OHIO OSTEOPATHIC ASSOCIATION
ACTIONS BY THE 2019 HOUSE OF DELEGATES

Submitted by OOA Executive Director Matt Harney, MBA & Secretary of the OOA House of Delegates

The OOA House of Delegates met April 26-27, 2019, during the Ohio Osteopathic Symposium. Delegates representing all ten districts discussed 17 resolutions. Seven of the resolutions were new to 2019 with three regarding OOA bylaws. All other resolutions impacted previously submitted policies.

During the Symposium, Charles D. Milligan, DO was installed as the OOA President. The other OOA officers include: President-Elect Sandra L. Cook, DO; Vice President Henry L. Wehrum, DO; and Treasurer Jennifer L. Gwilym, DO. Immediate Past President Jennifer J. Hauler, DO, will remain on the Executive Committee.

Speaker of the House David A. Bitonte, DO, and Vice Speaker Michael E. Dietz, DO, presided over the meeting. This was Dr. Bitonte's first House of Delegates as Speaker, after serving many years as Vice Speaker. With the promotion of Dr. Bitonte as Speaker, it was also the first year for Michael E. Dietz, DO, to serve as Vice Speaker. The House re-elected Sharon L. George, DO, to the Ohio Osteopathic Foundation Board of Trustees. The House also voted for a full House of Delegates slate to represent Ohio at the AOA House of Delegates in July.

Two reference committees convened—Constitution & Bylaws as well as Ad Hoc. The Constitution & Bylaws Reference Committee heard resolutions 1-2, 15-17. The Ad Hoc Reference Committee heard resolutions 3-14.

The Constitution and Bylaws Reference Committee included Nicholas T. Barnes, DO; Edward E. Hosbach, DO; Christine B. Weller, DO; Michael E. Dietz, DO; John F. Ramey, DO; Henry L. Wehrum, DO; Sandra L., Cook, DO; Paul T. Scheatzle, DO; Jennifer L. Gwilym, DO; Sharon L. George, DO; Andrew Williams, OMS-I; Carol Tatman, Staff. Dr. Gwilym served as Chair.

The Ad Hoc Reference Committee included Nicholas G. Espinoza, DO; Victor D. Angel, DO; John C. Baker, DO; John C. Biery, DO; Katherine H. Eilenfeld, DO; Melinda E. Ford, DO; Gregory Hill, DO; Mark S. Jeffries, DO; Tejal R. Patel, DO; Christine M. Samsa, DO; and Cheryl Markino, Staff. Dr. Espinoza served as Chair.

The following policy statements were reaffirmed by the House of Delegates by way of the five-year policy review:

1 - Automatic External Defibrillator Availability

RESOLVED, that the Ohio Osteopathic Association (OOA) supports placement of automatic external defibrillators (AED) in as many public places as possible and necessary legislation to limit liability resulting from such placement. *(Original 2009)*

2 - Cell Phone Usage While Driving

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

3 - Chicken Pox Vaccine for School Entry

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

4 - Collective Bargaining By Physicians

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

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

5 - Continuing Medical Education, Ohio State Medical Board Requirements

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

6 - Dietary Supplements Hazardous to Health

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

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

7 - E-prescribing of controlled substances

RESOLVED, that the Ohio Osteopathic Association supports state and federal regulations that ensure that e-prescriptions for controlled substances, written for patients in nursing homes and skilled nursing facilities, can be filled in a timely yet safe manner. *(Original 2009)*

8 - Extended Care Facilities

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

9 - Family Medical Leave Act (FMLA) Employee Relationship

RESOLVED, that the Ohio Osteopathic Association supports amendments to the Family and Medical Leave Act of 1993, to allow eligible employees to care for next of kin and their spouses when such individuals do not have a parent, spouse, or child to care for them. *(Original 2009)*

