital services and the elimination of excess bed capacity. They also encouraged selective contracting and the development of Centers of Excellence to ensure quality healthcare for specialty procedures.
- Managed Care Organizations (MCOs) and the business community, in trying to contain costs and foster competition, have caused a breakdown in traditional relationships between physicians and hospitals due to contractual and reimbursement issues.
- Because of their size, free-standing osteopathic hospitals were often unable to "get a seat at the table" to negotiate with MCOs, resulting in dramatic changes in osteopathic referral patterns to larger, full-service tertiary centers. In such instances, osteopathic specialists were compelled to obtain medical staff privileges at competing hospitals. Some allopathic medical staff specialty departments have resisted accepting osteopathic credentialing.
- When osteopathic hospitals did obtain managed care contracts, osteopathic specialists sometimes did not. Primary care DOs were therefore forced by MCOs to refer patients to allopathic hospitals and allopathic specialists that were in the patient's provider panels. All hospitals and medical staffs have experienced similar changes in referral patterns in varying degrees.
- The changing economics of the healthcare reimbursement system and intense competition have led to the sale and merger of osteopathic hospitals into larger healthcare systems. The surviving hospital systems have been consolidating medical and surgical services. Some have built specialized hospital facilities of their own.
- Declining governmental and private insurance reimbursement has placed considerable strain on physicians and hospitals in general. Cuts in Medicare and Medicaid reimbursement are making the situation even more acute.

Ohio Osteopathic Position Statement

- The Ohio Osteopathic Association (OOA)represents DO specialists, DO primary care physicians (who are 26 percent of the total number of family physicians in Ohio),

members of the Ohio Osteopathic Hospital Association, and the Ohio University College of Osteopathic Medicine. We believe the collective needs of the osteopathic community must be considered as it affects patient care and community service.

- OOA believes that for-profit and not-for-profit hospitals can provide cost-effective and quality medical services to the community. All hospitals have an obligation to support the needs of the community at large.
- OOA is strongly opposed to "exclusionary credentialing" and "economic credentialing." These practices include any process established by a hospital to: (1) limit a physician's medical staff privileges based in whole or in part by a physician's privileges or participation at a different hospital or hospital system; (2) impose limitations on medical privileges or participation at a hospital based in whole or in part on the physician's membership or membership of a partner, associate or employee at a different hospital or hospital system; or (3) exclude physicians from medical staff privileges due to physician ownership or investment—or that of a partner, association or employee—in a for-profit entity including but not limited to specialty hospitals, surgical centers, outpatient healthcare centers, radiology centers, or urgent care centers. OOA believes that hospital privileges should be based on training, expertise, competence, and a staff development plan. Hospital privileges should be unrelated to professional or business relationships; investment in other healthcare facilities; associations with other physicians or groups of physicians; or having medical staff membership or privileges at another hospital system or for-profit facility.
- OOA supports hospital ownership information disclosure to patients. OOA supports the patients' right to choose where they receive medical care.
- OOA calls on Ohio's hospitals and physicians to remain focused on working together to provide quality and cost effective healthcare services that address the needs of patients.
- OOA encourages the Ohio General Assembly, the Ohio Hospital Association, the Ohio State Medical Association along with the Ohio Osteopathic Association and other interested specialty and hospital organizations to develop a task force to reach consensus on how to best meet the needs of all interested parties within the community. *(Original 2006)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-18

SUBJECT: Zimmerman Osteopathic Dream Foundation

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POSITION STATEMENT ADOPTED IN 2010 BE DELETED:

RESOLVED, that the Ohio Osteopathic Association continues to encourage its members, district academies and affiliated groups to support the Zimmerman Osteopathic Dream Foundation by making financial contributions and providing additional assistance and referrals as appropriate. *(Original 1990)*

Explanatory Note: *The Zimmerman Osteopathic Dream Foundation (ZODF), originally endowed in Dayton to send children with life-threatening illnesses to Disney World, was administered for a number of years by the Ohio University Heritage College of Osteopathic Medicine. All ZODF Board members resigned in 2005, and the charity was dissolved. Proceeds were distributed to the Grandview Foundation (GF), where a temporarily restricted Osteopathic Dream Fund was created. Due to that fund's inactivity, a significant portion of the endowment was distributed to "Give Kids the World Village" in celebration of its 25th anniversary. The ZODF's exempt status as a separate foundation was automatically revoked by the IRS for failure to file a Form 990, 990-EZ, 990-N, or 990-PF for 3 consecutive years.*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-19

SUBJECT: Health Savings Accounts

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2010 BE AMENDED AND APPROVED:

RESOLVED that the Ohio Osteopathic Association continues to advocate ~~and lobby~~ for Health Savings Account programs as an alternative form of health insurance. *(Original 1995)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-23

SUBJECT: Osteopathic Medical Student, Resident, and Physician Mental Health

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

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

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

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

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

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

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

RESOLVED, that the OOA develop or connect those in need with a help line geared towards medical students, residents, and physicians to help physicians and medical students suffering from depression get appropriate assistance and have an outlet to talk openly without judgment; and, be it further

RESOLVED, that the OOA advocates to the American Osteopathic Association and American Association of College of Osteopathic Medicine to increase resources for students, residents, and practicing physicians to identify depression and mental health issues in themselves and their colleagues.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-24

SUBJECT: Expansion of Physician Scientist Residency Training

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, the state of Ohio has only four research-residency programs, all of which are allopathic[1]; and

WHEREAS, the Amedican Osteopathic Association/American Council on Graduate Medical Education single accreditation imposes more stringent expectations with regards to research or scholarly work [2], and

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

WHEREAS, osteopathic medical schools and the medical community at large have recognized the need for an increase in research at osteopathic schools [3 4] since, of the $11 billion given to medical schools by the National Institute of Health only 1.2 percent went to osteopathic institutions [5 6]; and

WHEREAS, physician-scientists are expected to achieve and maintain adequate research skills while also satisfying clinical milestones in traditional residencies[7], and

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

WHEREAS, lack of faculty mentors has been defined as a major barrier to conducting research in non-university residencies, however, this does not seem to limit the programs' ability to conduct scholarly work[8]; now, therefore, be it

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

RESOLVED, that the OOA supports the development of research-focused residency programs within the osteopathic profession; and, be it further

RESOLVED, that a copy of this resolution be sent to the Centers for Osteopathic Research and Education (CORE), the Osteopathic Heritage Foundations, the Brentwood Foundation, Ohio Health, the Cleveland Clinic and other potential partners for consideration in Ohio; and, be it further

RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association for consideration by the 2015 AOA House of Delegates.

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[1] Research Residency Programs. American Physician Scientists Association. http://www.physicianscientists.org/?page=ResidencyList. Accessed July 09, 2014.

[2] Nasca TJ. The Next GME Accreditation System – Rationale and Benefits. N Engl J Med. 2012:366(11): 1051- 1056.

[3] Howell JD. The paradox of osteopathy. N Engl J Med. 1999;341(19):1465-1468.

[4] Licciardone JC. Time for the osteopathic profession to take the lead in musculoskeletal research. Osteopath Med Prim Care. 2009;3:6.

[5] NIH Research Portfolio Online Reporting Tools (RePORT). US Department of Health & Human Services. http://projectreporter.nih.gov/reporter.cfm. Accessed July 10, 2014.

