2022 OSMA Annual Meeting
Resolution Committee Two
Resolutions 16-31

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 16 – 2022

Introduced by: OSMA Young Physician Section, OSMA District Two and OSMS District Five

Subject: Allowing Mature Minors to Consent for Vaccination

Referred to: Resolutions Committee No. # 2

WHEREAS, although parents do not have the right to decline medical care for their child if it endangers their child's welfare, this has not historically included preventative measures such as vaccinations; and

WHEREAS, vaccinations can prevent significant morbidity and mortality; and

WHEREAS, although in some states minors can legally decide whether or not they would like to get vaccinated, Ohio law requires parental consent1; and

WHEREAS, in sixteen states, teens have a broad right to make their own general medical care decisions without a parent's consent1; and

WHEREAS, in some states, the ability for a minor to consent to healthcare is based on age (e.g. Alabama - minors may consent at age 14, Kansas at age 15, Oregon at age 16)1; and

WHEREAS, in other states (Alaska, Arkansas, Idaho), a physician can determine when a minor is able to meet standards for informed consent1; and

WHEREAS, American Medical Association Policy D-440.926 makes model legislation available to aid states in developing legislation to allow "mature minors" to self-consent for vaccinations2; **therefore be it**

RESOLVED, that the Ohio State Medical Association (OSMA) recognize mature minors as certain older minors who have the capacity to give informed consent for care that is within the mainstream of medical practice, as determined by their physician; and, **be if further**

RESOLVED, that the OSMA supports allowing mature minors the ability to self-consent for vaccination.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

References

1. https://ohiocapitaljournal.com/2021/09/01/do-u-s-teens-have-the-right-to-be-vaccinated-against-their-parents-will-it-depends-on-where-they-live/
2. Our AMA: (1) supports physicians in assessing whether a minor has met maturity and medical decision-making capacity requirements when providing consent for vaccinations

and in developing protocols for appropriate documentation; and (2) will develop model legislation to aid states in developing their own policies to allow “mature minors”, defined as “certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a nonnegligent manner,” to self-consent for vaccinations.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 17 – 2022

Introduced by: OSMA Medical Student Section

Subject: Supporting Vaccine Mandates in Ohio

Referred to: Resolutions Committee No. # 2

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WHEREAS, in light of the Covid-19 pandemic and distribution of the vaccine, the Ohio House of Representatives has introduced multiple bills to the House which severely limit current vaccination requirements[1,2]; and

WHEREAS, in April 2021, the Ohio House of Representatives introduced HB248, *Enact Vaccine Choice and Anti-Discrimination Act,* prohibiting all vaccination requirements, vaccination status disclosures, or discrimination on the basis of vaccination status[1]; and

WHEREAS, the Ohio House of Representatives passed HB218, which prohibits public and private entities from requiring proof of vaccination against COVID-19 upon entry[3]; and

WHEREAS, removal of vaccine mandates and greater restrictions on vaccination requirements would greatly undermine public health and eliminate decades-long progress in eradicating highly infectious diseases such as measles and pertussis, and risk prolonging the Covid-19 pandemic[4]; and

WHEREAS, the ability of a population to realize herd immunity against certain diseases is contingent on widespread immunization or past exposure to the disease. According to Dr. Anthony Fauci, Chief Medical Advisor to the President of the United States, 70-85% of the population will need to be vaccinated to reach immunity against Covid-19,[5,6,7]; and

WHEREAS, the health of individuals who are immunocompromised is dependent on widespread vaccination as these individuals are more susceptible to getting infected and are less able to fight off infection[8]; and

WHEREAS, the current Covid-19 pandemic continues to be a threat to the public with multiple variants of SARS-CoV-2 detected since the start of the pandemic and rising infection rates in the Midwest and in counties around Ohio since July, 2021[9,10]; and

WHEREAS, despite public health efforts including incentives and public campaigns, Ohio is the 10th least vaccinated state in the nation with 53% of residents being fully vaccinated as of December 2021[11]; and

WHEREAS, as of December 2021 94.6% of Covid-19 hospitalizations and 95.4% of deaths in Ohio throughout 2021 are among patients who are not fully vaccinated[12]; and

WHEREAS, Ohio hospitals such as Mount Carmel have seen vaccination rates increase by 19 percent among employees since instituting a vaccine mandate in July 2021. Additionally,

states have experienced large gains in vaccination rates since instituting a vaccine mandate, such as Washington state where 95% of state employees are fully vaccinated [5,13–16]; and

WHEREAS, vaccine mandates are stronger than soft mandates that include increasing awareness and access to vaccines, in increasing influenza vaccination rates among healthcare workers[17]; and

WHEREAS, the Ohio State Medical Association (OSMA) has already supported the removal of non-medical exemptions for mandated immunizations recognizing a need for increased vaccination rates[18]; and

WHEREAS, the OSMA has supported the addition of certain vaccines, such as HPV, to the list of required vaccines necessary for attendance at public and private schools[18]; and