10 - Financial Aid for Ohio Medical Students

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

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

11 - Health Care Reform, OOA Position Statement

RESOLVED, that the Ohio Osteopathic Association continues to endorse and/or support introduction of legislation, which is consistent with the following statement and propose modification or defeat of any initiatives, which are not substantially consistent with these principles:

Statistics indicate that a significant percent of non-elderly Ohioans are uninsured. The OOA believes:

1. There should be universal access to health care for all Ohioans through a combination of public and private programs.
2. Proposed changes in the health care system should address those who do not have insurance. A total restructuring of the system is unnecessary, and, in fact, might create serious problems for the Ohioans who now have health care insurance.
3. The OOA endorses access by all Ohioans, regardless of income, to a basic health insurance package, which stresses preventive care and health maintenance. Basic benefits should be defined by physicians and other health care professionals.
4. Public programs should be expanded to include any Ohioans who cannot currently afford to purchase health insurance coverage in the private market.
5. Small business insurance market reforms are essential in correcting deficiencies. Insurance and health benefits plans should be required to accept applicants with preexisting conditions, and premiums should be based on a community rating system.

6. Consumers should share in the cost of health care insurance based on their ability to pay. All Ohioans who have access to health insurance in the private market should be required to purchase, at the very minimum, basic health care coverage in order to share risks and expand the financing basis. Younger, healthy consumers should not be able to opt out of the purchasing coverage.
7. Creative pilot projects should be implemented to investigate the effectiveness of medical IRAs and Medical Savings Accounts.
8. Cost, financing, and delivery of care issues should be addressed through proper utilization, quality assurance, and elimination of administrative costs, which are duplicative, non-standardized and unnecessary in some instances. Universal credentialing and claims forms should be required for use by all third-party payers. The Medicare fee schedule should not be utilized as a basis for market pricing.
9. All health care reforms should emphasize full freedom of choice of physicians, hospitals and insurance plans. Managed care programs which exclude physicians and hospitals are not essential to cost containment. Any providers of accepted quality health care, who are willing to accept cost containment methods, should not be excluded.
10. Public programs should be amended to stress early intervention, education and prevention. Since one of the largest segments of uninsured Ohioans are children under the age of six; aid to dependent children should be expanded. Public assistance for families should be distributed at Women, Infant and Children program sites and health centers in order to ensure compliance with health care as a prerequisite for public assistance.
11. An entity should be created within state government to oversee and implement a private/public partnership to provide universal access to health insurance. Providers should be adequately represented.
12. Primary care physicians should be the first step for health care services and payment and market reforms should be enacted to implement the medical home concept as defined by the American Osteopathic Association initiative.
13. Language should be retained in the Ohio Revised Code to ensure that AOA-approved education, postdoctoral training programs, and specialty certification are equally recognized for hospital staff privileges and inclusion in all health insurance and health benefit plans.
14. Multiple levels of insurance coverage should be available for those who opt for more extensive benefits.
15. Reimbursement for new technologies must be addressed, including the development of electronic healthcare records and health data interchange.
16. Tort reform and regulatory revisions pertaining to medical professional liability insurance issues must be addressed in all health care reform discussions.
17. Health care policy should encourage geographic redistribution of providers and services.
18. Expanded governmental support for medical education should be addressed as part of the health care reform package.
19. Long-term health care policy and statute issues must be addressed as part of any health care reform. *(Original 1989)*

12 - Health Planning

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

13 - Jury Duty For Physicians

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

14 - Lead Poisoning

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

15 - Licensure examinations for osteopathic physicians

RESOLVED, that the Ohio Osteopathic Association (OOA) continues to support the three-level Comprehensive Osteopathic Medical Licensing Examination (COMLEX) and the COMLEX-USA Level 2-Preformance Evaluation as the four-part national licensing examinations for ALL osteopathic physicians; and, be it further

