2016

OHIO OSTEOPATHIC ASSOCIATION HOUSE OF DELEGATES MANUAL

FRIDAY, APRIL 22 TO SATURDAY, APRIL 23

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

Index

OSTEOPATHIC PLEDGE OF COMMITMENT

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

I pledge to:

Provide compassionate, quality care to my patients;

Partner with them to promote health;

Display integrity and professionalism throughout my career;

Advance the philosophy, practice and science of osteopathic medicine;

Continue life-long learning;

Support my profession with loyalty in action, word and deed; and

Live each day as an example of what an osteopathic physician should be.

AGENDA

Ohio Osteopathic Association
House of Delegates

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

Friday, April 22, 2016

10:30 a.m. J.O. Watson, DO Memorial Lecture *Growth Hormone, Mini-Mice, Football, Dirty Shorts, and a New Drug* – John J. Kopchick, Ph.D., OU-HCOM Goll-Ohio Eminent Scholar – Easton A/B

11:30 a.m. Update from the American Osteopathic Association President – John W. Becher, DO, FACOEP, FAAEM – Easton A/B

12:00 Noon OOA President's Installation Luncheon featuring Robert W. Hostoffer, DO, President, and Geraldine N. Urse, DO, President-Elect – Regent Ballroom

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

BUSINESS SESSION 1 – Easton Ballroom C/D/E

1:45 p.m. Welcome and Call to Order – Robert W. Hostoffer, Jr., DO, President
- Pledge of Allegiance – Dr. Hostoffer
- Invocation – Charles G. Vonder Embse, DO
- Osteopathic Pledge of Commitment – Dr. Hostoffer
- Introduction of the Speaker/Vice Speaker – Dr. Hostoffer

2:00 p.m. Opening Remarks – John F. Uslick, DO, Speaker

2:05 p.m. Credentials Committee Report – Dr. Ramey

2:10 p.m. Program Committee Report – Geraldine N. Urse, DO, President-Elect

2:15 p.m. Routine Business – Dr. Uslick
- Appointment of Jon F. Wills as Secretary of the House
- Adoption of Standing Rules
- Approval of Executive Director's Report (2015 House Proceedings and Update of OOA Policy Manual: Policy Pertaining to Fees and Dues, as approved by the OOA Board/Executive Committee, February 2016)

2:20 p.m. AOA President's Remarks – Dr. Becher

2:30 p.m. State of the State Report – Dr. Hostoffer

2:45 p.m. Report of the Advocates for the AOA and OOA – Pam Kolinski, AAOA President; and Becky Marx, AOOA Secretary

2:55 p.m. Report of the State Medical Board of Ohio – Anita M. Steinbergh, DO

3:15 p.m. Assignment of Resolutions and Reference Committees – Dr. Uslick

3:30 p.m. **Professional Affairs Reference Committee – Magnolia**
Resolutions: 13, 19, 20, and 21
Initial Members: Charles D. Milligan, DO, Chair (District VIII)
James A Schoen, Jr., DO (District III)
Henry L. Wehrum, DO (District VI)
John J. Wolf, Jr., DO (District VII)
John C. Baker, DO (District X)

Public Affairs Reference Committee – Easton C/D/E
Resolutions: 14, 18, and 22
Initial Members: Jennifer J. Hauler, DO, Chair (District III)
Ying Chen, DO (District VI)
Mark J. Tereletsky, DO (District VIII)
Alyssa Ritchie, OMS I (OU-HCOM)
Luis L. Perez, DO (District V)

Ad Hoc Reference Committee – Lilac
Resolutions: 12, 15, 16, and 17
Initial Members: Peter A. Bell, DO, Chair (District VI)
Nicklaus J. Hess, DO (District III)
Christopher J. Loyke, DO (District VII)
Douglas W. Harley, DO (District VIII)
Nicole J. Danner, DO (District V)

Constitution & Bylaws Reference Committee – New Albany Board Room
Resolutions: 1, 2, 3, 4, 5, 6, 07, 08, 09, 10, and 11
Sandra L. Cook, DO, Chair (District VII)
Adele M. Lipari, DO (District VI)
Daniel K. Madsen, DO (District IV)
Gordon J. Katz, DO (District III)
Marc S. Ucchino, DO (District X)

6:00 p.m. **Awards Reception and Recognition Ceremony, Regent Ballroom**

Saturday, April 23, 2016

7:00 a.m. Poster Exhibition – Regent Ballroom *(Posters on Display until 1:00 pm)*

8:00 a.m. *PM & R: Modifiable Burnout Biomarkers and Rehabilitating the Autonomic Nervous System* – Raouf S. Gharbo, DO

9:00 a.m. Refreshment Break

10:00 a.m. *You are the Key to HPV Cancer Prevention* – Jody M. Gerome, DO

11:00 a.m. ***Keynote Address: The Patient Centered Medical Home: The Foundation of Transformation*** **– Paul Grundy, MD, MPH, FACOEM, FACPM, Director of Global Healthcare Transformation, IBM**

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

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 p.m. OOPAC Report – Robert S. Juhasz, DO, Chair

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

4:00 p.m. Professional Affairs Reference Committee Report – Charles D. Milligan, DO, Chair

4:15 p.m. Public Affairs Reference Committee Report – Jennifer J. Hauler, DO, Chair

4:30 p.m. Ad Hoc Reference Committee Report – Peter A. Bell, DO, Chair

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

5:00 p.m. Introduction of 2016-2017 OOA President Geraldine N. Urse, DO, OOA, and recognition of Robert W. Hostoffer, Jr., DO, outgoing president

5:15 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 ....Sean D. Stiltner, DO
Vice President .....Jennifer J. Hauler, DO
Treasurer.....Charles D. Milligan, 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 2019.....Sharon L. George, DO
Unexpired Term ending 2017 .....Paul T. Scheatzle, DO
Three-year Term expiring 2019.....E. Lee Foster, DO

Ohio Delegation to the AOA House (To be distributed)

6:00 p.m. Adjournment

6:30 p.m. **House of Delegates Reception with Students - Easton A/B (Spouses Welcome)**

OOA HOUSE OF DELEGATES

PASS THE TORCH

MATCH AND MENTOR CELEBRATION

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

AND
CELEBRATE WITH FOURTH YEAR STUDENTS WHO WILL BE STARTING RESIDENCY PROGRAMS

SATURDAY APRIL 23, 2016

REGENT BALLROOM
6:30 PM – 8:30 PM

2017 OHIO OSTEOPATHIC SYMPOSIUM

COLUMBUS HILTON AT EASTON

Columbus, Ohio
April 19 – 23, 2017

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

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

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

6. Persons addressing the House shall identify themselves by name and the district they represent.

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

8. 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

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

10. 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.

11. 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.

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

13. 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.

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

15. 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.

16. 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 2015 House of Delegates

Submitted by Jon F. Wills, Executive Director

The OOA House of Delegates met, April 24-25, 2015, at the Hilton at Easton Town Center in Columbus during the Ohio Osteopathic Symposium. Physician-delegates representing the OOA's ten districts approved 23 of the 26 resolutions that were submitted, including new policy statements about independent practices in rural health, food allergies and sensitivities, medical professionals' mental health, and physician-scientist residency training. One of the resolutions, *Osteopathic Medical Student, Resident, and Physician Mental Health*, was sent to the AOA House of Delegates in July where it also passed.

During the Symposium, Robert W. Hostoffer, Jr, DO, of Cleveland, was installed as the 109th OOA president. Other elected officers include: President-elect Geraldine N. Urse, DO, of Columbus; Vice President Sean D. Stiltner, DO, of Piketon; and Treasurer Jennifer J. Hauler, DO, of Dayton. Immediate Past President Paul T. Scheatzle, DO, Canton, remains on the Executive Committee as past president. Speaker of the House John F. Uslick, DO, of Canton, and Vice Speaker David A. Bitonte, DO, MBA, MPH, presided over the meeting. Both were re-elected to another term. The House also elected Robert L. Hunter, DO; M. Terrance Simon, DO; and Gilbert S. Bucholz, DO, to the Ohio Osteopathic Foundation Board of Trustees and voted for a full slate of physicians to represent Ohio at the AOA House of Delegates in July.

NEW POLICY STATEMENTS ADOPTED

Three committees met on the first day of the House session to evaluate each resolution and conduct a five-year review of existing policies. Committee chairs then provided a report the following day to the entire House. Douglas W. Harley, DO, of Akron, chaired the Professional Affairs Committee and the following served on the panel: Jennifer L. Gwilym, DO; Edward E. Hosbach II, DO; Robert W. Hostoffer, Jr., DO; Darren J. Sommer, DO; and Jon F. Wills. The Public Affairs Committee was led by Cleanne Cass, DO, of Dayton, and the following served on the committee: Peter A. Bell; DO; Andrew B. Bown, DO; Michael E. Dietz, DO; Luis L. Perez, DO; and Cheryl Markino. Henry L. Wehrum, DO, of Columbus, chaired the Ad Hoc Committee. Members of the committee included: Melinda E. Ford, DO; Gordon Katz, DO; Lili A. Lustig, DO; Charles D. Milligan, DO; and Carol Tatman. John F. Ramey, DO, of Sandusky, chaired the Credentials Committee. Delegates adopted four new positions. The full text of those resolutions is printed here.