[6] Suminski RR. Bibliometric Measures and National Institutes of Health Funding at Colleges of Osteopathic Medicine, 2006-2010. J Am Osteopath Assoc. 2012:112(11): 716-724.

[7] Arbuckle MR. Bridging the Gap: Supporting Translational Research Careers Through an Integrated Research Track Within Residency Training. Acad Med. 2013:88(6): 759-765

[8] Levine RB. Resident Research and Scholarly Activity in Internal Medicine Residency Training Programs. J Gen Intern Med. 2005:20(2): 155-159

ACTION TAKEN: _____

DATE: _____

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: 01, 04, 07, 11, 16, 17, 21, 22, 25, 26

Members:

Cleanne Cass, DO, Chair (District IX)
Peter A. Bell, DO (District VI)
Andre B. Bown, DO (District IX)
Michael E. Dietz, DO (District IIII)
Luis L. Perez, DO, (District V)
Cheryl Markino, OOA Staff

Easton C/D/E

RES. NO.
2015-01

SUBJECT: Advance Directives and Complementary Documents

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY ADOPTED IN 2005 BE AMENDED AND APPROVED:

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

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

ACTION TAKEN: _____

DATE: _____

Note: *The legislature passed HB 126 in December 2013 that allows appointment of a guardian to be made through a healthcare power of attorney. The change required amending Ohio's advance directive documents to conform with the new laws. Eric Jones, OOA legal counsel, has been part of the team revising the documents, which bears the logos of the Midwest Care Alliance, Ohio State Medical Association, Ohio Hospital Association, Ohio Osteopathic Association, and the Ohio State Bar Association. The new document can be downloaded from the OOA website, under "Resources/Patient Education".*

SUBJECT: Reaffirmation of Policy Statements

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENTS ADOPTED IN 2010 BE REAFFIRMED:

Automobile Passive Restraints

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

Family Caregivers

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

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

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

Home Health Care

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

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

Insurance Identification Card for Patients

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the development of universal insurance identification cards for patients utilizing advanced technology

information systems. *(Original 2000)*

Licensed Practical Nurses

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

Prompt Pay Statues

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

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

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

Managed Care, Automatic E/M Down Coding

RESOLVED, that the Ohio Osteopathic Association (OOA) opposes the practice of automatic down-coding by Health Insuring Corporations (HICs); and, be it further

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

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

Managed Care, On-Line Formulary Directory

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

Third Party Reimbursement for Physician Services

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

Universal Credentialing (2010)

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

ACTION TAKEN: _____

DATE: _____

SUBJECT: Obesity Epidemic

SUBMITTED BY:

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, APPROVED IN 2010, BE DELETED AS A SEPARATE STATEMENT, COMBINED WITH THE 2014 STATEMENT ON CHILDHOOD OBESITY AND AMENDED BY SUBSTITUTION AND APPROVED AS A NEW COMPREHSIVE POLICY ON THE OBESITY EPIDEMIC:

~~**Childhood Obesity**~~

~~WHEREAS, the Ohio Osteopathic Association's House of Delegates in June 2009, voted to support the *Ohio Obesity Prevention Plan*, which was released in March 2009 by the Office of Healthy Ohio; and~~

~~WHEREAS, the Ohio Business Roundtable (OBRT) released an extensive report in 2009 outlining the alarming increase in obesity rates, unhealthy eating habits and physical inactivity, pointing out that "today's children could be the first generation of Ohioans to have shorter lives than their parents"; and~~

~~WHEREAS, the Partnership to Fight Chronic Disease, in November 2009, released an obesity study commissioned by United Health Foundation, Partnership for Prevention, and American Public Health Association to supplement the 2009 America's Health Rankings report; and~~

~~WHEREAS, the supplemental report, written by Kenneth Thorpe, MD, is the first document to estimate obesity prevalence and costs at the state and national level 10 years from now, projecting that Ohio's obesity rate (now 34 percent) will exceed 50 percent in 2018, with healthcare costs exceeding $16 billion for the entire state, or $1,800 per person; and~~

~~WHEREAS, the OBRT worked closely with a team of pediatricians and medical professionals from the state's leading healthcare institutions, child advocacy organizations, and community leaders to develop solutions to the obesity epidemic; and~~

~~WHEREAS, as a first step the OBRT decided to focus on Ohio schools, where children spend the bulk of their time outside the home and where policymakers can have an immediate impact; and~~

~~WHEREAS, the Healthy Choices for Healthy Children Coalition, which includes the Ohio Osteopathic Association, was formed to support bipartisan companion legislation~~

~~consisting of HB 373, sponsored by Representatives John Patrick Carney (D) and Lynn Watchman (R) in the House and SB 210, introduced by Senators Kevin Coughlin (R) and Eric Kearney (D) in the Senate; and~~

~~WHEREAS, the *Healthy Choices for Healthy Children* legislation would: (1) set standards for the food and beverages offered in vending machines and ala carte offerings in schools; (2) increase the time dedicated to physical activity and quality physical education; and (3) measure the progress of these interventions through periodic, confidential body mass index (BMI) assessments in kindergarten, third, fifth, and ninth grades; now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association continue to support legislation that encourages Ohio's schools, parents, and the healthcare community to work together to eliminate childhood obesity by encouraging physical activity and good nutrition standards at home and in the schools. *(Original 2005, Substituted 2010))*~~

~~Childhood Obesity, Dangers of~~

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

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

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

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

RESOLVED, that the OOA supports the State of Ohio's ~~*Ohio Obesity Prevention Plan* and~~ ongoing initiatives ~~by the Ohio Department of Health~~ to combat the epidemic of adult and childhood obesity across Ohio ~~*(Original OOA resolution 2004, reaffirmed 2009, amended and reaffirmed 2014)*~~; and, be it further

RESOLVED, that the OOA continues to support legislation, programs, and initiatives that encourage~~s~~ Ohio's schools, parents, and the healthcare community to work together to eliminate childhood obesity by encouraging physical activity and good nutrition standards at home and in the schools; ~~*(Original OOA Resolution 2005, Substituted 2010)*~~; and, be it further

RESOLVED, that the OOA urge its members to educate their patients and communities

about the dangers of obesity and support community-based programs that improve nutrition, and increase physical activity.