RESOLVED, that the OOA also supports the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX) as the examination that should be used by state medical licensing boards to re-examine a DO’s ongoing level of basic medical knowledge for endorsement of licensure, reinstatement, reactivation of a license after a period of inactivity, or where the state licensing board is aware of concerns and/or has questions about a DO’s fitness to practice. *(Original 1984)*

16 - Managed Care

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

17 - Managed Care Plans, Termination Clauses

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

18 - Mandatory Assignment

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

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

19 - Medical Malpractice Tort Changes

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

20 - Ohio’s Indoor Smoking Ban

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

21 - OOA Professional Liability Insurance

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

22 - Ohio State Medical Board, State Funding

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

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

23 - Osteopathic Unity

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

24 - Prescriptions, Generic Substitution

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

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

25 - Professional Liability: Attorney Fees Limit for Medical Injury Awards

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

26 - Professional Liability Insurance Company Ratings

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

27 - Professional Liability Insurance, Legislation and Tort Reform

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

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

6. Periodic payments of jury awards; and be if further

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

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

28 - Substance Abuse Insurance Coverage

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

29 - Substance Abuse, Position Statement

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

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

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

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

30 - Uncompensated Care, Tax Credits For Providers

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

The following policy statements were deleted by the OOA House of Delegates:

Advocates for the OOA

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

Explanatory statement: The Advocates for the OOA dissolved effective May 31, 2018.

Postponing ICD-10

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

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

The following policy statements were amended and approved by the OOA House of Delegates:

Childhood Obesity, Dangers of

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

Explanatory Note: In June 2013, the Ohio Department of Health announced a new initiative to combat childhood obesity in Ohio. The early childhood obesity prevention grant program funds high-need communities and builds on existing community-based obesity prevention efforts. The state provided $500,000 for the program in 2013 and 2014. Funding did not continue beyond the 2014 fiscal year.

Quality Improvement Organizations – Eleventh Statement of Work

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

RESOLVED, the OOA seek osteopathic representation on any state governing board or advisory committee formed by the winning contractor for the State of Ohio for either the BFCC or QIN-QIO work; and be it further; *(Original 2004)*

~~RESOLVED that the OOA help recruit osteopathic physicians and osteopathic institutions in Ohio to participate in any review work and care innovation initiatives~~

~~required by the 11th Statement of Work (SOW) which includes any of the following Quality Improvement Aims, each of which has separate Tasks, and technical assistance projects:~~

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

Recreational Marijuana's Impact on Patients

RESOLVED, that the Ohio Osteopathic Association considers marijuana to be a harmful substance for recreational use due to the potentially harmful physiological and psychological effects that it can have on patients, and encourages federal agencies to adapt consistent policies following this same position on recreational use~~; and be it further~~ (Original 2014)

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

Footnotes:
(1) http://www.drugabuse.gov/publications/marijuana-abuse/how-does-marijuana-use-affect-your-brain-body
(2) uptodate.com
(3) medicalmarijuana.ohio.gov

Explanatory notes:
Current AOA policy: As marijuana decriminalization moves forward, there is a greater need to educate health professionals about the evidence-based benefits and risks of marijuana use for both medicinal and recreational purposes. All policies should focus on assuring that the public health threat of marijuana is minimalized and that the benefit of the drug, where indicated by evidence, is available to patients in need.

- *The American Osteopathic Association does not support recreational use of marijuana by patients due to uncertainties in properties, dosing, and potential for impairment. Recreational marijuana use is legal only as determined by specific state law.*
- *The American Osteopathic Association recognizes that the use of marijuana is an evolving field of research, and thus, encourages the NIH and other research entities to conduct research on the effects of cannabis use on cognition as well as the public health implications of marijuana use.*
- *The American Osteopathic Association shall review its policy in light of any new evidence that will be generated by research entities and update this policy as necessary.*