Independent Practices in Rural Areas

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

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

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

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

WHEREAS, economic theory suggests that small businesses are an integral part in stimulating communities and the economy which could play a large role in rural areas; and
WHEREAS, a significant barrier to proper health care for individuals living in under served areas is the accessibility of a health care office in rural parts of Ohio; and

WHEREAS, transportation issues, cultural barriers, and long geographic distances keep patients living in rural areas of Ohio from receiving proper health care; 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 health care systems to open rural practices, to provide better access to health care for Ohioans living in underserved rural areas, especially those with limited access to any type of primary health care.

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

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

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

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

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

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

WHEREAS, FALCPA 2004 fails to list gluten along with the eight key antigens; now, therefore, be it

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

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

Osteopathic Medical Student, Resident, and Physician Mental Health

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

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

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

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

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

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

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

Expansion of Physician-Scientist Residency Training

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

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

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

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

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

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

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

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

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

EXISTING POSITION STATEMENTS DELETED, AMENDED, SUBSTITUTED AND/OR REAFFIRMED

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

Advance Directives and Complementary Documents

RESOLVED, the Ohio Osteopathic Association continues to urge its members to educate 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)

Silent PPOs

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

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

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

AOA Health Policy Fellowship

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)

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 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 Statutes

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

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

Centers for Osteopathic Research and Education (CORE)
(This policy statement was amended by substitution.)

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

RESOLVED that the OOA, CORE and 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.

Charity Care

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to advocate for tax incentives and credits for physicians who provide pro bono care to uninsured patients with financial need; and, be it further

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

Obesity Epidemic

(Policy statements from 2010 and 2014 regarding obesity and childhood obesity were combined and amended by substitution for a new comprehensive policy. This resolution is being further updated this year.)

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 US 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 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 Ohio Osteopathic Association (OOA) supports the State of Ohio's ongoing initiatives to combat the epidemic of adult and childhood obesity across Ohio; and, be it further

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

RESOLVED, that the OOA 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.

Leveraging Electronic Health Records (EHRs) for Value Based Payment

(This policy was amended by substitution.)

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

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

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

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

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

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

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

WHEREAS, the Gov. John 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.

Gratis Medications

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

Leadership Development

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

Long-Term Care Facilities

RESOLVED, that the Ohio Osteopathic Association continues to advocate for government regulations and institutional protocols in long-term care facilities that allow pharmacists to accept verbal orders from nurses

acting as agents of attending physicians to ensure patients have timely access to controlled substances (CII – VI). (Original 2010)

Medical Error Reporting System in Ohio

(This resolution was amended by substitution and approved.)

WHEREAS, the Ohio Patient Safety Institute (OPSI) is a subsidiary of the Ohio Health Council, which was founded by the Ohio Hospital Association, Ohio State Medical Association, and 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 Ohio Patient Safety Institute (OPSI) programs to improve patient safety for all Ohioans. (Original 2005)

Nursing Homes, Staffing

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

Osteopathic Identity

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

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

Hospital – Physician Relationships and Medical Staff Credentialing

(OOA White Paper Position Statement, Hospitals and Economic and Exclusionary Credentialing, originally approved in 2006 and revised and affirmed in 2010; was amended by substitution as follows and the original White Paper filed in the OOA archives for historical reference.)

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:

- 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;
- 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
- 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 health care 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 health care 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 health care services that address the needs of patients.
Explanatory Note: As noted on the CMS website: 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.

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

WHEREAS, State Reps. 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 John 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.

Transformation of Ohio DO Primary Care Practices into Medical Homes
(This resolution was amended by substitution and approved.)

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 John 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 to apply 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 (OOA) continues to strongly encourage its members to seek assistance in transform their practices into patient centered medical homes; and, be it further

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

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

Zimmerman Osteopathic Dream Foundation

The position statement was deleted. (ZODF), originally endowed in Dayton to send children with life-threatening illnesses to Disney World, was administered for a number of years by 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 paperwork for three consecutive years.

Health Savings Accounts

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

RESOLUTIONS DEFEATED, REFERRED, OR WITHDRAWN

Two resolutions were referred back to the Academy for clarification and one resolution was defeated. By a standing vote, delegates approved the Committee recommendation to refer Expansion of Gender Questions on Ohio Medical School Secondary Applications back to District 9 Athens/Marietta for greater clarity. Eliminating Non-Healthy Food Choices in Health Care Facilities was referred back to District 6 Columbus for clarification. Use of Alcohol-Based Hand Sanitizer *Dispensers in Hospital Bathroom Stalls* was defeated.

OHIO OSTEOPATHIC ASSOCIATION POLICIES PERTAINING TO FEES AND DUES

On August 22, 2015, the Ohio Osteopathic Association Executive Committee voted to amend the **OOA Administrative Guide: Policies Pertaining to Fees and Dues** to charge all new members a first year rate of $395. All current members, however, were renewed for 2015-16 at the rate they were previously billed based on the five-year, incremental step increases for new members. New members, therefore, will only receive a discounted membership the first year they join the association and will be billed the regular rate of $525 for the second year of membership. The OOA Board of Trustees voted in September 2016, to approve the change recommended by the Executive Committee. The attached Administrative Guide has been revised to reflect the two-tired dues level, and is being submitted to the OOA House of Delegates as required by the OOA Bylaws. The OOA Executive Committee also voted in August, following discussion, to retain a non-dues status for students, interns and residents rather than charging a nominal fee.

OHIO OSTEOPATHIC ASSOCIATION

POLICIES PERTAINING TO FEES AND DUES

February 2016

OOA Administrative Guide

(As Approved by the OOA Board of Trustees September 13, 2015)

Initiation Fees, Annual Dues and Assessments

Initiation Fees. The Board, by a majority of the total voting members, may establish an initiation fee at any time. Such initiation fee shall continue for all new members until such time it is rescinded or revised by the Board. *(Article IV, Section 1)*

Regular Dues. Effective fiscal year 2016-17 and thereafter, the annual dues of the Ohio Osteopathic Association shall be as follows: First year of membership $395; Second year of membership and thereafter $525.

Assessments. The Board may levy assessments in times of financial emergency or to raise money for a specific purpose that requires special funding. A motion to assess must be passed by a majority of the total voting Board members. Members must be informed in writing of the purpose for all assessments and given a reasonable period to pay. If a member does not pay an assessment within the year it is initially assessed, the assessment shall continue to be billed on the member's annual dues statement until it is paid. The Board may determine when it is appropriate to drop a member for failing to pay an assessment. *(Article IV, Section 1)*

Failure to Pay Dues. Members who fail to pay their dues by November 1st of each fiscal year shall be placed on inactive status and notified in writing. The written notification shall be approved by the Board and maintained as a part of this administrative guide. Inactive members shall cease receiving all member communications and benefits at the same time they are placed on the inactive list. Inactive members shall be billed annually and reinstated upon payment of dues for the current fiscal year. Members, who fail to maintain continuous membership with 25 years of consecutive dues payments, may not qualify for life membership unless they pay any outstanding amount for the years they failed to be a member. *(Article IV, Section 1)*

Reduced Dues. A member may request the Board to grant reduced dues based on retirement, disability or financial hardship by submitting a Petition for Reduced Membership Dues on a form approved by the Board and maintained as a part of this administrative guide. The form shall specify the amounts and conditions required for each category and require the member to certify the accuracy of the information on the form. The District Trustee shall review petitions from members of his/her district and authenticate the information for accuracy. The Board, by majority vote, may approve the petition upon recommendation of the District Trustee. Dues reductions based on temporary disability or financial hardship must be verified annually by the OOA Director of Membership. *(Article IV, Section 3)*

Interns/Residents and Fellows. The OOA Director of Membership shall contact Ohio hospitals by September of each year to obtain the contact information for any DO who is in an approved internship or residency program in the state of Ohio. All DOs in training shall be eligible for membership without application. A DO who is in an approved out of state residency/internship program may petition for membership by applying as a resident member and certifying his/her intent to return to Ohio to establish a practice. The Board shall approve a resident application and maintain it as part of this administrative guide. Osteopathic residents/interns in Ohio programs are not required to complete a membership application and shall be automatically enrolled as members. *(Article IV, Section3)*

Student Members. The OOA Director of Membership shall contact the Ohio University College of Osteopathic Medicine by September of each year and enroll all incoming freshmen as OOA student members. Ohio students in out of state colleges may petition for OOA membership by applying as an out of state student member and certifying his/her intent to return to Ohio to pursue an internship, residency and/or permanent practice. The Board shall approve a student application and maintain it as part of this administrative Guide. OU-COM students are not required to complete a membership application and shall be automatically enrolled as members. *(Article IV, Section 4)*

Associate Members. Graduates of accredited schools of medicine and surgery, or podiatric medicine and surgery, who are licensed in Ohio, may apply for associate membership to receive the same benefits as regular members. Such benefits include (1) discounts offered through the OOA Business Partners Program; (2) Convention registration at the membership fee; and (3) all publications and communications sent to regular members. Such members may serve on OOA Committees, however they shall not have the privilege of serving as a voting member of the OOA House of Delegate or the right to hold an office. Associate members shall apply on a form approved by the board and maintained as part of this administrative guide. *(Article IV, Section 6)*

Associate Dues. Effective Fiscal year 2016-17 and thereafter, dues for associate members shall be as follows First year of Membership $395; second year of membership and thereafter $525. *(Article IV, Section 6)*:

Allied Member Benefits/Dues. Allied members shall receive the same communications as regular members and may register for the OOA Convention at member fees. Allied members shall apply on an application approved by the Board and maintained in this administrative guide. *(Article IV, Section 6)* Categories of allied members and the fees applicable to each are as follows:

(1) Ohio licensed non-physician clinicians who are currently employed with an active member of the OOA, contribute to the practice of that member, and support the goals and objectives of the OOA: $100.00

(2) Medical Doctors (MDs), Doctors of Podiatric Medicine (DPMs), and Doctors of Chiropractic (DCs) who are licensed in Ohio and support the mission of the OOA and subscribe to its code of ethics. To receive discounts and benefits of the OOA Business Partners program an MD or DPM must become Associate members and pay dues required of associate members. Amount: $150.00

(3) Doctoral and other non-doctoral personnel holding teaching, research or administrative positions in Ohio accredited hospitals and/or colleges. Amount: $35.00

(4) Administrative employees of this association, accredited hospitals or colleges, affiliated organizations and district academies. Amount: $35.00

(5) Any other professionals as determined by the Board of Trustees: Amount $35.00

Out of State Members. *(Article II, Section 7)* The Director of Membership shall offer out of state membership to any OOA member who moves out of state, at the time of renewal. Any DO residing in another state may apply for out of state membership, provided he/she is a member of his/her respective state divisional society. Amount: $50

Uniformed Personnel. *(Article II, Section 9)* Any DO on active duty in the uniformed services of the federal government and stationed with the state of Ohio shall be considered first-year members for the duration of their active duties. The Board may waive the dues of any physician who resides in Ohio and is an active duty member of a member of the Ohio National Guard or a reserve corps of the U.S. Armed Services if he/she is called to active duty for more than 6 months.

Institutional Members. *(Article IV, Section 7)* Institutional dues shall be fixed by agreement of the Ohio Osteopathic Hospital Association and the OOA Executive Committee.

Buckeye Subscriptions. Nonmembers may purchase an annual subscription to the Buckeye Osteopathic Physician for $25.00. The OOA Director of Membership shall bill all non-member subscribers annually. Non-member osteopathic physicians are not eligible to purchase a subscription.

Academy Dues. The OOA may collect dues for any District upon request. The District must notify the OOA Director of Membership of any changes in the amount of dues to be bill no later than January 1st. The OOA Director of Membership shall disburse local dues collected to each academy on a quarterly basis. Academies which use the OOA dues collection process must make their fiscal year coincide with that of the OOA (May 1 – April 30).

OOA Dues Billing Cycle. The OOA Director of Membership shall send dues statements to all members, inactive members, and non-members on a form approved by the OOA Board of Trustees and maintained in this administrative Guide. The dues statement may be considered an application for the purpose of enrolling a non-member as a new member. Dues statements shall be mailed as follows:

First Notice: February 1st
Second Notice: May 1st
Third Notice: August 1st
Fourth Notice with drop letter: November

OHIO OSTEOPATHIC ASSOCIATION
PETITION FOR REDUCED MEMBERSHIP DUES

The OOA Board of Trustees, upon verification by your local academy, grants dues reductions, for retirement, disability or financial hardship. In order to receive consideration, please complete section one or two below, and return this petition to the OOA Central Office, 53 W Third Ave, PO Box 8130, Columbus OH 43201-0130.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ E-Mail: _____

Section 1: Retired/Semi-Retired Rates (If retirement is due to disability/financial, complete Section 2 only)

_____ Retired rate * $50 I hereby certify that, on (date) _____, I retired completely from practice and am not gainfully employed in any phase of professional activity related to the field of osteopathic medicine. I further certify that I have been a member of the OOA for at least 10 years prior to retirement and I, therefore, petition the Board of Trustees of the Ohio Osteopathic Association to grant "Retired Status" for OOA membership. I further verify that my date of birth is: _____.

_____ Semi-Retired rate * $250 I hereby certify that I am semi-retired and working 20 hours or less in any phase of professional activity related to the field of osteopathic medicine. I further verify that I have been a member of the OOA for 10 consecutive years or more. I, therefore, petition the Board of Trustees of the Ohio Osteopathic Association to grant "Semi-Retired Status" for OOA membership.

Date: _____ Signature: _____

Section 2: Reduced Rate Due to Physical Disability or Financial Hardship

I hereby petition the OOA Board of Trustees for Reduced Dues in the following category (check one):

_____ Totally disabled, unable to engage in any substantial gainful activity	None
_____ Disabled/part-time practice limited to 20-30 hours per week	$100 *
_____ Disabled/practice restricted to less than 20 hours per week	$50 *
_____ Financial hardship	Discretion of the board *

My disability is (check one): _____ Permanent _____ Temporary

On the back of this form, please state the reason(s) for your request and describe the nature of your disability. If the reason is financial, please indicate the amount of dues you are willing and able to pay or the length of time you need a waiver.

I hereby certify the above information to be true. I further agree to notify the board of any change in my disability or financial status which might affect my dues status.

Date: _____ Signature: _____

*All categories become eligible for life membership at age 70 or after 50 years of active practice if you have had 25 consecutive years of membership.

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: 13, 19, 20, and 21

Members:

Charles D. Milligan, DO, Chair (District VIII)
James A Schoen, Jr., DO (District III)
Henry L. Wehrum, DO (District VI)
John J. Wolf, Jr., DO (District VII)
John C. Baker, DO (District X)

Magnolia Room

SUBJECT: Explore Incentives to Increase Patient Involvement in Cancer Clinical Trials

SUBMITTED BY: Medical Student Section

REFERRED TO:

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

WHEREAS, only three percent of cancer patients are enrolled in new clinical trials[2]; and

WHEREAS, "The limited involvement of [primary care] physicians in clinical research reduces physician referrals of patients to clinical research studies, as well as the total number of investigators available to conduct the research[4];" and

WHEREAS, it has been suggested that a "mechanism to adequately compensate physicians for referring patients to clinical trials could improve recruitment rates of U.S. patients[4];" and

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

WHEREAS, this is due to the fact that clinical investigators face many obstacles. These include "locating funding, responding to multiple review cycles, obtaining Institutional Review Board (IRB) approvals, establishing clinical trial and material transfer agreements with sponsors and medical centers, recruiting patients, administering complicated informed consent agreements, securing protected research time from medical school departments, and completing large amounts of associated paperwork[4];" and

WHEREAS, as a result of these challenges, many who try their hand at clinical investigation drop out after their first trial[4]; and

WHEREAS, this exhibits a lack of progress and advancement in oncological innovation[2]; and

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

RESOLVED, that the Ohio Osteopathic Association (OOA) supports increasing the number of cancer patients in Ohio that are enrolled in clinical trials via educational promotions; and, be it further

RESOLVED, that the OOA explore educational promotions to increase patients' awareness of clinical trial opportunities.

Explanatory Statement: The statistic of three percent of cancer patients being enrolled in clinical trials is a worrisome fact. As physicians and as a part of a healthcare team, we should promote avenues to seek patient healing and treatment advancement such as clinical trials. Clinical trials are often covered by insurance or drug companies and as such are no cost to the patient. We should be maximizing the opportunities to improve research and our patients' health.

ACTION TAKEN: _____

DATE: _____

References:

[1] "Cancer Facts & Figures 2015." *Cancer.org*. American Cancer Society, 2015. Web. 08 Nov. 2015.
[2] Marhall, John L., MD. "Why Are Only 3% of US Cancer Patients in Clinical Trials." *Medscape Multispecialty*. Medscape, 17 Jan. 2013. Web. 08 Nov. 2015.
[3] "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>.
[4] Institute of Medicine (US) Forum on Drug Discovery, Institute of Medicine (US) Forum on Drug Discovery, Development, and Translation. Washington (DC). *Challenges in Clinical Research*. U.S. National Library of Medicine, 2010. Web. 03 Jan. 2016. <http://www.ncbi.nlm.nih.gov/books/NBK50888/>.

RES. NO.
2016-19

SUBJECT: Eugenic Selection with Preimplantation Genetic Diagnosis

SUBMITTED BY: Medical Student Section

REFERRED TO:

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

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

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

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

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

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

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

RESOLVED, that the Ohio Osteopathic Association (OOA) opposes the use of Preimplanatation Genetic Diagnosis (PGD) to choose a fetus' traits unrelated to disease.

Explanatory Statement: Preimplantation Genetic Diagnosis can prevent inheritance of diseases such as Cystic Fibrosis, tumor suppressor genes, diabetes, obesity, depression, hemophilia, some anemias, etc. With technological advancement, parents will have the ability to choose their children's genes for non-disease traits. Selecting genetic traits in children that have no correlation with pathologies unwillingly predetermines a child's fate. For instance, preimplantation sex selection is appropriate to avoid the birth of children with genetic disorders; it is not acceptable when used solely for non-medical reasons. Phenotypes such as hair, eye, and skin color could be selected. The United Kingdom has taken an initiative to stop the selection of non-pathological traits. The OOA needs to advocate for the United States to follow this precedent.