ACTION TAKEN: _____

DATE: _____

SUBJECT: Long-Term Care Facilities

SUBMITTED BY: OOA Council On resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, patients in long term care facilities (LTCF) are suffering in pain without CII opioids; and~~

~~WHEREAS, this is due to the Drug Enforcement Administration's (DEA) new policy that doesn't recognize nurses from extended care facilities as agents of the physicians in these facilities; and~~

~~WHEREAS, the DEA interpretation of the policy requires physicians to call in these meds or fax a prescription which creates an administrative burden due to multiple phone calls and results in a delay in delivery and administration of pain meds; and~~

~~WHEREAS, pain has become the fifth vital sign, and due to the DEA interpretation of the policy, the patient is the one who suffers due to the delay of delivery medications which could ease suffering even in times of the dying process; and~~

~~WHEREAS, when patients are admitted to a LTCF and when emergent changes arise, an immediate action is required to address the pain need of the patient to alleviate pain and suffering which dictates the need for the facility nurse to take a verbal order when appropriate for CII medications from the attending physician; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association ~~petition the American Osteopathic Association (AOA) lobby the Drug Enforcement Administration (DEA) to amend its policy~~ continues to advocate for government regulations and institutional protocols in long-term care facilities that allow pharmacists to accept verbal orders from nurses acting as agents of attending physicians to ensure patients have timely access to controlled substances (CII – VI). ~~to allow pharmacists to accept verbal orders from nurses at long-term care facilities as agents of the attending physicians in order to rapidly treat patient pain~~. *(Original 2010)*

ACTION TAKEN: _____

DATE: _____

SUBJECT: Tanning Facilities ~~Parlor, Prohibit the Sale of Ultraviolet Rays to those Under 18 Years of Age~~

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

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

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

~~WHEREAS, there are more than 1,000,000 new cases of skin cancer diagnosed each year and most of these skin cancers were preventable, representing almost 50 percent of the more than 2,000,000 total overall cancers diagnosed each year; and~~

~~WHEREAS, melanoma rates have increased by 60 percent since the mid-1970s; and~~

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

~~WHEREAS, the US Food and Drug Administration has ruled that tanning rays are carcinogenic agents and the World Health Organization recently recommended that no one under the age of 18 use tanning beds and sunlamps; and~~

~~WHEREAS, 28 states currently regulate the practice of indoor tanning by children under the age of 18, and 21 of those 28 states restrict youth access to indoor tanning facilities in some way; and~~

~~WHEREAS, current AMA policy (H-440.959 and H-440.980) which recognizes the harmful effects of UV light and the correlation between the use of indoor tanning equipment and the incidence of skin cancer has resulted in AMA policy (Directive D-440.969) to take federal action limiting the availability of indoor tanning equipment to anyone under age 18; now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association support state legislation to prohibit the sale of tanning parlor ultraviolet ray to those under 18 years of age except as prescribed by a physician and that OOA widely disseminate this legislation to its component societies.~~

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

WHEREAS, HB 131, effective June 23, 2015, was signed into law by Governor Kasich and establishes consent requirements, which vary depending on the age of the Individual and must be satisfied before a tanning facility operator or employee may allow an individual to use sun lamp tanning services; now, therefore, be it

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

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

ACTION TAKEN: _____

DATE: _____

Ohio Legislative Service Commission

Final Analysis

Kelly Bomba

Sub. H.B. 131

130th General Assembly
(As Passed by the General Assembly)

Reps. Johnson and Stinziano, Antonio, Beck, Boyd, Dovilla, Driehaus, Duffey, Fedor, Grossman, C. Hagan, R. Hagan, Letson, Ramos, Ruhl, Slaby, Stebelton, Wachtmann, Bishoff, Anielski, Baker, Butler, Carney, Kunze, Mallory, Milkovich, O'Brien, Rogers, Sprague, Terhar

Sens. Kearney, Hite, Lehner, Seitz, Turner

Effective date: June 23, 2015

ACT SUMMARY

Establishes consent requirements, which vary depending on the age of the individual, that must be satisfied before a tanning facility operator or employee may allow an individual to use sun lamp tanning services.

Requires a tanning facility operator or employee to follow procedures established by the Board of Cosmetology to determine the age of an individual seeking to use the facility's sun lamp tanning services.

Requires the Board to impose a fine on a tanning facility operator or employee for certain violations.

Requires that the Board regulate tanning facilities that use tanning chemicals, such as spray-on tans, and facilities that use visible light for cosmetic purposes.

CONTENT AND OPERATION

Consent requirements for fluorescent sun lamp tanning

The act establishes consent requirements that must be satisfied, beginning June 23, 2015, before an individual uses fluorescent sun lamp tanning services at a tanning facility. It prohibits a tanning facility operator or employee from allowing an individual to use those services without first satisfying the consent requirements, which vary

depending on the age of the individual.[1] The act also repeals a provision requiring the State Board of Cosmetology to adopt rules requiring a consumer under age 18 to obtain written consent from the individual's parent or legal guardian prior to receiving tanning services.[2]

Adults

For an individual age 18 or older, the act specifies that the consent requirements are satisfied if the individual signs the consent form developed by the Board (see "**Consent form**," below). The consent is valid indefinitely.[3]

Children who are 16 or 17

For an individual who is at least age 16 but less than age 18, the act specifies that the consent requirements are satisfied if the individual's parent or legal guardian signs the consent form in the presence of the tanning facility operator or employee. The consent is valid for 90 days, and the operator or employee may not allow the individual to use the sun lamp services for more than 45 sessions during that 90-day period. A session may not last longer than the maximum safe time of exposure specified by the Board.[4]

Children under 16

For an individual under age 16, the act specifies that the consent requirements are satisfied if the individual's parent or legal guardian does both of the following:

(1) Signs the consent form in the presence of a tanning facility operator or employee before each sun lamp tanning session;

(2) Is present at the tanning facility for the duration of each sun lamp tanning session.[5]

Consent form

The act requires the Board to develop the consent form that is to be used to satisfy the consent requirements. The form must describe the health effects of sun lamp

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[1] R.C. 4713.50(B) and Section 3.

[2] R.C. 4713.08(A)(17)(f) (repealed).

[3] R.C. 4713.50(B)(1).

[4] R.C. 4713.50(B)(2).

[5] R.C. 4713.50(B)(3).

radiation, including the possible relationship of the radiation to skin cancer. In developing the form, the Board is to consult with the Department of Health, dermatologists, and tanning facility operators. The Board must make the form available on its Internet website.[6]

Electronic signature

The act specifies that the consent form may be signed electronically.[7]

Age verification

To determine which consent requirements must be satisfied, the act requires a tanning facility operator or employee to make reasonable efforts to determine the age of an individual seeking to use sun lamp tanning services. In a corresponding change, the act requires the Board to adopt rules establishing procedures a tanning facility operator must follow in making reasonable efforts to determine the age of an individual seeking to use sun lamp tanning services.[8]

Penalties

For a first-time offender, the act requires the Board to fine a tanning facility operator or employee $500 for (1) failure to make reasonable efforts to determine the age of an individual seeking to use the facility's sun lamp tanning services or (2) allowing an individual under age 18 to use the sun lamp tanning services without satisfying the consent requirements. For subsequent offenders, the act permits the Board to determine the appropriate punishment in accordance with its existing authority, which could include a fine, suspension or revocation of a license or permit the Board issues, or requiring the license or permit holder to take corrective action courses.[9]

Regulation of other tanning facilities

The act provides for the regulation of additional tanning facilities beginning June 23, 2015. Under continuing law, a tanning facility is defined as a room or booth that houses equipment or beds used for tanning human skin by the use of fluorescent sun lamps using ultraviolet or other artificial radiation. The act expands that definition to also include premises that contain a room or booth with:

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[6] R.C. 4713.51.

[7] R.C. 4713.50(C).

[8] R.C. 4713.50(A) and 4713.08(A)(17)(g).

[9] R.C. 4713.64(D).