Marijuana Use by Osteopathic Physicians and Students

RESOLVED, that the Ohio Osteopathic Association recognizes the dangers of ~~recreational use of~~ marijuana among practicing physicians, osteopathic physicians in training, and osteopathic medical students and encourages the American Osteopathic Association to enact a policy statement against the recreational use of marijuana by practicing osteopathic physicians in response to its legalization in states like Alaska, California, the District of Columbia, Colorado Maine, Massachusetts, Michigan, Nevada, Oregon, Vermont, and Washington. (Original 2014)

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

Footnotes:
(1) uptodate.com (Marijuana)
(2) http://www.whitehouse.gov/ondcp/state-laws-related-to-marijuana
(3) medicalmarijuana.ohio.gov

Explanatory notes:
Current AOA policy: As marijuana decriminalization moves forward, there is a greater need to educate health professionals about the evidence-based benefits and risks of marijuana use for both medicinal and recreational purposes. All policies should focus on assuring that the public health threat of marijuana is minimalized and that the benefit of the drug, where indicated by evidence, is available to patients in need.

- *The American Osteopathic Association does not recommend any use of cannabis by physicians and medical students because of patient safety concerns.*

- *Recreational marijuana use is legal only as determined by specific state law.*
- *The American Osteopathic Association recognizes that the use of marijuana is an evolving field of research, and thus, encourages the NIH and other research entities to conduct research on the effects of cannabis use on cognition as well as the public health implications of marijuana use.*
- *The American Osteopathic Association shall review its policy in light of any new evidence that will be generated by research entities and update this policy as necessary.*

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

RESOLVED, that the Ohio Osteopathic Association partner with Ohio University Heritage College of Osteopathic Medicine to develop policies to permit medical students the opportunity to document and practice order entry on electronic medical records; ~~and, be it further~~ (Original 2014)

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

Explanatory notes:
In 2014, the AOA passed H345/14 ELECTRONIC MEDICAL RECORD (EMR) STUDENT ACCESS AND USE. The American Osteopathic Association will work with the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Association of Medical Informatics to promote the opportunity for medical students to document and practice order entry in EMRs at facilities where osteopathic medical students are trained.

Prohibit the Sale of ~~E-Cigarettes to Minors to Minors~~ <u>all Forms of Nicotine to Persons Under the Legal Age</u>

RESOLVED, that the Ohio Osteopathic Association (OOA) supports efforts to eliminate the sale of ~~E-cigarettes to minors~~ <u>all forms of nicotine to persons under the legal age</u>. (Original 2014)

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

(1) www.fda.gov/newsevents/publichealthfocus/ucm172906.htm

Explanatory note:
In 2014, the AOA passed H435-A/14 E-CIGARETTES AND NICOTINE VAPING – REGULATION OF, which in part, states" the AOA supports the FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 18. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes."

Direct to Consumer Sales of Durable Medical Equipment (DME)

RESOLVED, that the Ohio Osteopathic Association (OOA) support efforts to eliminate direct to consumer sales of DME; ~~and, be it further,~~ (Original 2014)

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

~~*In 2018, the AOA passed H209-A/18 SALE OF HEALTH-RELATED PRODUCTS AND DEVICES The American Osteopathic Association believes that it is (1) appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data and, in the opinion of the physician, are medically necessary or will provide a significant health benefit provided that such action is permitted by the state licensing board(s) of the state(s) in which the physician practices; and (2) inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to distribute health related products or devices in which distribution results in a profit for the physician. 1999; revised 2004; reaffirmed 2018*~~

~~*Additionally, the AOA only has opposition policy on direct to consumer ads for pharmacy and testing; not durable medical equipment.*~~

Ohio Chronic Pain Management and Prescription Drug Abuse Initiatives

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

RESOLVED, that the OOA continue to offer continuing medical education programs to help physicians adopt and implement evidence-based, best practices in pain management and drug addiction treatment; and, be it further

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

RESOLVED, that the OOA petition the Ohio General Assembly to establish an on-going task force of stakeholders, public officials and legislators to oversee state chronic pain treatment and prescription drug abuse education and prevention initiatives to ensure that patients have access to effective pain management, addiction screening, treatment, and recovery resources; ~~and be it further~~ (Original 2014)