WHEREAS, fentanyl test strips can allow providers to engage with drug users and seekers with higher engagement, allowing for the dissemination of safe practices, overdose prevention, and support program the American Medical Association (AMA) has encouraged physicians to "proactively develop policies and procedures for responding to epidemic or pandemic disease" as part of section 8.7 of AMA's code of medical ethics for physicians[19,20]s[16]; **therefore be it**

RESOLVED, the OSMA supports the right of public and private entities to enforce vaccine mandates for employees, staff, and students for highly communicable diseases and increasing efforts to expand Covid-19 vaccination rates in Ohio; and, **be it further**

RESOLVED, the OSMA supports the right of public and private entities to require proof of vaccination to enter an establishment.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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RELEVANT OSMA POLICY

Policy 08 – 2019 – HPV Immunization
1. The OSMA supports increased access to the HPV vaccine. 2. The OSMA supports adding the HPV vaccine to the current schedule of required vaccines for attendance at public and private schools, subject to existing exemption policies.

Policy 21 – 2017 – Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries
1. The OSMA supports the use of immunizations to reduce the incidence of preventable diseases. 2. The OSMA supports the removal of non-medical exemptions for required school immunizations. 3. The OSMA encourages the use of immunization reporting systems for patients of all ages.

Policy D – 1932 – Medical Legislation
1. The OSMA re-emphasizes and re-endorses the established and fundamentally-sound policies of medical organization of Ohio toward all legislation affecting public health, scientific medicine and medical practice, namely: a. The medical profession of Ohio is opposed to the enactment of any legislation which would be detrimental to the health of the citizens of the State or which would hinder or prevent effective public health administration. b. The medical profession of Ohio condemns and opposes those proposals which would interfere with the advancement of scientific medicine; lower the high standards surrounding medical practice in Ohio, and jeopardize the health and welfare of the people by extending legal privileges to unqualified, incompetent and untrained individuals. 2. All OSMA members should take an active, personal interest in molding public opinion in accordance with the foregoing principles, and aid in selecting for public office - national, state and local - persons who can be depended upon to protect and further the best interests of the public generally, and who will look to the medical profession for counsel and advice on those matters pertaining to public health, medical practice and scientific medicine.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 18 – 2022

Introduced by: OSMA Medical Student Section

Subject: Establish Collaborations with the American Medical Association, Association of American Medical Colleges and Ohio Medical Schools to Create Formal Training in Telemedicine

Referred to: Resolutions Committee No. # 2

WHEREAS, the importance of telemedicine is rapidly increasing, as telemedical care has expanded by 683% in the United States in response to the COVID-19 pandemic and is likely to continue to grow post-pandemic[1]; and

WHEREAS, telemedicine has the potential to tackle disparities in healthcare access and outcomes for underserved populations, including the elderly, resource-poor residents of urban areas, residents of rural communities, and populations with language barriers[2-5]; and

WHEREAS, delivery of effective telemedical care involves the use of unique tools and skills that are not part of the traditional, in-person medical work-up[6-8]; and

WHEREAS, currently, the available training for telehealth is not adequate, with only one specialty mentioning telehealth in its Accreditation Council for Graduate Medical Education Milestone document[9], and only half of medical schools incorporating telehealth into their curriculum[9-10]; **therefore be it**

RESOLVED, the Ohio State Medical Association (OSMA) collaborate with the American Medical Association and the Association of American Medical Colleges to integrate telemedical education into the medical school curriculum, including at the pre-clinical and clinical stages of training; and, **be it further**

RESOLVED, the OSMA encourages Ohio medical schools to integrate telemedical education into the medical school curriculum independently of its work with the AMA.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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RELEVANT OSMA AND AMA POLICY

OSMA Policy 05 – 2021 – Ohio Telehealth (video/audio or audio-only)
1. The OSMA will continue to advocate for the widespread adoption of telehealth (video/audio or audio-only) services in the practice of medicine for physicians and physician-led teams post SARS-COV-2.

2. The OSMA will support equitable access to telehealth (video/audio or audio-only) services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients.

3. The OSMA will support telehealth parity laws that require public and private insurers to cover and reimburse telehealth-provided services (video/audio or audio-only) equivalent to that of in-person services, and not limit coverage only to services provided by select corporate telehealth providers.
4. The OSMA will encourage appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telehealth and its capabilities and limitations

5. The OSMA will consider model legislation provided by the AMA's Advocacy Resource Center in its ongoing legislative advocacy efforts regarding Telehealth in Ohio.

AMA Policy on Professionalism in Telemedicine and Telehealth D-480.974
The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate.