(1) Equipment that applies chemicals to human skin to create the appearance of being suntanned, including chemical applications commonly referred to as spray-on, mist-on, or sunless tans; or

(2) Equipment or beds that use visible light for cosmetic purposes.[10]

Under the act, the Board is to regulate these tanning facilities in much the same manner as it regulates fluorescent sun lamp tanning facilities. For example, the operator of one of these tanning facilities also must obtain a permit from the Board, renew the permit biennially, and pay the required fees established by Board rule ($65 for an initial permit; $50 for biennial renewal).[11] Failure to do so is a fourth degree misdemeanor on a first offense and a third degree misdemeanor on subsequent offenses.[12] Such a tanning facility also becomes subject to standards, adopted by the Board in rules, for installing and operating a tanning facility in a manner that ensures the health and safety of consumers.[13] Finally, the Board is authorized to inspect facilities and to discipline operators for failing to comply with any requirement found in statute or rule.[14]

HISTORY

ACTION	DATE
Introduced	04-17-13
Reported, H. Health & Aging	05-28-14
Passed House (92-4)	06-04-14
Reported, S. Commerce & Labor	12-10-14
Rereported, S. Rules	12-11-14
Passed Senate (26-4)	12-11-14
House concurred in Senate amendments (86-3)	12-17-14

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[10] R.C. 4713.01.

[11] R.C. 4713.08(A)(16) and R.C. 4713.48, not in the act; Ohio Administrative Code 4713-19-03.

[12] R.C. 4713.14(Q) and 4713.99, not in the act.

[13] R.C. 4713.08(A)(17).

[14] R.C. 4713.06 and 4713.48, not in the act, and R.C. 4713.64.

SUBJECT: Transformation of Ohio DO Primary Care Practices into Medical Homes

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, the American Osteopathic Association, American Academy of Family Physicians, American Academy of Pediatrics, and American College of Physicians in 2007 released the *Joint Principles of the Patient-Centered Medical Home*, and~~

~~WHEREAS, the patient centered medical home (PCMH) is an approach to providing comprehensive primary care to adults, youth and children in order to broaden access to primary care, while enhancing care coordination; and~~

~~WHEREAS, the Medicare Physician Payment Commission, in its June 2008 report to Congress called on CMS to initiate a Medicare medical home pilot project, which must meet stringent criteria, including at least the following capabilities:~~

- ~~Furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),~~
- ~~Conduct care management,~~
- ~~Use health information technology for active clinical decision support,~~
- ~~Have a formal quality improvement program,~~
- ~~Maintain 24 hour patient communication and rapid access,~~
- ~~Keep up to date records of beneficiaries' advance directives, and~~
- ~~Maintain a written understanding with each beneficiary designating the provider as a medical home; and~~

~~WHEREAS, the Patient Centered Primary Care Collaborative (PCPCC), with more than 600 members is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians and many others who have joined together to develop and advance the patient centered medical home (PCMH); and~~

~~WHEREAS, on January 2, 2008, the National Committee for Quality Assurance (NCQA) released standards for Physician Practice Connections® Patient-Centered Medical Home (PPC-PCMH™); and~~

~~WHEREAS, the PPC-PCMH program builds upon NCQA's current Physician Practice Connections program to identify primary care practices that function as patient-centered medical homes, where care is facilitated by registries, information technology, health~~

~~information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner; and~~

~~WHEREAS, the PPC-PCMH program has nine PPC standards, including 10 must pass elements, which can result in one of three levels of recognition for physician practices; and~~

~~WHEREAS, in July 2009, the Ohio General Assembly created the Ohio Health Care Coverage and Quality Council (HCCQC) following its initial creation by an Executive Order from Governor Ted Strickland, as a public-private partnership designed to improve the coverage, cost, and quality of Ohio's health insurance and health care system; and~~

~~WHEREAS, the Council builds on Ohio's participation in two national programs, the State Coverage Initiative (SCI) and the State Quality Improvement Institute (SQII), and resulted in the creation of four task forces focused on Payment Reform, Medical Homes, Consumer Engagement and Health Information Technology; and~~

~~WHEREAS, Richard J. Snow, DO, represents the Ohio Osteopathic Association on the HCCQC and has been appointed chair of the Council's Medical Home Task Force; and~~

~~WHEREAS, the Medical Home Task Force has focused on developing a medical home definition for use in Ohio by identifying the characteristics of a medical home by reviewing existing definitions used in other states and developed by national professional organizations; and~~

~~WHEREAS, the Council has now formed a Multi-Payer Enhanced Primary Care Home Initiative to develop a medical home funding model in the state of Ohio; and~~

~~WHEREAS, Representatives Peggy Lehner (R-Dayton) and Peter Ujvagi (D-Toledo) have cosponsored HB 198 with the ongoing support of the OOA, which creates the Ohio Patient Centered Medical Home Education Pilot Project and establishes a Patient Centered Medical Home Education Advisory Group that includes a representative of the Ohio University College of Osteopathic Medicine and one individual appointed by the Ohio Osteopathic Association; and~~

~~WHEREAS, HB 198 passed the Ohio House of Representatives by a vote of 96-0 after 11 different versions of the bill were drafted and discussed; and~~

~~WHEREAS, HB 198, which is currently on fast track in the Senate Health Committee, requires the Advisory Committee to select up to ten practices affiliated with the Centers for Osteopathic Research and Education of the Ohio University College of Osteopathic Medicine to participate in the Medical Home Education Pilot Project; now, therefore, be it~~

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

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

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

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

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

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

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

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

RESOLVED, that the Ohio Osteopathic Association continues to strongly encourage its members ~~to study the medical home model and assist its primary care physician members in~~ to seek assistance in transform~~ing~~ their practices into patient centered medical homes; and, be it further

RESOLVED, that the OOA work with the State of Ohio, ~~primary care physicians through the~~ CliniSync/Ohio Health Information Partnership and other physician organizations, to assist physicians ~~practices in purchasing and implementing electronic medical records, which is an important part of obtaining medical home certification under the National Committee on Quality Assurance~~ in preparing their practices to be ready for new payment methods; and, be it further

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

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-21

SUBJECT: Expansion of FALCPA Labeling Requirements to Restaurant and School Foods in Ohio

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

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

WHEREAS, newer food allergies (e.g. gluten) have been linked to preventable end-organ damage with chronic consumption;[1] and

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

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

WHEREAS, restaurants can easily compile this information at the time of recipe design; and

WHEREAS, furthermore FALCPA 2004 fails to list gluten as one of their eight key antigens; now, therefore, be it

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

RESOLVED, that the OOA recommend to the Ohio Department of Health that gluten be considered an allergen in addition to the eight FALCPA defined allergens.