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

The following resolutions were submitted initially in 2019 and approved:

Osteopathic Physicians and the Availability of Naloxone

SUBMITTED BY: Dayton District (III) Academy of Osteopathic Medicine

WHEREAS, opioid deaths are at epidemic proportion. In 2017, the number of overdose deaths involving opioids was 6 times higher than in 1999; and *

WHEREAS, on average 130 Americans die every day from an opioid overdose. (ibid, 2017); and

WHEREAS, rapid administration of naloxone can potentially reverse the effects of opioid overdose; and

WHEREAS, studies have shown naloxone administration by bystanders significantly improve the odds of recovery compared to no naloxone administration; now, therefore, be it **

RESOLVED, that physicians discuss naloxone and how to obtain it with their patients and patient's families, struggling with opioid addiction, and encourage them to have these kits available at all times; and, be it further

RESOLVED, that a copy of this resolution be submitted to the American Osteopathic Association (AOA) for consideration at the 2019 AOA House of Delegates.

References:
*(ref. Wide-ranging online data for epidemiological research (WONDER). Atlantic, Ga.: CDC, National Center for Health Statistics; 2017.

**(ref. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis, Rebecca Giglio, et al. Injury Epidemiology. 2015 Dec: 2(1): 10.

Encourage Medicaid and Pharmacy Benefit Managers to Allow and Support Noncontrolled Alternatives to Formulary Controlled Substances or Safer Alternative to Class II Opioid

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

WHEREAS, there is an opioid epidemic in the United States nationally and especially in the states of Ohio and West Virginia; and

WHEREAS, the safety of the citizens of these states may be at increased risk of addiction when Medicaid and Pharmacy Benefit Managers (PBMs) may be making formulary decisions on a financial basis and not always based on the safest alternative for patients; and

WHEREAS, there are frequently safer and/or less addictive alternatives for treatment of conditions such as acute pain, chronic pain, and Attention Deficit Hyperactivity Disorders; and

WHEREAS, in many cases there are non-formulary/noncontrolled generic alternatives to formulary-approved medications that are covered by Medicaid and PBMs; and

WHEREAS, physicians are frequently forced to prescribe formulary medications due to the patients' financial status or because the PBMs will not allow prescribers to try an alternative medication without requiring patient to first try a medication that has a higher rating on the controlled substance scale (e.g. a CII product versus a CIII, CIV, or CV); now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) strongly encourage Medicaid PBMs and commercial PBMs to provide a noncontrolled alternative as a first line option to a controlled substance (e.g. Atomoxetine vs methylphenidate or mixed amphetamine Salts); and, be it further

RESOLVED, that the OOA strongly encourage Medicaid and PBMs to allow prescribers an option to try a less habit forming alternative for chronic pain treatment, where nonsteroidal anti-inflammatory drugs are ineffective or contraindicated.

Parental Leave Policies for Accreditation Council for Graduate Medical Education (ACGME) Residency

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

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) requires that graduate medical education institutions give written statements regarding parental leave policy availability, without requiring implementation or standardization of leave policies across programs[1]; and

WHEREAS**,** length and availability of parental leave policies in place for resident physicians are determined by respective specialty boards (e.g. American Board of Family Medicine, etc.)[1]; and

WHEREAS, there is discrepancy across specialties regarding establishment and encouragement to utilize parental leave policies[1,2,3,4]; and

WHEREAS, some specialty boards encourage minimum 8 weeks maternal leave, while female surgical residents report that the American Board of Surgery leave policies are a barrier to taking more than 6 weeks of leave[1,2,3,4]; and

WHEREAS, 90% of pediatric residency programs have established maternal leave policies, as compared to only 36.54% of plastic surgery residency programs[5,6,7]; and