ACTION TAKEN: _____

DATE: _____

References:

1. Braude, P., Pickering, S., Flinter, F., & Ogilvie, C. M. (2002). Preimplantation Genetic Diagnosis. *Nature Reviews Genetics, 3*, 941-952. Retrieved March 14, 2016.
2. Breeding out disease with reproductive genetics. (2014, October 26). Retrieved March 14, 2016, from http://www.cbsnews.com/news/breeding-out-disease-with-reproductive-genetics/
3. Steinbock, B. (2008). Designer babies: Choosing our children's genes. *The Lancet, 372*(9646), 1294-1295.
4. Women's Health Care Physicians. (n.d.). Retrieved March 14, 2016, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Issues-in-Genetic-Testing

RES. NO.
2016-20

SUBJECT: Preventing Harassment of Physicians

SUBMITTED BY: Medical Student Section

REFERRED TO:

WHEREAS, physicians are regularly assaulted and harassed for providing care to their patients, and

WHEREAS, a 2002 study showed that 52% of the clinical staff of an urban psychiatric unit had been the target of stalking, threatening or harassing behavior outside the hospital or other locked settings during their careers. [1]; and

WHEREAS, physicians treating HIV and AIDS patient during the height of the epidemic during the 1990s, faced harassment and intimidation by the public. [2]

WHEREAS, since 2010, threats against abortion providers nationwide have doubled; and

WHEREAS, abortion providers in Ohio have been targeted using intimidation tactics at their homes and offices. [4]; and

WHEREAS, pediatricians who diagnose and treat child abuse cases have come under attack by the British press and by parents who have been investigated for possible abuse, which has resulted in fewer pediatricians being willing to care for abused children or to testify in child abuse cases. [5]; and

WHEREAS, globally, physicians have been targets of persecution and harassment in times of conflict and war, most recently in Syria, Bahrain and Iran. [6]; and

WHEREAS, there is not legislation in Ohio to protect physicians and other healthcare workers from harassment and intimidation regarding their career. [7]; and

WHEREAS, aggression or the fear of aggression can lead to the deterioration of the doctor-patient relationship. [8]; and

WHEREAS, patients are entitled to receive uniform service delivery from healthcare professionals, and those professionals have the right to provide care without fear of harassment or abuse. [9]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports legislation to protect physicians from intimidation and harassment; and, be it further

RESOLVED, that the OOA opposes attempts to deter or intimidate physicians who practice in accordance with their conscience and consistent with the American Osteopathic Association Code of Ethics.

ACTION TAKEN: _____

DATE: _____

References:

1. Sandberg D, McNiel D, Binder R. Stalking, Threatening, and Harassing Behavior by Psychiatric Patients Toward Clinicians. Journal of the American Academy of Psychiatry and the Law 2002;30(2):221-229.
2. Debating a duty to treat: AIDS and the professional ethics of American medicine. Wallis P. Bull Hist Med. 2011 Winter;85(4):620-49.
3. Wilson T. Threats Against Abortion Providers Have Doubled Since 2010, Report Finds. RH Reality Check. 2015
4. Campaign targets abortion clinic doctors. Columbus Dispatch. 2015 July 17.
5. The intimidation of British pediatricians. Jenny C. Pediatrics. 2007 Apr;119(4):797-9.
6. Physicians for Human Rights. Persecution of Health Workers. 2015.
7. Borchardt J. Abortion clinic buffer zones proposed in new Ohio bill. Cleveland.com. 2015;
8. Aggression against doctors: a review. Hobbs FD, Keane UM. J R Soc Med. 1996 Feb;89(2):69-72.
9. Conscientious Objection in Medicine: Private Ideological Convictions must not Supercede Public Service Obligations. Schuklenk U. Bioethics. 2015 Jun;29(5):ii-iii

RES. NO.
2016-21

SUBJECT: Providing CME Credits for Physicians Pursuing Further Education

SUBMITTED BY: Dayton District Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, there are osteopathic physicians who are currently pursuing additional educational degrees in public health, business administration, etc; and

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

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

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

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

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: 14, 18, and 22

Members:

Jennifer J. Hauler, DO, Chair (District III)
Ying Chen, DO (District VI)
Mark J. Tereletsky, DO (District VIII)
Alyssa Ritchie, OMS I (OU-HCOM)
Luis L. Perez, DO (District V)

Easton C/D/E

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

SUBMITTED BY: Medical Student Section

REFERRED TO:

WHEREAS, according to the National Center for Transgender Equality and The National Gay and Lesbian Task Force, 90 percent of transgender people report experiencing harassment, mistreatment or discrimination on the job [1]; and

WHEREAS, according to a study by the Williams Institute, it was estimated in 2010 there were 700,000 transgender individuals living in the US [2]; and

WHEREAS, Lesbian Gay Bisexual Transgender and Queer/Questioning (LGBTQ) individuals face health disparities linked to societal stigma, victimization, and denial of civil rights; resulting in high rates of depression, anxiety, eating disorders, substance abuse, and suicide than heterosexual individuals [4]; and

WHEREAS, according to the CDC transgender women are at high risk for HIV infection. In addition African American transgender women have the highest percentage of new HIV positive test results [5,6]; and

WHEREAS, patient intake forms routinely inquire about demographic information in order to allow physicians to provide them with the most relevant prevention information, and screen them for pertinent health conditions [7]; and

WHEREAS, many forms that do try to be inclusive of trans identities often only list three categories: "Male, Female, or Transgender," which does not provide ways for many gender variant people to accurately indicate their gender identity [8]; and

WHEREAS, many genderqueer or gender variant people do not personally identify as trans due to cultural beliefs, social networks, geographic locations, or a belief that it is in their past and not a present identification [9]; and

WHEREAS, including multiple questions will allow for more specific disclosure of a patient's history, better care, provide a sense of inclusivity [3]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) supports the inclusion of a two part demographic inquiry on patient intake forms, requesting patients indicate their "Sex" (assigned at birth) and "Gender Identity," separately; and, be it further

RESOLVED, that the "Gender Identity" question provide the following four options: "Male," "Female," "Transgender," and "Additional category (please specify)."

Explanatory Statement: It is our role as physicians to be inclusive of all gender identities, and to provide patients with the most appropriate care. Transgender and genderqueer

individuals currently face significant disparities in mental health and medical health care, linked to social stigma and discrimination they encounter, when compared to heterosexual or LGB cis-gendered individuals. It is our hope that the OOA HOD would encourage physicians to make patient-intake forms more welcoming and inclusive of potential Trans and genderqueer patients, in order to reduce what can be a significant barrier to meeting their healthcare needs.

ACTION TAKEN: _____

DATE: _____

References:

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5. *Ward, Brian W., PhD, James M. Dahlhamer, PhD, Adena M. Galinsky,, PhD, and Sarah S. Joestl, D. PH. "Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013." National Health Statistics Reports, Number 77. CDC: Division of Health Interview Statistics. Department of Health and Human Services, 15 July 2014. Web. 10 Nov. 2015. <http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf>.*
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7. *Bradford, Judith B., PhD, Sean Cahill, PhD, Chris Grasso, MPH, and Harvey J. Makadon, MD. "How to Gather Data on Sexual Orientation and Gender Identity in Clinical Settings." Policy Focus. The Fenway Institute, 09 Jan. 2012. Web. 14 Jan. 2016. <http://www.fenwayhealth.org/documents/the-fenway-institute/policy-briefs/Policy_Brief_HowtoGather..._v3_01.09.12.pdf>.*
8. *"Transgender Terminology." Primary Care Protocol for Transgender Patient Care. UCSF: Center of Excellence for Transgender Health, Web. 13 Jan. 2016. <http://transhealth.ucsf.edu/trans?page=protocol-terminology>.*
9. Sausa, L., Sevelius, J., Keatley, J., Iniguez, J., & Reyes, M. (2009). Policy Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services. Center of Excellence for Transgender HIV Prevention: University of California, San Francisco.

RES. NO.
2016-18

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

SUBMITTED BY: Medical Student Section

REFERRED TO:

WHEREAS, title VII prohibits discrimination in the workplace based on sex and guarantees equal employment opportunities [1,2]; and

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

WHEREAS, for example, housing insecure individuals were more likely to report delayed doctors' visits, a poor or fair health outcome, and two or weeks more of poor health or mental health limiting daily activity in the past month [3]; and,

WHEREAS, in 2011, there was a law that passed in Ohio that prohibits discrimination under state employment in cases of sexual orientation, but *not* gender orientation [4]; and

WHEREAS, oftentimes, only one parent in a same sex couple is able to claim parental rights and power of attorney, thus the other parent lack the ability to have the same hospital rights over their own child [4]; and

WHEREAS, there is a law in Ohio that protected same sex couples from being discriminated against adopting a child, however this does not protect these couples from unequal hospital rights [4]; and

WHEREAS, over 115 Anti-LGBTQ bills were introduced in 2015, and 27 states have pending anti LGBTQ legislation in 2016[5]; and

WHEREAS, due to the aforementioned housing, employment, and hospital rights issues, LGBTQ patients and their families are at a predisposition for adverse healthcare outcomes [3]; and

WHEREAS, these laws will authorize businesses, individuals, and taxpayer-funded entities to cite religion as a reason to refuse goods or services to the LGBT population as well as allowing adoption and foster care agencies to discriminate against same-sex couples [5,6]; and

WHEREAS, Ohio has existing pro-equality laws and pending initiates to combat this anti-LGBTQ legislation [4,5]; and now therefore be it

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

RESOLVED, that the OOA work with legislators to provide more comprehensive equal rights, protections, to all patient populations.