ACTION TAKEN: _____

DATE: _____

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[1]http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/Allergens/ucm106187.htm http://consensus.nih.gov/2004/2004CeliacDisease118html.htm

RES. NO.
2015-22

SUBJECT: Expansion of Gender Questions on Ohio Medical School Secondary Applications

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, an estimated 0.5-1.0% of the population identify as transgender or gender non-conforming and over the last decade the transgender community has become much more represented and visible in health professional schools[1]; and

WHEREAS, the American Medical Association (AMA) has an implemented policy outlining their support for increased diversity across all specialties in the physician workforce in categories including sexual orientation/gender identity; thus medical schools should greet this growing demographic with a similar welcoming and equitable climate[2]; and

WHEREAS, hundreds of medical schools use American Medical College Application Service (AMCAS) and American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) for applications, which require individuals to designate a male or female gender, and state one must use their Designated at Birth (DAB) gender; and

WHEREAS, the DAB gender of a medical school applicant is not a necessary factor in determining the quality and competitiveness of their candidacy for matriculation; and

WHEREAS, expanding the number and type of gender questions on Ohio's Medical School Secondary Applications would not only acknowledge a transgender applicant's identity but help encourage institutional equity and establish a precedent of a more sensitive, knowledgeable and welcoming educational environment for all applicants[3]; and

WHEREAS, as medical professionals, we have special knowledge and expertise of the breadth and depth of human and biological diversity of gender and sex, and the gender questions asked on medical school applications should reflect this professional acknowledgement of the diverse issues involving human sexual orientation and gender identity[4]; and

WHEREAS, a large majority of transgender people report avoiding employment discrimination by hiding their gender or gender transition (71%) or delaying their gender transition (57%); thus Ohio should empower transgender medical students to be their authentic selves like their cis-gender (i.e. identifying as their DAB gender) colleagues[5]; and

WHEREAS, the Ohio medical community should continue to be at the forefront of change aligning with the Human Rights Campaign Foundation's Healthcare Equality Index 2014, which identified Ohio hospitals as leaders in LGBT health care equality[6]; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association shall adopt a position that all accredited Ohio Medical Schools should expand their gender identity questions to include legal sex, gender identity and preferred pronouns on secondary applications by the matriculating class of 2021; and, be it further

RESOLVED, that the OOA petition the American Osteopathic Association and American Medical Association to adopt a position and lobby for expansion of the gender identity questions on the applications of all accredited allopathic and osteopathic medical schools in the United States.

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[1] Snowdon, S. (2013). Recommendations for Enhancing the Climate for LGBT Students and Employees in Health Professional Schools. Retrieved December 12, 2014, from www.glma.org

[2] AMA Policy on LGBT Issues. (2014, January 1). Retrieved December 12, 2014, from www.ama.org

[3] Transgender Health Resources. (2014, March 24). Retrieved December 14, 2014, from www.AMSA.org

[4] West, N. (2014, Spring). Diversity and Inclusion Update. Retrieved December 12, 2104, from http://pritzker.uchicago.edu/about/news/pritzkerpulse/2014spring/sex-and-gender.shtml

[5] Grant, J., Mottet, L., & Tanis, J. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Retrieved December 14, 2014, from http://transequality.org/PDFs/Executive_Summary.pdf

[6] Magaw, T. (2014, October 25). Local hospitals step up as leaders on LGBT issues. Retrieved October 28, 2014, from http://www.crainscleveland.com/article/20141025/FREE/141029855/local-hospitals-step-up-as-leaders-on-lgbt-issues

ACTION TAKEN: _____

DATE: _____

SUBJECT: The Use of Alcohol-Based Hand Sanitizer Dispensers in Hospital Bathroom Stalls

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, people do not always wash their hands after using the bathroom with one study estimating that one in five people fail to practice any hand-washing hygiene after using public restrooms[1]; and

WHEREAS, individuals using hospital restrooms can touch items including but not limited to their clothing, the toilet handle, the bathroom stall lock and the sink facet before taking any steps to sanitize their hands, allowing potential propagation of infection-causing germs to fomites that could ultimately get passed to patients; and

WHEREAS, one study demonstrated that vancomycin-resistant Enterococcus faecium and methicillin-resistant Staphylococcus aureus (MRSA) could survive on fomites for 24 hours and that Pseudomonas aeruginosa could survive for one hour[2]; and

WHEREAS, a Centers for Disease survey has reported that on any given day, about one in 25 hospital patients has at least one healthcare-associated infection (HAIs) including but not limited to hospital-onset MRSA[3]; and

WHEREAS, numerous studies show that better hand hygiene practices can greatly reduce the spread of infections in the hospital[4]; and

WHEREAS, although Alcohol-Based Hand Sanitizer (ABHS) are not as effective against spore-forming bacteria such as Clostridium difficile, they do have proven efficacy of acting fast and significantly reducing the number of many gram positive and negative bacterias, mycobacteria and fungal and viral pathogens on the skin[5]; and

WHEREAS, the use of ABHS immediately after using of the restroom while still within the stall could reduce the incidence and prevalence of certain HAIs by limiting the opportunity for infection-causing germs to colonize on fomites; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association lobby for further research into the use of ABHS dispensers inside bathroom stalls as an cost effective means to reduce the incidence of preventable HAIs; and, be it further

RESOLVED, that the Ohio Osteopathic Association report the research results on the use of ABHS dispensers inside bathroom stalls as a means to reduce incidence of preventable HAIs to our American Osteopathic Association; and, be it further

RESOLVED, that the Ohio Osteopathic Association lobby for continued education of good hand-washing hygiene both through the use of ABHS and traditional soap and water.

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[1] Study Finds Decline in Handwashing Behavior. (2007, December 1). Retrieved January 15, 2015, from http://forms.asm.org/microbe/index.asp?bid=55081

[2] Weaver, J. (2005, Fall). The Increasing Use of Alcohol-Based Hand Sanitizers. Retrieved January 15, 2015, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586789/

[3] HAI Prevalence Survey. (2015, January 12). Healthcare Associated Infections (HAIs) from Centers for Disease Control and Prevention. Retrieved January 15, 2015, from http://www.cdc.gov/HAI/surveillance/

[4] Hand Hygiene. (2001, January 1). Infection Control and Epidemiology from University of Michigan Health Systems. Retrieved January 15, 2015, from http://www.med.umich.edu/ice/info.htm

[5] Show Me the Science - When to Use Hand Sanitizer. (2014, October 17). Handwashing: Clean Hands Save Lives from Centers for Disease Control and Prevention. Retrieved January 15, 2015, from http://www.cdc.gov/handwashing/show-me-the-science-hand-sanitizer.html

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-26

SUBJECT: Eliminating Non-Healthy Food Choices in Health Care Facilities

SUBMITTED BY: Columbus Osteopathic Association

REFERRED TO:

WHEREAS, according to the Centers for Disease Control and Prevention (CDC) the top two leading causes of death in 2012 were heart disease and cancer; the fourth stroke, and the seventh diabetes[1]; and

WHEREAS, the US Department of Agriculture Economic Research Service determined that diet is a significant factor in the risk of heart disease, some cancers, stroke and diabetes; similarly, playing a major role in the development of hypertension and obesity[2]; and

WHEREAS, the CDC stated that in 2012 more than one-third of Americans (34.9 percent) were categorized as obese based on BMI standards[3]; and

WHEREAS, a 2005 study found that 89 percent of US pediatric hospitals had some form of fast-food outlet on their campus[4]; and

WHEREAS, the Partnership for a Healthy America noted in their 2013 reports that nearly 400 hospitals joined the Hospital Health Food Initiative with the goal to provide healthy meals filled with more fruits, vegetables, whole grains and fewer calories for patients and their family members at prices equal to or lower than other menu options[5]; and

WHEREAS, historic scholars have provided strong messages regarding the impact of diet on health, including Hippocrates who said, "Let food be thy medicine and let thy medicine be food." Likewise, Thomas Edison noted, "The doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease"; and

WHEREAS, the Osteopathic Pledge of Commitment expects members of the osteopathic medical profession to promote health[6]; and

WHEREAS, the Osteopathic Oath expects members to "be mindful always of my great responsibility to preserve the health and life of my patients..."[6]; now, therefore be it

RESOLVED that the Ohio Osteopathic Association supports the crusade for all health care facilities to eliminate non-healthy food options provided to patients, employees and all other persons associated with the facility; and, be it further

RESOLVED that this resolution be submitted to the American Osteopathic Association for consideration at the 2015 AOA House of Delegates.