WHEREAS**,** many residency programs do not have paternal leave policies[8]; and

WHEREAS**,** in a survey conducted by the Association of Women Surgeons of 347 female surgical residents with one or more pregnancies during residency, 72% reported that the six or less weeks of leave they could obtain was inadequate and 39% seriously considered leaving surgical residency due to the challenges faced regarding childbearing and leave[3]; and

WHEREAS**,** residents in some specialties often face discouragement when taking parental leave, and feel perceived stigma regarding pregnancy[1,2,3]; and

WHEREAS**,** the Family and Medical Leave Act, covering 60% of American workers including medical residents, states eligible employees are entitled to: “unpaid, job-protected leave for specified family and medical reasons,” including up to twelve work weeks within a 12 month period for birth of a child and care for the newborn[9]; and

WHEREAS**,** a substantial decrease in infant mortality was found when women were given 12 weeks of maternity leave following the Family and Medical Leave Act[10]; now, therefore, be it

RESOLVED**,** the Ohio Osteopathic Association (OOA) request the American Osteopathic Association (AOA) encourages the ACGME to promote the standardization, within the common program requirements; availability; and accessibility of requesting adequate parental leave in adherence with the Family and Medical Leave Act; and, be it further

RESOLVED**,** the OOA requests the AOA to encourage the ACGME to advocate for transparency of parental leave policies at the time of residency matching; and be it further

RESOLVED, that a copy of this resolution be submitted to the AOA for consideration at its 2019 House of Delegates.

References

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Additionally, there were three approved amendments to the OOA bylaws.

RESOLVED, THAT ARTICLE I, SECTION 5 OF THE BYLAWS BE AMENDED AS FOLLOWS:

Section 5 – Requirements. The Board of Trustees of the Ohio Osteopathic Association shall enforce the requirements relative to the organization and maintenance of district academies of osteopathic medicine. <u>District leadership shall send a current district membership list to the Ohio Osteopathic Association in August and November to confirm members in good standing</u>.

Explanatory statement: The OOA already collects dues for a majority of district academies. This amendment provides an enforcement mechanism to ensure coordination.

RESOLVED, THAT ARTICLE I, SECTION 6 OF THE BYLAWS BE AMENDED AS FOLLOWS:

Section 6 - Academy Meetings. Each district academy shall hold a minimum of ~~four~~ two regular meetings during each fiscal year. One of these regular meetings may be a social meeting.

Explanatory statement: The OOA has spent the last year assessing the bylaws compliance of its district academies. Several districts are not currently compliant regarding the annual district meetings requirement. This amendment ensures an achievable requirement for all districts. Those district academies that meet more often are strongly encouraged to maintain their respective level of engagement. Resources for district academies such as a template for district bylaws and a district budget have been added to the OOA website in the past year to help aid district academy operations.

RESOLVED, THAT ARTICLE VI, SECTION 4 OF THE BYLAWS BE AMENDED AS FOLLOWS:

Section 4 - Election of AOA Delegates. The officers and district trustees shall be voting members of the elected delegation to the American Osteopathic Association House of Delegates during their term of office. The additional delegates and alternates shall be nominated and elected at the annual meeting of the Ohio Osteopathic Association House of Delegates in the same year they will be serving in the AOA House. ~~One-third of the elected delegates shall be elected each year for a three-year term. If the number of additional delegates cannot be divided by three, the remainder shall be elected to one-year terms.~~ These nominations and elections shall follow the same procedure as provided for in Section 1 of this Article. The student delegate and alternate assigned by the AOA to the Ohio delegation shall enjoy the same rights and privileges as all other elected delegates and alternates and shall have one vote.

Explanatory statement: The OOA Nominating Committee requests this amendment to streamline the delegate selection process. By virtue of policy, the Nominating Committee requires geographic diversity of its osteopathic physician members that ensures a balanced roster developed through broad consensus. The current requirement regarding three-year terms unnecessarily complicates the selection process that must already accommodate varying physician leader availability.