Explanatory Statement: Despite Title VII protections and recent civil rights advances, LGBTQ individuals still face several legal obstacles to secure employment, housing, and even affect the hospital rights of same-sex parents with an ill child in our care as physicians. There is no question that losing one's home or job would impact the healthcare needs and access of any of our patients, but these legal barriers, or lack of protections, have become frequently specific to LGBTQ persons due to widespread introduction of Anti-LGBTQ legislative bills. We urge the OOA HOD to support initiatives and legislation that promotes equal rights for all, and protects LGBTQ individuals from harmful discriminating practices and harassment.

ACTION TAKEN: _____

DATE: _____

References:

[1]"U.S. Constitutional Amendments - FindLaw." *Findlaw*. N.p., 2015. Web. 13 Jan. 2016. <http://constitution.findlaw.com/amendments.html>.

[2]"Title VII of the Civil Rights Act of 1964." *Title VII of the Civil Rights Act of 1964*. US Equal Employment Opportunity Commission, n.d. Web. 13 Jan. 2016. <http://www.eeoc.gov/laws/statutes/titlevii.cfm>.

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[4]*ADOPTION BY LESBIAN, GAY, AND BISEXUAL PARENTS: AN OVERVIEW OF CURRENT LAW I. INTRODUCTION: LESBIAN, GAY, AND BISEXUAL PARENT FAMILIES. A. A Growing Number of Children Live In Families With Two Same-Sex Parents.* (n.d.): n. pag. *National Center for Lesbian and Gay Rights*. 2014. Web. 21 Jan. 2016. <http://www.nclrights.org/wp-content/uploads/2013/07/adptn0204.pdf>.

[5]"Queer (in)justice: The Criminalization of LGBT People in the United States." *Choice Reviews Online* 49.02 (2011): n. pag. *Human Rights Campaign*. Web. 13 Jan. 2016. <http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/2016_Legislative-Doc.pdf>.

[5]Peters, Stephen. "HRC Previews Anti-LGBT State & Local Legislation." *Human Rights Campaign*. N.p., 8 Jan. 2016. Web. 13 Jan. 2016. <http://www.hrc.org/blog/hrc-previews-anti-lgbt-state-local-legislation>.

SUBJECT: TRICARE Health Insurance for our Military

SUBMITTED BY: Dayton District Academy of Osteopathic Medicine

REFERRED TO:

WHEREAS, TRICARE is the Department of Defense's choice health insurance program connecting civilian healthcare providers with Active Duty, National Guard and Reserve Service Members, retirees and their families worldwide; and

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

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

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

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

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

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

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

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

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

RESOLVED, the Ohio Osteopathic Association (OOA) supports the efforts of the TRICARE health care delivery system by providing information regarding TRICARE on the OOA web site; and be it further

RESOLVED, the OOA encourages physicians, physician practices and all medical communities to join these other Ohio physician providers and help treat the more than 155,500 Ohio service and family members' beneficiaries who sacrifice so much to protect our freedoms.

ACTION TAKEN: _____

DATE: _____

Ad Hoc Reference Committee

Purpose: To consider resolutions not having a specific category.

Resolutions: 12, 15, 16, and 17

Members:

Peter A. Bell, DO, Chair (District VI)
Nicklaus J. Hess, DO (District III)
Christopher J. Loyke, DO (District VII)
Douglas W. Harley, DO (District VIII)
Nicole J. Barylski-Danner, DO (District V)

Lilac Room

RES. NO.
2016-12

SUBJECT: Improving Outcomes of Law Enforcement Responses to Mental Health Crises Through the Crisis Intervention Team Model

SUBMITTED BY: Medical School Section

REFERRED TO :

WHEREAS, people with mental illnesses are overrepresented in the criminal justice system in the United States, and the prevalence of certain mental disorders among those being handled by criminal justice ranges from three to 12 times greater than that observed among community members[1]; and

WHEREAS, a 2009 study found that approximately 14.5% and 31.0% of jailed men and women, respectively, display symptoms of serious mental illness[2]; and

WHEREAS, a 1996 survey of 174 police departments throughout the United States revealed that seven percent of police contacts with civilians involved individuals believed to have a mental illness, while only 55 percent of the departments possessed a protocol specifically designed to manage these types of interactions[3]; and

WHEREAS, police officers are often the "first line of response" to individuals experiencing mental health crises,[4] and, accordingly, they are frequently tasked with determining when to divert people into mental health services rather than into the criminal justice system[4,5] ; and

WHEREAS, a 2004 survey indicated that police officers do not believe that their departmental training in managing encounters with people in mental health crisis is adequate[6]; and

WHEREAS, police officers fear encounters with individuals with mental illness due to a lack of understanding about their condition and the misconception that they are all violent[7,8]; and

WHEREAS, without appropriate training, police officers will apply the same response to those with mental illness who resist law enforcement as to those without mental illness[8]; and

WHEREAS, surveys of police officers have demonstrated that they perceive the mental health services into which they could divert individuals experiencing mental health crises as inaccessible, difficult to work with, and time-consuming[9]; and

WHEREAS, the lack of adequate communication and a shared strategy for coordinating responses to individuals experiencing mental health crises between law enforcement and mental health providers observed in certain communities further compounds the difficulties police officers have in connecting people with the appropriate mental health resources[9]; and

WHEREAS, the Crisis Intervention Team (CIT) model serves to increase the safety of encounters between police officers and individuals with mental illnesses and to train police officers to divert individuals to collaborating mental health services when appropriate[10]; and

WHEREAS, the CIT model involves 40 hours of voluntary training for police officers within a given police force facilitated through lectures and scenario-based skill training, and it encompasses education on recognizing symptoms of mental illnesses, mental health treatments, de-escalation techniques, social issues affecting mental health, and relevant legal concerns[11-13]; and

WHEREAS, officers trained in CIT feel more confident and prepared to take on calls regarding persons with mental illness and also report greater satisfaction with the effectiveness of their police departments in handling mental health crises[12,14]; and

WHEREAS, preliminary studies have suggested that CIT training in police departments corresponds to lower arrest rates of individuals with mental illnesses and higher rates of diversion to mental health services[12,15,16]; and

WHERAS, a comparative study of sworn CIT-trained and non-CIT-police officers in the Chicago Police Department illustrated that CIT-trained officers were more likely to avoid escalation by using less overall force when dealing with individuals displaying increasing levels of resistance[17]; and

WHEREAS, police officers surveyed pre- and post-CIT training demonstrated improved attitudes towards individuals with mental illness, increased knowledge about of signs of mental illness and treatment options, and increased application of skills relating to handling mental health crises[18,19]; now, therefore be it

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

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

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

ACTION TAKEN: _____

DATE: _____

References:

1. Prins S (2015). The Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review. *Psychiatric Services*, 65(7): 862-872.

2. Steadman H, Osher F, Robbins P, Case B, Samuels S (2009). Prevalence of Serious Mental Illness Among Jail Inmates. *Psychiatric Services*, 60(6): 761-765.
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8. Ruiz J, Miller C (2004). An Exploratory Study of Pennsylvania Police Officers' Perceptions of Dangerousness and Their Ability to Manage Persons with Mental Illness. *Police Quarterly*, 7(3): 359-371.
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11. National Alliance on Mental Illness. (2015). "What is CIT?" Available at https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health/What-Is-CIT.
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16. Steadman H, Deane M, Borum R, Morrissey J (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services* 51(5): 645-649.
17. Morabito M, Kerr A, Watson A, Draine J, Ottati V, Angell B (2012). Crisis Intervention Teams and People with Mental Illness: Exploring the Factors That Influence the Use of Force. *Crime & Delinquency* 58(1): 57-77.
18. Hanafi S, Bahora M, Demir B, Compton M (2008). Incorporating Crisis Intervention Team (CIT) knowledge and skill into the daily work of police officers: a focus group study. *Community Mental Health Journal* 44(6): 427-432.
19. Ellis H (2014). Effects of a Crisis Intervention Team (CIT) Training Program Upon Police Officers Before and After Crisis Intervention Team Training. *Archives of Psychiatric Nursing* 28(1): 10-16.

RES. NO.
2016-15

SUBJECT: Removing the Federal Ban on Funding Gun Research

SUBMITTED BY: Medical Student Section

REFERRED TO:

WHEREAS, each year more than 32,000 US residents die from gunshot wounds as a result of violence, suicides, and accidents involving firearms; another 84,000 a year are injured by firearms, and the cost of treatment of these injuries and deaths totals over 40 billion dollars annually[1,2]; and

WHEREAS, in a period from 1985 to 2005, the rate of gun death per year remained stagnant while over a similar period (1993 to 2013), the rate of mortality in motor vehicle crashes, fires, and drowning has decreased by 31%, 38% and 52% respectively[3]; and

WHEREAS, in a statement, the American College of Physicians, the American College of Emergency Physicians, the American Congress of Obstetricians and Gynecologists, the American College of Surgeons, the American Psychiatric Association, the American Public Health Association, and the American Bar Association have recognized that firearm violence is not just a criminal violence issue but also a major public health problem[1]; and

WHEREAS, basic data about gun possession, distribution, ownership, acquisition, and storage are lacking and no single database captures the number, locations, types of firearms, and firearm owners in the United States; any databases that do exist are incomplete, inconsistent, or incompatible[4]; and

WHEREAS, in 2013, there were 9707 publications on pediatric neoplasms but only 33 regarding firearms, despite these two factors contributing almost equally to the number of deaths among individuals under the age of 18; 1443 from firearm incidents, 1733 from malignant neoplasms[5]; and

WHEREAS, the Institute of Medicine has identified a need to bolster information about the factors associated with gun violence, including the identification of factors that increase the risk of such violence (such as a possible effect from violent media on real-life gun violence), that protect against gun violence, and that have preventive effects such as gun safety technology[6]; and

WHEREAS, since the 1996 budget appropriation passed by Congress, the CDC has operated under statutory restrictions on firearm research [7]; and

WHEREAS, a recent review found that the National Institutes of Health had funded just three major grants for researches on firearm injury in the last 30 years[8]; and

WHEREAS, the complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should beincorporated into the strategies used to prevent future harm and injuries. This public health approach involves three elements: a focus on prevention, a focus on scientific methodology to identify risk and patterns, and multidisciplinary collaboration to address the problem[4]; now, therefore be it

RESOLVED, that the Ohio Osteopathic Association (OOA) recognizes gun violence as a public health concern; and, be it further

RESOLVED, that the OOA supports local, state, and federal funding for research about contributing factors to gun violence and the removal of statutory restrictions on use of federal funds in researching gun violence; and, be it further

RESOLVED, that the OOA supports research about contributing factors to gun violence at local, state, and federal levels.