ACTION TAKEN: _____

DATE: _____

REFERENCES:

[1] Jiaquan Xu, MD; Kenneth D. Kochanek, MA; Sherry L. Murphy, BS; Elizabeth Arias, PhD. Mortality in the United States, 2012. NCHS Data Brief. No. 168. October 2014

[2] Aldrich, Lorna. Food Safety Policy: Balancing Risks and Costs. FoodReview, US Dept. Agr., Econ. Res. Serv., Vol. 17, No. 2, pp. 9-13, May-Aug. 1994.

[3] Centers for Disease Control and Prevention. NCHS Data on Obesity. NCHS Fact Sheet. http://www.cdc.gov/nchs/data/factsheets/factsheet_obesity.htm.

[4] Centers for Disease Control and Prevention. Health Hospital Choices. Division of Nutrition, Physical Activity, and Obesity.

[5] Partnership for a Healthier America, 2013 Annual Progress Report. www.ahealthieramerica.org

[6] American Osteopathic Association. AOA Code of Ethics and Osteopathic Pledge of Commitment. www.Osteopathic.org

Ad Hoc Reference Committee

Purpose: To consider resolutions not having a specific category.

Resolutions: 02, 03, 06, 08, 09, 12, 13, 20

Members:

Henry L. Wehrum, DO, Chair (District VI)
Melinda E. Ford, DO (District IX)
Aaron P. Hanshaw, DO (District III)
Lili A. Lustig, DO (District VII)
Charles D. Milligan, DO (District VIII)
Carol Tatman, OOA Staff

Lilac Room

RES. NO.
2015-02

SUBJECT: ~~Antitrust Laws and Insurance Companies~~ Silent PPO's

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2010 BE AMENDED AND APPROVED:

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

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

RESOLVED, that the OOA continue to advocate for prohibitions against such practices at the state and national levels.~~.; and be it further~~

~~RESOLVED, that the OOA continues to encourage the American Osteopathic Association (AOA) to seek revisions in antitrust laws that exempt the insurance industry from antitrust statutes under the McCarran-Ferguson Act and are detrimental to physicians and other healthcare providers.~~ *(Original 2000)*

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-03

SUBJECT: AOA Health Policy Fellowship

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2010 BE AMENDED AND APPROVED:

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-06

SUBJECT: Charity Care

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED THAT THE FOLLOWING POLICY STATEMENT ADOPTED IN 2009 BE AMENDED AND APPROVED:

~~WHEREAS, current economic conditions will increase the number of patients unable to pay for needed medical care; and~~

~~WHEREAS, there are limited options for these patients to obtain care; and~~

~~WHEREAS, physicians are willing to continue to provide uncompensated services to those in need; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to advocate ~~federal and state governments establish mechanisms~~ for tax incentives and credits ~~relief~~ for physicians ~~providing~~ who provide pro bono care to ~~designated~~ uninsured patients with financial need; and, be it further

RESOLVED, that the OOA encourage all physicians to ~~increase their~~ participate~~ion~~ in pro bono care programs that provide health care services to Ohio's most vulnerable and needy populations.~~; and, be it further~~

~~RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association (AOA) for consideration at the 2009 AOA House of Delegates.~~ (*Original 2009)*

ACTION TAKEN: _____

DATE: _____

SUBJECT: ~~Electronic Medical Records, Helping the Osteopathic Profession in Ohio Achieve Meaningful Use of (2010)~~ **Assisting the Osteopathic Profession in Leveraging Electronic Health Records (EHRs) For Value Based Payment**

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, the State of Ohio's 2010-11 biennial budget allocates $8 million in non-general revenue funds to the Ohio Department of Insurance to support activities related to health information technology; and~~

WHEREAS~~, Governor Ted Strickland, in September 2009, designated~~ CliniSync/Ohio Health Information Partnership ~~(OHIP)~~ was established in 2009 as a private, non-profit foundation with $51 million in state and federal grants to lead the implementation and support of health information technology throughout Ohio ~~as a public-private collaboration~~; and

WHEREAS, ~~Governor Strickland asked~~ the Ohio Osteopathic Association, Ohio State Medical Association, and Ohio Hospital Association~~, BioOhio, and the Ohio Department of Insurance to be the original incorporating members of OHIP and to apply for federal stimulus money allocated under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH),~~ continue as permanent members of CliniSync's executive committee and have developed a business model to sustain CliniSync as Ohio's Health Information Exchange (HIE); and

~~WHEREAS, OHIP -- with endorsements of most of the state's physician associations, hospital systems and the major third party payers, applied for and received a $14.9 million HITECH grant to create a statewide Health Information Exchange (HIE) and a $28.5 million grant to create a statewide Regional Extension Center (REC) using the $8 million allocated to the Ohio Department of Insurance as match money~~; and

WHEREAS, the Partnership has met its original a goal of assisting more than 6,000 primary care physicians with the adoption, implementation, and use of electronic health records at Stage 1 Meaningful Use ~~Stage 1, resulting in; the goal of REC grant is to assist 6,000 priority primary care providers (PPCPs) in Ohio to achieve meaningful use of electronic health records by 2011~~; and

WHEREAS, this assistance, along with that provided by HealthBridge in Cincinnati, has resulted in 170 hospitals and at least 7,000 Ohio primary care providers receiving more

than $1.2 billion in incentive payments from Medicare and Medicaid; and

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

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

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

~~WHEREAS, OHIP has designated seven regional RECs composed of a broad-based coalition of stakeholders, that will provide direct assistance support to PPCPs for:~~
~~1. Vendor selection and group purchasing~~
~~2. Implementation and project management~~
~~3. Practice and workflow redesign~~
~~4. Functional interoperability and health information exchange~~
~~5. Privacy and security best practice~~
~~6. Progress towards meaningful use; and~~

~~WHEREAS, OHIP will also be coordinating efforts with HealthBridge, of Cincinnati, which received a separate REC grant from the federal government, covering 11 counties in Southwest Ohio; and~~

~~WHEREAS, federal funds will be disbursed to OHIP and its regional partners based on helping these providers reach three milestones, which include (1) signing provider contracts with the next 12 months; (2) going live with Electronic Health Records (EHR) with at least e-prescribing and public reporting use; and (3) achieving "meaningful use" (MU) of EHRs which is currently being defined by federal rule; and~~

~~WHEREAS, physicians, regardless of specialty, who achieve meaningful use can receive up to $63,750 in incentive money from Medicaid or $44,000 in incentive money from Medicare if they achieve meaningful use of EHRs by 2012; now, therefore, be it~~
~~RESOLVED, that the Ohio Osteopathic Association urge its districts and affiliated organizations to promote OHIP as a mechanism to help all DOs in the state of Ohio to implement electronic medical records and achieve meaningful use by 2012; and, be it further~~

~~RESOLVED, that the OOA strongly encourage its members to take advantage of Medicare or Medicaid incentive payments for implementing EHR in their practices; and, be it further~~

