OHIO OSTEOPATHIC ASSOCIATION
Action by the 2016 House of Delegates

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

During the Symposium, Geraldine N. Urse, DO, of Columbus, was installed as OOA president. Other elected officers include: President-elect Sean D. Stiltner, DO, of Piketon; Vice President Jennifer J. Hauler, DO, of Dayton; and Treasurer Charles D. Milligan, DO, of Orville. Immediate Past President Robert W. Hostoffer, Jr, DO, of Cleveland, remains on the Executive Committee.

Speaker of the House John F. Uslick, DO, of Canton, and Vice Speaker David A. Bitonte, DO, MBA, MPH, presided over the meeting. Both were re-elected to another term.

The House also elected E. Lee Foster, DO; Sharon L. George, DO; and Paul T. Scheatzle, DO, to the Ohio Osteopathic Foundation Board of Trustees and voted for a full slate of physicians to represent Ohio at the AOA House of Delegates in July.

Four reference committees met on the first day of the House session to evaluate each resolution and conduct a five-year review of existing policies. Committee chairs then provided a report the following day to the entire House.

Peter A. Bell, DO, of Columbus, chaired the Ad Hoc Committee and the following served on the panel: Nicole J. Barylski-Danner, DO; Douglas W. Harley, DO; Nicklaus J. Hess, DO; and Christopher J. Loyke, DO.

Sandra L. Cook, DO, of Cleveland, chaired the Constitution & Bylaws Committee. Committee members included David A. Bitonte, DO (ex officio); Charles D. Hanshaw, DO; Adele M. Lipari, DO; Daniel K. Madsen, DO; and Marc S. Ucchino, DO.

The Public Affairs Committee was led by Jennifer J. Hauler, DO, of Dayton, with committee members: Ying Chen, DO; William F. Emlich, Jr., DO; Luis L. Perez, DO; Mark J. Tereletsky, DO; Alyssa Ritchie, OMSI; and Cheryl Markino.

Charles D. Milligan, DO, of Orville, led the Professional Affairs Committee. John C. Baker, DO; James A. Schoen, DO; Henry L. Wehrum, DO; John J. Wolf, DO; and Carol Tatman served on the committee.

John F. Ramey, DO, of Sandusky, chaired the Credentials Committee.

New Policy Statements Adopted

Delegates adopted nine new positions. The full text of those resolutions is printed here.

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

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

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

WHEREAS, a 1996 survey of 174 police departments throughout the United States revealed that seven percent of police contacts with civilians involved individuals

believed to have a mental illness, while only 55 percent of the departments possessed a protocol specifically designed to manage these types of interactions; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Explore Incentives to Increase Patient Involvement in Cancer Clinical Trials

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

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

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

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

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

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

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

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

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

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

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

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

Addressing Food and Housing Insecurity for Patients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Human Trafficking Education for Health Care Workers

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

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

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

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

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

Eugenic Selection with Preimplantation Genetic Diagnosis

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

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

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

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

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

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

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

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

TRICARE Health Insurance for our Military

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

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

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

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

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

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

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

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

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

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

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

Providing CME Credits for Physicians Pursuing Further Education

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED, that the OOA supports equal rights and protections to all patient populations.

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

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

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

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

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

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

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

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

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

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

Existing Position Statements Amended and/or Reaffirmed

By action of the Board of Trustees, the OOA Resolutions Committee submits each policy statement to the House of Delegates every five years for reaffirmation, deletion or amendment. The "whereas" clause is deleted when a resolution is 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)*

Health Literacy and Cultural Competency

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

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

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

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

Ohio Automated Rx Reporting System (OARRS)

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

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

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

Ohio Bureau of Workers Compensation Health Partnership Program

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

Childhood Obesity and School Health Policies

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

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

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

Physician Signatures, Reduction of Unnecessary

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

Existing Position Statements Amended by Substitution and Approved

Pain Management Education

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

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

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

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

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

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

Medicare Three-Day Qualifying Policy for Skilled Nursing Facility Care

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

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

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

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

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

Existing Position Statements Deleted

As part of the five-year review, the OOA Resolutions Committee recommended the following position statement be deleted as they are no longer pertinent. The House of Delegates approved the recommendation.

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

Terminally Ill Patient Access to Pain Medications
Rules implementing HB 93 and subsequent legislation addressing pain management exclude terminally ill patients

Prescriptions for Over-the-Counter Medications
Some of the language in the 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.

Resolutions Defeated, Referred, or Withdrawn

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