ACTION TAKEN _____

DATE _____

References:

1. US medical societies call for action on gun violence. BMJ. 2015 Feb 24;350:h1027.
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4. Priorities for Research to Reduce the Threat of Firearm-Related Violence. Institute of Medicine. June 5, 2013.
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7. In memory of Daniel--reviving research to prevent gun violence. N Engl J Med. 2015 Feb 26;372(9):800-1.
8. Reducing firearm violence: a research agenda. Inj Prev. 2007 Apr;13(2):80-4.

SUBJECT: Addressing Food and Housing Insecurity for Patients

SUBMITTED BY: Medical Student Section

REFERRED TO:

WHEREAS, more than one in six Ohioans (about 2 million individuals) turn to the Ohio Association of Foodbanks network for food assistance.[1]; and

WHEREAS, Ohio ranks sixth in the country for highest levels of food insecurity. [2]; and

WHEREAS, a study found a 27% increase in hospital admissions of low-income patients for hypoglycemia during the last week of the month compared to the first week of the month, which correlates to the exhaustion of food budgets. [3]; and

WHEREAS, malnourished patients tend to stay three times longer upon hospital admission than patients with proper nutrition. [4]; and

WHEREAS, food insecurity is strongly associated with other health-related social problems in youth such as issues with health care access, education, and substance abuse; and early screening of food insecurity may help identify other health-related social problems which can be addressed to improve health. [5]; and

WHEREAS, the Department of Health and Human Services has defined housing insecurity as high housing costs in proportion to income, poor housing quality, unstable neighborhoods, overcrowding, or homelessness. [6]; and

WHEREAS, in 2013, 26%, 17% and 22% of households in Cleveland, Columbus and Cincinnati, respectively, were housing insecure. [7]; and

WHEREAS, housing insecure individuals were more likely to delay doctors' visits, have poor or fair health, and have 14 days or more of poor health or mental health limiting daily activity in the past 30 days. [8]; and

WHEREAS, from 2011-2014, over half of all US adults had to make at least one sacrifice, such as cutting back on health care or healthy foods, in order to pay rent or their mortgage. [9]; and

WHEREAS, there are many resources around Ohio to support food and/or housing insecure individuals and families, such as food banks, the Women, Infants and Children supplemental nutrition program (WIC), Supplemental Nutrition Assistance Program (SNAP), rent assistance, utilities assistance and shelters.[10,11]; and

WHEREAS, screening tools have been developed for many health outcome predictors, such as depression, anxiety, alcohol abuse, food and housing insecurity, etc.[12,13]; and

WHEREAS, addressing social determinants of health (such as housing and food insecurity) can lead to fewer health care costs and improved health outcomes.[14]; now, therefore be it

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

RESOLVED, the OOA encourages the use of housing and food insecurity screening tools by physicians and healthcare staff, similar to the depression screening tools; and, be it further

RESOLVED, the OOA supports legislation that aims to decrease food and housing insecurity in Ohio.

ACTION TAKEN _____

DATE _____

References:

1. Ohio Association of Foodbanks. Hunger in Ohio 2014 Executive Summary. 2014. http://ohiofoodbanks.org/docs/publications/hunger_in_OH_2014_summary.pdf.
2. Food Insecurity in Ohio on Rise while Declining Nationally. Statehouse News, The Center for Community Solutions 2015;131-1(31).
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4. Isabel T. D. Correia M. The impact of malnutrition on morbidity, mortality, length of hospital stay and costs evaluated through a multivariate model analysis. Clinical Nutrition 2003;22(3):235-239.
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8. Stahre M, VanEenwyk J, Siegel P, Njai R. Housing Insecurity and the Association With Health Outcomes and Unhealthy Behaviors, Washington State, 2011. Preventing Chronic Disease 2015;12.
9. MacArthur Foundation. Housing Challenges Real For Many Americans, Finds 2014 How Housing Matters Survey. 2014.
10. Ohio Association of Second Harvest Foodbanks. Child Hunger in Ohio. Columbus, OH: 2012.
11. U.S. Department of Housing and Urban Development. Rental Help: Ohio. http://portal.hud.gov/hudportal/HUD?src=/states/ohio/renting.
12. SAMHSA-HRSA Center for Integrated Health Solutions. Screening Tools.
13. American Academy of Pediatrics. Mental Health Screening and Assessment Tools for Primary Care. 2010.
14. Doran K, Misa E, Shah N. Housing as Health Care — New York's Boundary-Crossing Experiment. New England Journal of Medicine 2013;369(25):2374-2377.

RES. NO.
2016-17

SUBJECT: Human Trafficking Education for Health Care Workers

SUBMITTED BY: Medical Student Section

REFERRED TO:

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

WHEREAS, it is estimated that 18,000 men, women, and children are trafficked from other countries into the US in addition to thousands of domestic victims every year (5); and

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

WHEREAS, it is estimated that twenty-eight to fifty percent of human trafficking victims, while in captivity, encounter a healthcare worker and are not recognized (4, 7); and, be it further

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

Explanatory Statement: The following AOA policy does not address the gravity of the situation adequately. As HT continues to grow as a problem, it is time that HCW are not just "aware" of the issue, but are trained to recognize the victims. Without hospitals requiring mandatory training, it is likely that victims will continue to go unrecognized by HCW and be forced into slavery.

"AOA policy H401-A/14 Human Trafficking—Awareness as a global health problem The American Osteopathic Association acknowledges human trafficking as a violation of human rights and a global public health problem encourages osteopathic physicians TO be aware of the signs of human trafficking and the resources available to aid them in identifying and addressing the needs of victims of human trafficking, including appropriate medical assessment and reporting to law enforcement. 2014 "

ACTION TAKEN _____

DATE _____

References:

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Constitution & Bylaws Reference Committee

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

Resolutions: 1, 2, 3, 4, 5, 6, 07, 08, 09, 10, and 11

Members:

Sandra L. Cook, DO, Chair (District VII)
Adele M. Lipari, DO (District VI)
Daniel K. Madsen, DO (District IV)
Gordon J. Katz, DO (District III)
Marc S. Ucchino, DO (District X)
David A. Bitonte, DO, Ex Officio

New Albany Board Room

RES. NO.
2016-01

SUBJECT: Reaffirmation of Policy Statements

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENTS BE REAFFIRMED:

Diagnostic, Therapeutic, and Reimbursement

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to oppose any managed care policy which interferes with a healthcare professional's ability to freely discuss diagnostic, therapeutic and reimbursement options with patients. *(Original 2001)*

Drug Enforcement Administration Numbers

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

Home Health Care, Physician Reimbursement

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

Hospital Medical Staff Discrimination

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

OOA Physician Placement Information Service

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

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

RESOLVED, that the OOA encourages Ohio's hospitals and other institutional healthcare

employers to become members of MOO. *(Original 1991)*

Photo IDs for Scheduled Drug Prescriptions

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

Third Party Payers, Osteopathic Representation

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

Safe Prescriptions and Drug Diversion Tactics

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

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

ACTION TAKEN: _____

DATE: _____

SUBJECT: AOA Resolution 29 (AOA Approval of ACGME Residency in an Option-1 Specialty) Repeal

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE DELETED:

~~WHEREAS, osteopathic physicians are responsible to the public as providing assurance of the quality and integrity of osteopathic training for osteopathic physicians who hold osteopathic certification; and~~

~~WHEREAS, the Ohio Osteopathic Association, serves the members of the Ohio osteopathic family as the representative in not only professional but educational affairs; and~~

~~WHEREAS, Ohio is an influential state in both osteopathic (DO) and allopathic (MD) professions and has a tradition in providing quality medical education; and~~

~~WHEREAS, AOA Resolution 29, as approved at the July 15, 2010, AOA Board of Trustees meeting and at the 2010 AOA House of Delegates, as currently written exerts a potential negative effect on the ongoing stability and future of AOA accredited residency programs that are both purely osteopathic and dually accredited; and~~

~~WHEREAS, AOA Resolution 29 may have the unintended consequence of the closure of existing osteopathic accredited graduate medical education (OGME) programs; and~~

~~WHEREAS, AOA Resolution 29 grants AOA approval of Accreditation Council for Graduate Medical Education (ACGME) training for osteopathic physicians by a nominal application process, minimal evidence of parity between~~