~~RESOLVED, that the OOA urge all priority primary care physicians to sign OHIP agreements and take advantage of educational opportunities and implementation assistance that will be provided by the OHIP and its Regional Extension Centers.~~

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

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

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

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-09

SUBJECT: Gratis Medications

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

~~WHEREAS, there is an increase in the need for medical care; and~~

~~WHEREAS, this has resulted in an associated need for gratis medications; and~~

~~WHEREAS, a significant amount of expired medications are disposed of and unavailable for patients; and~~

~~WHEREAS, a recent review in *The Medical Letter* (Vol. 51, Issue 1327/1328, p. 100) indicates that most medications are good for clinical use far beyond the manufacturer's date of expiration; and~~

~~WHEREAS, the US Food and Drug Administration (FDA) regulations currently prohibit the clinical use of adulterated medications, including adulteration by means of expiration; and~~

~~WHEREAS, a significant increase in the availability of gratis medications would be provided if FDA regulations would allow reasonable and prudent use of expired medications; now, therefore, be it~~

RESOLVED, the Ohio Osteopathic Association (OOA) ~~petition the FDA for~~ supports changes in Food and Drug Administration regulations ~~regarding shelf life extensions on medications~~, to allow the gratis distribution of medications to needy patients after the manufacturer's expiration date with patient consent, provided such medications are deemed safe by the FDA for clinical use, based on evidence-based studies by independent researchers. ~~deemed appropriate by the FDA for patients, with patient consent; and, be it further~~

~~RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association for consideration at the 2010 House of Delegates.~~

ACTION TAKEN: _____

DAYE: _____

SUBJECT: Medical Error Reporting System in Ohio

SUBMITTED BY OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED BY SUBSTITUTION AND APPROVED:

~~RESOLVED, that the Ohio Osteopathic Association supports the creation of an Ohio "patient safety center" which would be a cooperative venture of the Ohio Osteopathic Association, Ohio Hospital Association, Ohio State Medical Association, Ohio Department of Health, Ohio State Medical Board, and other appropriate public and private agencies that would include the development of a protocol for medical error disclosure to patients and a statewide uniform medical error reporting system; and, be it further,~~

~~RESOLVED, that the OOA supports legislation that would mandate and fund an "Ohio patient safety center," to (1) coordinate patient safety efforts at institutions across the state; (2) identify best practices in patient safety; (3) educate health care providers about best practices; (4) identify funding sources for the implementation of best practice strategies; (5) develop data collection systems and protocols for error reporting; and (6) make appropriate recommendations to the Legislature concerning the funding of such activities; and, be it further;~~

~~RESOLVED, that any medical error reporting system in Ohio maintain strict confidentiality of all patient, physician and hospital data and only report data in the aggregate to encourage the full reporting of medical errors to the center.~~ *(Original 2005)*

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

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

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2015-13

SUBJECT: Nursing Homes, Staffing

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ADOPTED IN 2010 BE AMENDED AND APPROVED:

RESOLVED, that the Ohio Osteopathic Association supports ~~the efforts of~~ by the State of Ohio ~~Ohio Department of Health to improve nursing home care by~~ to increase the number of training programs for State Tested Nurses Aides (STNAs) to ensure appropriate staffing ratios and quality of care in Ohio's nursing homes. ~~the availability of appropriate nursing home staff to provide quality care; and, be it, further~~

~~RESOLVED, that the Ohio Osteopathic Association OOA supports efforts to train more certified nurse assistants in the state of Ohio, so that a serious shortfall between regulated staffing and availability of that staffing does not further limit the quality of care available to Ohio's nursing home residents.~~ *(Original 2000)*

ACTION TAKEN: _____

DATE: _____

SUBJECT: Independent Practices in Rural Areas

SUBMITTED BY: Marietta (IX) Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, with the current state of the healthcare system, it is more cost effective for physicians to be employed under a hospital or take part in Accountable Care Organizations[1]; and

WHEREAS, from 2012 to 2013 independent practices decreased, while the number of hospital-employed doctors grew from 20 percent to 26 percent[2]; and

WHEREAS, the primary reasons physicians choose to leave private practice are high overhead cost and reimbursement cuts[3]; and

WHEREAS, after the passage of the Affordable Care Act, the shift from a fee-for-service model to an outcome-based model for physician reimbursement has yielded more Accountable Care Organizations and far fewer independent practices[4]; and

WHEREAS, economic theory suggests that small businesses are an integral part in stimulating communities and the economy which could play a large role in rural areas[5]; and

WHEREAS, a significant barrier to proper healthcare for individuals living in under served areas is the accessibility of a health care office in rural parts of Ohio[6]; and

WHEREAS, transportation issues, cultural barriers, long geographic distances keep patients living in rural areas of Ohio from receiving proper healthcare[7]; and

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

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

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[1] (2013): 1-19. Jackson Healthcare, Apr. 2013. Web. 27 Dec. 2014. <http://www.jacksonhealthcare.com/media/191888/2013physiciantrendsvoid_ebk0513.pdf>.
[2] Ibid.
[3] Ibid

[4] "Health Wanted: The State of Unmet Need for Primary Healthcare in America." (2012): 1-37. National Association of Community Health Centers, Mar. 2012. Web. 27 Dec. 2014. <https://www.nachc.com/client//HealthWanted.pdf>.

[5] Zakaria, Fareed. "A Flight Plan for the American Economy." Fareed Zakaria. CNN, 19 May 2011. Web. 27 Dec. 2014. <http://fareedzakaria.com/2011/05/19/a-flight-plan-for-the-american-economy/>.

[6] v Jarmusz, Donna F. "REJournals.com - Commercial Real Estate Property News for Chicago and the Midwest." Affordable Care Act Effects Major Changes|REJournals.com. N.p., 21 Mar. 2014. Web. 27 Dec. 2014. <http://www.rejournals.com/2014/03/21/affordable-care-act-effects-major-changes/>.

[7] Ibid.

ACTION TAKEN: _____

DATE: _____

Appendix

EXECUTIVE COMMITTEE 2014-15

President	Paul T. Scheatzle, DO
President-Elect	Robert W. Hostoffer, Jr., DO
Vice President	Geraldine N. Urse, DO
Treasurer	Sean D. Stiltner, DO
Immediate Past President	Robert L. Hunter, DO
Executive Director	Mr. Jon F. Wills

BOARD OF TRUSTEES 2014-15

DISTRICT		TERM EXPIRES
NW OHIO-I	Nicholas G. Espinoza, DO	2017
LIMA-II	Wayne A. Feister, DO	2017
DAYTON-III	Jennifer J. Hauler, DO	2017
CINCINNATI-IV	Sean D. Stiltner, DO	2017
SANDUSKY-V	Gilbert S. Bucholz, DO	2016
COLUMBUS-VI	Henry L. Wehrum, DO	2016
CLEVELAND-VII	John J. Wolf, DO	2016
AKRON/CANTON-VIII	Charles D. Milligan, DO	2015
MARIETTA-IX	Jennifer L. Gwilym, DO	2016
WESTERN RESERVE-X	John C. Baker, DO	2015
RESIDENT	Edward A. Craft, DO	*
OU-COM STUDENT	Daniel Krajcik, OMS II	2015