~~AOA and ACGME training, and no input from specialty colleges; and~~

~~WHEREAS, AOA Resolution 29 grants AOA approval to ACGME training for osteopathic physicians that may have different lengths of training, may contain no training in osteopathic principles and practice (OP&P) and different curricula than comparable AOA training programs; and~~

~~WHEREAS, AOA approval of ACGME certification of osteopathic physicians is confusing in presentation and lacks checks and balances; and~~

~~WHEREAS, the membership of the Association of Osteopathic Directors and Medical Educators (AODME) at the AODME's General Membership Meeting on April 14, 2011, in Baltimore, Maryland, voiced concern regarding AOA Resolution 29; and~~

~~WHEREAS, at the April 2011 AODME general membership meeting, the members voted in the affirmative to repeal Resolution 29, that a moratorium be placed on petitions pending under AOA Resolution 29 and that the AOA modify existing resolutions or write a new resolution to replace AOA Resolution 29; and~~

~~WHEREAS, it is a necessity to have an appropriate mechanism of AOA approval of ACGME training and the current AOA Resolution 29 may have unintended consequences; now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association (OOA) support the recommendations that AOA Resolution 29 be repealed; a one-year moratorium be placed on any petitions under Resolution 29 and be replaced with an appropriate, functional resolution that assures the integrity of the AOA approval of ACGME training of osteopathic physicians; and be it further~~

~~RESOLVED, that the OOA support the AODME's recommendation that the Bureau of Osteopathic Medical Educators (BOME) produce a white paper evaluating the AOA approval of ACGME residency training; and be it further~~

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

Explanatory Statement: This resolution is no longer pertinent.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-03

SUBJECT: Health Literacy and Cultural Competency

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMENDED AS FOLLOWS AND APPROVED:

~~WHEREAS, an estimated 21 million Americans simply cannot read; and~~

~~WHEREAS, reading abilities are typically three to five grade levels below the last year of school completed; and~~

~~WHEREAS, more than 10 million Americans have graduated from high school reading at a 7th or 8th grade level and one in five high school graduates cannot read their diplomas; and~~

~~WHEREAS, the US Department of Health and Human Services report Healthy People 2010 states health literacy is the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions; and~~

~~WHEREAS, more than one-half of all Americans have health literacy issues; and~~

~~WHEREAS, two-thirds of US adults age 60 and over have inadequate or marginal literacy skills; and~~

~~WHEREAS, 81 percent of patients age 60 and older cannot read or understand basic materials such as prescription labels and 85 percent of unwed mothers are illiterate; and~~

~~WHEREAS, approximately half of all Medicare/Medicaid recipients read below the fifth-grade level; now, therefore, be it~~

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

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

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

RESOLVED, that the OOA strongly encourages all practitioners and medical facilities to incorporate health literacy improvement and cultural competency in their missions, planning and evaluation to create a shame-free environment where ~~low literate~~ all patients can seek help without feeling stigmatized *(Original 2011)*. ~~; and, be it further~~.

~~RESOLVED, that this resolution be forwarded to the American Osteopathic Association's House of Delegates for consideration at its 2011 annual meeting.~~

Explanatory Statement: This resolution was taken to the AOA House of Delegates in 2011, where it was amended and approved with minor changes recommended by the Public Affairs Reference Committee.

ACTION TAKEN: _____

DATE: _____

SUBJECT: Ohio Automated Rx Reporting System (OARRS) ~~and HB 93~~

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMENDED AS FOLLOWS AND APPROVED:

~~WHEREAS, the Ohio Automated Rx Reporting System (OARRS) was established by the Ohio State Board of Pharmacy (OSBP) to enable prescribers and distributors of controlled substances to access a database to help identify patients who are misusing or diverting substances of abuse, or who may be "doctor shopping"; and~~

~~WHEREAS, Ohio House Bill 93 of the 129th General Assembly requires the OSBP to adopt rules that establish standards and procedures to be followed by physicians regarding the review of patient information available through the drug database; and~~

~~WHEREAS, OARRS can help doctors feel confident that they are treating "real patients with real pain"; and~~

~~WHEREAS, the OARRS is currently underutilized by primary care physicians in Ohio; now, therefore, be it~~

RESOLVED, that the Ohio Osteopathic Association (OOA) strongly supports the Ohio Automated Rx Reporting System (OARRS) as an important tool for identifying patients who may be "doctor shopping" and misusing or abusing controlled substances; ~~that osteopathic physicians in Ohio become familiar with OARRS and utilize it when they deem it appropriate~~; and, be it further

~~RESOLVED, that the Ohio Osteopathic Association (OOA) play an active role in the Ohio State Medical Board (OSMB) development of regulations requiring physicians to interact with OARRS to assure that these regulations are not cumbersome and overly demanding of a physician's time; and, be it further~~

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

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-05

SUBJECT: Ohio Bureau of Workers Compensation Health Partnership Program

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORGINALLY ADOPTED IN 2011, BE AMENDED AS FOLLOWS AND APPROVED.

~~WHEREAS, osteopathic physicians have traditionally provided care for injured workers in the State of Ohio; and~~

~~WHEREAS, the Ohio Osteopathic Association, business representatives, organized labor, other health care provider organizations, and the Bureau of Workers Compensation jointly created the Health Partnership Program (HPP) as a unique managed care system to meet customers' needs for years to come; and~~

~~WHEREAS, HPP is truly a partnership, where the private sector managed care organizations (MCOs) are working together with the BWC to provide comprehensive claims management and medical management services for the employers and employees of Ohio; now therefore, be it~~

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

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-06

SUBJECT: Pain Management Education~~: Addressing Ohio's Pain Problem Through Improved Physician Education~~

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMENDED BY SUBSTITUTION AS FOLLOWS AND APPROVED:

~~WHEREAS, former Ohio Governor Ted Strickland convened the Ohio Prescription Drug Abuse Task Force in response to the catastrophic incidence of opioid prescription related overdose and death in the state; and~~

~~WHEREAS, members of the task force representing 26 agencies and professional organizations examined the origins and causes of the problem and with counsel from many experts developed consensus on 26 recommendations which were accepted by the Governor on October 1, 2010; and~~

~~WHEREAS, these recommendations include the imperative for improved education on pain management for physicians and physician extenders; and~~

~~WHEREAS, the Ohio Compassionate Care Task Force identified nearly one million Ohioans who are under-treated for pain or have no access to pain management; and~~

~~WHEREAS, the Compassionate Care Task Force recommended attention to the need for improved knowledge of pain management among prescribers; and~~

~~WHEREAS, knowledge of good pain management can decrease the need for prescribing opioids in order to treat pain; and~~

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

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

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

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

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

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

~~RESOLVED, that the Ohio Osteopathic Association encourage Ohio University College of Osteopathic Medicine to continue to support basic clinical education in pain management and the prevention of addiction, diversion and abuse in Ohio.~~

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-07

SUBJECT: ~~SNF, Providing Exceptions for the~~ Medicare Three-Day Qualifying Policy for Skilled Nursing Facility Care

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMENDED BY SUBSTITUTION AS FOLLOWS AND APPROVED;

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

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

WHEREAS, ~~there is an incredible~~ a study published in the August 2015 issue of *Health Affairs (vol. 34, no. 8, pages 1324 – 1330)*, comparing Medicare Advantage plans that still have the rule in place with ones that don't, concludes that hospital stays were shorter for patients in plans without the rule and no connection was found to either plan having more hospital admissions or more admissions to SNFS; and ~~amount of wasted resources and increased healthcare cost as delineated by the current criteria;~~ and

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

WHEREAS, ~~it is more prudent to participate in~~ it is sometimes more cost effective and medically appropriate to provide preventative or proactive care ~~(such as with~~ to sub-acute patients ~~that could~~ who would benefit from skilled nursing care prior to requiring a full hospital admission~~)~~; now, therefore, be it

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

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

Explanatory Statement: Amended and approved with minor changes recommended by the Professional Affairs Reference Committee.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-08

SUBJECT: Childhood Obesity and School Health Policies

SUBMITTED BY: OOOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMENDED AS FOLLOWS AND APPROVED:

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

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

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

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

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

RESOLVED, that the OOA continues to encourage ~~its physician~~ OOA members ~~to educate and caution their patients, school superintendents, and members of school boards across Ohio about the importance of~~ to be advocates for comprehensive school health and fitness programs in K-12 in their communities and to educate parents about their role in preventing childhood obesity. *(Original 2005)* ~~the health consequences of consuming carbonated soft drinks and urge them to eliminate the sale of these products on school property; and be it further~~

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-09

SUBJECT: Terminally Ill Patient Access to Pain Medications

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011 BE DELETED.

~~WHEREAS, Ohio House Bill 93 of the 129th General Assembly appropriately addresses the serious concerns of prescription drug abuse and diversion in Ohio; and~~

~~WHEREAS, Ohio House Bill 187, "The Intractable Pain Law of 1997" specifically excluded from regulatory oversight prescribers utilizing prescription drugs for the treatment of patients with a terminal illness and patients with a progressive illness that may in the course of progression be expected to become terminal, and excluded treatment for pain with medications that do not exert their action at the level of the central nervous system; and~~

~~WHEREAS, the definitions of chronic and intractable pain are changed in the new law; and~~

~~WHEREAS, HB 93 specifically excludes hospices from the definition of "pain clinic"; and~~

~~WHEREAS, hospice and palliative care patients deserve to receive care from the physicians of their choice; and~~

~~WHEREAS, HB 93 may seek to limit the quantity of an opioid or other substance that can be prescribed in a given time interval; now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association support rules promulgated to enact HB 93 that specifically and clearly exclude terminally ill patients and patients that may be expected to become terminally ill in the course of their illness.~~

Explanatory Statement: Rules implementing HB 93 and subsequent legislation addressing pain management exclude terminally ill patients.