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

NEW TRUSTEES 2015-16

Akron/Canton-VIII	Charles D. Milligan, DO	2018
Western Reserve-X	John C. Baker, DO	2018
Resident	Daniel Chang, DO	2016
OU-COM Student Rep.	Andre Bown, OMS I	2016

2014-15 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	Gordon J. Katz, DO	Christine B. Weller, DO
IV	Michael E. Dietz, DO	Scott A. Kotzin, DO
V	Nicole J. Barylski-Danner, DO	James E. Preston, DO
VI	J. Todd Weihl, DO	Carrie A. Lembach, DO
VII	Michael P. Rowan, DO	Katie Pestak, DO
VIII	Douglas W. Harley, DO	Kevin A. Zacour, DO
IX	Melinda E. Ford, DO	Poncet C. Bills, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2015-16 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	Jennifer J. Hauler, DO	Aaron P. Hanshaw, DO
IV	Michael E. Deitz, DO	Scott A. Kotzin, DO
V	Nicole J. Danner, DO	James E. Preston, DO
VI	Darren J. Sommer, DO	Carrie A. Lembach, DO
VII	John J. Wolf, Jr., DO	Katie E. Pestak, DO
VIII	Mark J. Tereletsky, DO	David A. Bitonte, DO
IX	Melinda E. Ford, DO	Poncet C. Bills, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2015 OOA DELEGATES AND ALTERNATES

Academy	Voting Members	Delegates/ Votes	Delegates	Alternates
Northwest Ohio	84	6/11	Nicholas G. Espinoza, DO, Chair George N. Darah, DO Tracy O'Neal Hooker, DO Ray J. Miller, DO Nicholas J. Pfleghaar, DO Roger L. Wohlwend, DO	All Northwest Ohio Members
Lima	39	3/5	John C. Biery, DO, Chair Edward E. Hosbach, DO Lawrence J. Kuk, Jr., DO	All Lima Members
Dayton	240	16/32	James A. Schoen, Jr., DO, Chair Brent Bamberger, DO Barbara A. Bennett, DO Cleanne Cass, DO Katherine A. Clark, DO Davis D. Goldberg, DO Aaron P. Hanshaw, DO Charles D Hanshaw, DO Jennifer J. Hauler, DO Robert L. Hunter, DO Mark S. Jeffries, DO Gordon J. Katz, DO Patrick J. Lytle, DO Paul A. Martin, DO Jeffrey S. Rogers, DO Ruth M. Thomson, DO	All Dayton Members
Cincinnati	45	3/6	Victor D. Angel. DO, Chair Michael E. Dietz, DO Sean D. Stiltner, DO	All Cincinnati Members
Sandusky	59	4/8	John F. Ramey, DO, Chair Gilbert S. Bucholz, DO Brett R. Kuns, DO Luis L. Perez, DO	All Sandusky Members
Columbus	313	21/42	Darren J. Sommer, DO, Chair Peter A. Bell, DO Ying H. Chen, DO John A. Cocumelli, DO Andrew P. Eilerman, DO William F. Emlich, Jr., DO Donald R. Furci, DO Miriam L. Garcellano, DO Mark W. Garwood, DO Adele M. Lipari, DO Albert M. Salomon, DO Gary L. Saltus, DO Anita M. Steinbergh, DO Eugene F. Trell, DO Charles G. Vonder Embse, DO Henry L. Wehrum, DO Maury L. Witkoff, DO	All Columbus Members
Cleveland	135	9/18	John J. Wolf, Jr., DO, Chair	All Cleveland Members

			Sandra L. Cook, DO Katherine Hovsepian Eilenfeld, DO Robert W. Hostoffer, Jr., DO Gerald F. Lackey, DO Susan H. Lackey, DO Lili A. Lustig, DO Karen H. Rickert, DO George Thomas, DO	
Akron/Canton	186	12/25	Douglas W. Harley, DO, Chair David A. Bitonte, DO Richard L. Fuller, DO Charles D. Milligan, DO Eugene D. Pogorelec, DO James R. Pritchard, DO Paul T. Scheatzle, DO M. Terrance Simon, DO Mark J. Tereletsky, DO John F. Uslick, DO Schield M. Wikas. DO Kevin A. Zacour, DO	All Akron-Canton Members
Marietta	114	9/16	Melinda E. Ford, DO, Chair. Jennifer L. Gwilym, DO Kenneth H. Johnson, DO Jean S. Rettos, DO Edward W. Schreck, DO	All Marietta Members
Western Reserve	90	6/12	Sharon L. George, DO, Chair John C. Baker, DO E. Lee Foster, DO Thomas J. Mucci, DO John J. Vargo, DO Robert M. Waite, DO	All Western Reserve Members
OU-COM	1	1/1	Andre Bown, OMS I	Samuel Nobilucci, 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 the III (Dayton), VI (Columbus), VII (Cleveland), VIII (Akron-Canton) academies and two (2) that are selected from the I (Toledo), II (Lima), IV (Cincinnati), V (Sandusky), IX (Marietta), X (Youngstown), XI Madison, and XII (Warren) academies 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, first vice president, second 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

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. Shall hear open debate on each assigned resolution

5. Shall meet in executive session after all resolutions have been discussed

6. Shall check resolutions for accuracy and format and may request staff or appropriate individuals to return during executive session.

7. Shall prepare a report for presentation by the chairman to the House of Delegates according to the Reference Committee Procedure for conducting business:

8. 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 he cannot attend the meeting and recommend a replacement from his academy

Committee Procedures

1. Purpose: The purpose of a reference committee is to hear open debate on each resolution under its consideration. The chair should limit debate and ensure that no one speaks for more than five minutes on any one topic. After all assigned resolutions have been discussed, the committee meets in executive session and then recommends that a resolution be (1) approved, (2) disapproved, (3) amended in substance and/or wording for clarity and consistency or (4) amended by substitution of another resolution.

2. Reports should be typed and worded so that the chairman can make a simple and clear report to the house. The format should be as follows:
   a. The title and number of the resolution should be typed in all caps followed by the resolution number in parenthesis.
   b. The following wording should follow each resolution title:

3. Mr. Speaker, I move adoption of Res. No. __ and the committee recommends that it be (a, b, c, or d)
   a. approved
   b. disapproved. (an explanatory note of why may be included)
   c. amended as follows and approved (see below)
   d. amended by substitution as follows and approved (see below).

4. If the committee is recommending amendment, the passage in question should be typed in full. The existing language should have a line through it and the amended passage typed in all caps:

   a. With respect to fee information,
   b. IT SHALL NOT BE CONSIDERED UNETHICAL
   c. FOR a physician TO include his charge for a standard office visit or his fee or range of fees for particular types of services.

5. If a substitute resolution is recommended the entire substitute resolution should be included in the report.

6. The committee may group multiple resolutions into a "consent calendar" for collective action by the full House of Delegates. Such calendar shall only contain resolutions that the committee agrees should be adopted as submitted without amendment. The calendar shall list the number of each resolution, followed by its title under the motion, "Mr. Speaker, I move adoption of the following resolutions and the Committee recommends that they be approved.

7. All "WHEREAS' clauses shall be dropped from resolutions that are adopted by the House of Delegates, unless they are to be forwarded to the American Osteopathic Association for consideration at the national level.

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 five years after each policy is passed for reconsideration by the full house

3. Shall recommend that such policies be reaffirmed, amended, 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

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.