ACTION TAKEN: _____

DATE: _____

SUBJECT: Prescriptions for Over-the-Counter Medications

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE DELETED:

~~WHEREAS, the Affordable Care Act Section 9003 established new rules for reimbursing the cost of over-the-counter medicines and drugs from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs) as of January 1, 2011; and~~

~~WHEREAS, this legislation mandates that distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription; and~~

~~WHEREAS, the United States Food and Drug Administration (FDA), defines over-the-counter medications as drugs that are safe and effective for use without a prescription by a licensed medical practitioner; and~~

~~WHEREAS, data from the 2007 National Health Interview Survey (NHIS) Alternative Medicine Supplement showed that 17.7 percent of US adults had used natural products in the previous year, including herbs and other naturally occurring non-botanical supplements; and~~

~~WHEREAS, health care providers commonly suggest over-the-counter medications, herbals and supplements be used for treatment of various medical conditions; and~~

~~WHEREAS, the writing of over the counter prescriptions for patients: 1) places a significant financial and time burden on health care providers in researching patient medical histories, looking for drug interactions, writing a prescription for each medicine encounter, and then retaining a copy for patient records, and 2) needlessly increases the medicolegal responsibilities of the health care provider; and~~

~~WHEREAS, the American Osteopathic Association declares in its policy statement (H234-A/07) in matters concerning the regulation of health care: "Where the need for (health care) regulation has been demonstrated, it should emanate from the lowest applicable level of government;" now, therefore, be it~~

~~RESOLVED, that the Ohio Osteopathic Association support the repeal of Section 9003 of the Affordable Care Act requiring prescriptions for over-the-counter medications for reimbursement from health flexible spending arrangements (health FSAs) and health~~

~~reimbursement arrangements (HRAs) due to the significant burden placed on health care providers in the writing of these prescriptions; and be it further~~

~~RESOLVED, that upon successful passage of this resolution, a copy be sent to the American Osteopathic Association House of Delegates for consideration and discussion at its 2011 annual meeting.~~

Explanatory Statement: Some of the language in the resolution was incorporated into another resolution on the same topic by the Ad Hoc Reference Committee and the alternate resolution was approved in lieu of the Ohio resolution, which was redundant.

ACTION TAKEN: _____

DATE: _____

RES. NO.
2016-11

SUBJECT: Physician Signatures, Reduction of Unnecessary

SUBMITTED BY: OOA Council on Resolutions

REFERRED TO:

RESOLVED, THAT THE FOLLOWING POLICY STATEMENT, ORIGINALLY ADOPTED IN 2011, BE AMMENDED AS FOLLOWS AND APPROVED:

RESOLVED, that the Ohio Osteopathic Association (OOA) ~~continue to study the issue of physician signature burden, identify areas of potentially unnecessary signature requirements, and seek a reduction in same with the appropriate agencies and institutions doing business in the State of Ohio. *(Original 2001,amended and reaffirmed 2006)*~~ supports continuous evaluation of physician signature requirements imposed by agencies, institutions and private businesses, to eliminate non-essential validation mandates and reduce administrative burdens on physician offices *(Original 2001)*.

ACTION TAKEN: _____

DATE: _____

APPENDIX

EXECUTIVE COMMITTEE 2015-16

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

BOARD OF TRUSTEES 2015-16

DISTRICT		TERM EXPIRES
NW OHIO-I	Nicholas G. Espinoza, DO	2017
LIMA-II	Wayne A. Feister, DO	2017
DAYTON-III	Nicklaus J. Hess, DO	2017
CINCINNATI-IV	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	2018
MARIETTA-IX	Jennifer L. Gwilym, DO	2016
WESTERN RESERVE-X	John C. Baker, DO	2016
RESIDENT	Anastasia "Staci" L. Bessas, DO	*
OU-COM STUDENT	Andre B. Bown, OMS II	2016

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

NEW TRUSTEES 2016-17

Sandusky	Gilbert S. Bucholz, DO	2019
Columbus	Henry L. Wehrum, DO	2019
Cleveland	John J. Wolf, DO	2019
Marietta	Jennifer L. Gwilym	2019
Western Reserve-X	John C. Baker, DO	2019
Resident	Anastasia "Staci" L. Bessas, DO	2017
OU-COM Student Rep.	Alyssa Ritchie, OMS I	2017

2015-16 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	Jennifer J. Hauler, DO	Aaron P. Hanshaw, DO
IV	Michael E. Dietz, DO	Scott A. Kotzin, DO
V	Nicole J. Barylski-Danner, DO	James E. Preston, DO
VI	Darren J. Sommer, DO	Carrie A. Lembach, DO
VII	John J. Wolf, Jr., DO, DO	Katie Pestak, DO
VIII	Mark J. Tereletsky, DO	Schield M. Wikas, DO
IX	Melinda E. Ford, DO	Timothy D. Law, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2016-17 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	Ruth M. Thomson, DO	H. Brent Bamberger, DO
IV	Michael E. Deitz, DO	Scott A. Kotzin, DO
V	Nicole J. Barylski-Danner, DO	James E. Preston, DO
VI	Alex S. Tsai, DO	Carrie A. Lembach, DO
VII	John J. Wolf, Jr., DO	Katie E. Pestak, DO
VIII	Mark J. Tereletsky, DO	David A. Bitonte, DO
IX	Melinda E. Ford, DO	Timothy D. Law, DO
X	Sharon L. George, DO	Robert M. Waite, DO

2016 OOA DELEGATES AND ALTERNATES

Academy	Voting Members	Delegates/ Votes	Delegates	Alternates
Northwest Ohio	77	5/10	Nicholas G. Espinoza, DO, Chair Tracy O'Neal Hooker, DO Kristopher L. Lindbloom, DO Jennifer L. Pfleghaar, DO Roger L. Wohlwend, DO	All Northwest Ohio Members
Lima	35	2/5	John C. Biery, DO, Chair Edward E. Hosbach, DO	All Lima Members
Dayton	211	14/28	James A. Schoen, Jr., DO, Chair Brent Bamberger, DO Barbara A. Bennett, DO Cleanne Cass, DO Davis D. Goldberg, DO Charles D Hanshaw, DO Jennifer J. Hauler, DO Nicklaus J. Hess, DO Mark S. Jeffries, DO Gordon J. Katz, DO Paul A. Martin, DO Ruth M. Thomson, DO Christine B. Weller, DO Charles J. Zeller, III, DO	All Dayton Members
Cincinnati	38	3/6	Victor D. Angel, DO, Chair Daniel K. Madsen, DO Sean D. Stiltner, DO	All Cincinnati Members
Sandusky	54	4/7	John F. Ramey, DO, Chair Nicole J. Barylski-Danner, DO Luis L. Perez, DO	All Sandusky Members
Columbus	264	18/35	Adele M. Lipari, DO, Chair Peter A. Bell, DO David L. Bowman, DO William J. Burke, DO Ying H. Chen, DO John A. Cocumelli, DO William F. Emlich, Jr., DO Miriam L. Garcellano, DO Mark W. Garwood, DO Shelby K. Raiser, DO Gary L. Saltus, DO Anita M. Steinbergh, DO Eugene F. Trell, DO Geraldine N. Urse, DO Charles G. Vonder Embse, DO Henry L. Wehrum, DO Maury L. Witkoff, DO	All Columbus Members
Cleveland	130	9/17	John J. Wolf, Jr., DO, Chair Sandra L. Cook, DO Robert W. Hostoffer, Jr., DO Robert S. Juhasz, DO Christopher J. Loyke, DO George Thomas, DO	All Cleveland Members

Akron/Canton	190	13/25	Douglas W. Harley, DO, Chair David A. Bitonte, 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	All Akron-Canton Members
Marietta	106	7/14	Melinda E. Ford, DO, Chair Jennifer L. Gwilym, DO Kenneth H. Johnson, DO Timothy D. Law, DO Jean S. Rettos, DO Edward W. Schreck, DO	All Marietta Members
Western Reserve	86	6/11	Sharon L. George, DO, Chair John C. Baker, DO E. Lee Foster, DO Marc S. Ucchino, DO Robert M. Waite, DO	All Western Reserve Members
OU-COM	1	1/1	Alyssa Ritchie, OMS I	Jordan Brown, OMS I

House of Delegates

Authority/Responsibilities from Constitution and Bylaws:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authority Given by the Ohio Osteopathic Foundation Code of Regulations

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

Nominating Committee

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

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

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

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

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

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

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

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

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

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

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

House Officers and Committees

Speaker Of The House

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

Vice Speaker

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

Secretary

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

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

Credentials Committee

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

Committee on Standing Rules

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

Program Committee

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

3. Shall present the agenda for approval at the House

Resolutions Committee

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

Referral of Business to Reference Committees

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

Reference Committees

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

Reference Committee Duties and Responsibilities

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

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

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

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

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

Reference Committee Hearings and Duties of the Chair

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

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

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

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

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

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

Reference Committee Reports

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

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

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

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

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

Reference Committee Written Reports and Presentation to the House

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

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

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

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

House of Delegates Code of Leadership

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

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

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

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

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

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

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

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

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

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

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