AMA Policy on Addressing Equity in Telehealth H-480.937
Our AMA:

(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 19 – 2022

Introduced by: OSMA Medical Student Section

Subject: Advocating Creation of a State-Level All-Payer Claims Database

Referred to: Resolutions Committee No. # 2

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WHEREAS, Ohio's healthcare infrastructure has consistently ranked in the lower quartiles relative to state counterparts, especially in the realm of population health outcomes[1]; and

WHEREAS, many of Ohio's health disparities can be remedied by more comprehensive data pooling and efficient information exchange between public health systems and health care systems[1]; and

WHEREAS, rapidly changing rules in payer adjudication, disparities in electronic medical record (EMR) systems' ability to link to insurer claims, and redundant information requests contribute to poor payer-provider communication[2-4]; and

WHEREAS, a 2019 survey of 982 Ohioans found that a majority of those surveyed experienced concerns related to healthcare cost, and that over 90% of those surveyed favored increased transparency with regards to healthcare cost[5]; and

WHEREAS, an analysis of states' policies and their effect on healthcare affordability ranked Ohio 20th of 47 states, with low-scoring areas being excess healthcare cost and low-value care[6-8]; and

WHEREAS, delinquent medical payments are a growing problem as the percentage of patients owing between $500 and $1000 almost doubled from 34% in 2017 to 59% in 2018[9-10]; and

WHEREAS, price transparency would facilitate patient payments with 65% of patients willing to make an up-front partial payment if given transparent price estimates [9-10]; and

WHEREAS, all-payer claims databases (APCDs) are large-scale state databases that include medical claims, pharmacy claims, along with eligibility and provider files that are collected from private and public payers all of which are reported to the State directly by insurers[11]; and

WHEREAS, states with APCDs have been able to create tools and legislation aimed at reducing healthcare cost and improving cost transparency, specifically by bolstering initiatives to decrease surprise billing, control costs, ensure network capacity, and identify benchmark prices in Colorado, Washington, Maine, Virginia, and other states[12]; and

WHEREAS, APCDs serve as a repositories for accurate retrospective price information for consumers, and six states that have made substantial progress towards greater price transparency are due largely to their robust claims databases[13]; and

WHEREAS, there is substantial heterogeneity in the rules and processes used by different claims databases to classify inpatient versus outpatient visits from Health Insurance Claim Form (HCFA-1500) and Universal Billing form (UB-92) raw data[14]; and

WHEREAS, within individual claims databases there is inconsistency from year to year in how claims are classified as inpatient[14]; and

WHEREAS, applying a standardized coding model to different claims databases makes the prevalence of inpatient admissions much more consistent across databases [14]; and

WHEREAS, APCDs offer the advantage of information mandated from most, if not all, insurance agencies including private entities operating throughout the state compared to other datasets [11,15]; and

WHEREAS, APCDs incorporate broadened measures of patient care that are otherwise unaccounted for in discharge data systems, along with greater sample sizes, geographic and site representation, and longitudinal details [11,15]; and

WHEREAS, an APCD can be tailored to state-specific objectives by attending to some or all of six identified uses of existing APCDs: reporting on health care spending, utilization, and performance; enhancing state policy and regulatory analysis; informing the public about health care prices and quality; enabling value-based purchasing and health care improvement; supporting public health monitoring and improvement; providing reliable data for healthcare research and evaluation[16-17]; and

WHEREAS, several states have demonstrated the feasibility of merging state-level claims data to track beneficiaries' transitions between types of coverage, providers, and encounter data to inform research and health reform[18-19]; and

WHEREAS, eight states with established APCDs with diverse formation, governance, and operation profiles have outperformed national averages in health system performance, insurance market competition, publicly available information, and health care price transparency [20]; and

WHEREAS, APCDs can inform health consumers to make appropriate value-based selections from a centralized portal reflecting pertinent, accurate, and transparent pricing data, unencumbered by insurer siloing[21]; and

WHEREAS, the Ohio Patient-Centered Primary Care Collaborative, established by the Ohio Department of Health, advocated for the implementation of a statewide APCD in 2014, leading to the Health Policy Institute of Ohio of the Ohio APCD Collaborative studying the impact of APCD creation in 2015 [22-24]; **therefore be it**

RESOLVED, Our Ohio State Medical Association advocates for the creation of a centralized, comprehensive state-level all-payer claims database that requires health insurance issuers, including but not limiting to group health plans (self-insured and fully-insured), and non-federal governmental plans to submit claims data.

Fiscal Note: $ (Sponsor)
$ 50,000 (Staff)

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RELEVANT OSMA POLICY

1. Policy 16 – 2006 – Professional Liability Carrier Anti-Competitive Practices
   a) The OSMA shall work with the Ohio Department of Insurance to ensure appropriate transparency of claims data between a PLI carrier and its insured.
2. Policy 10 – 2011 – Standardize Insurance Payment Policies
   b) The OSMA supports a requirement that all private insurers standardize their payment policies to accept claims for at least one year after date of service and that private insurers limit their ability to retroactively require provider reimbursement for rejected claims to 6 months or less.

RELEVANT AMA AND AMA-MSS POLICY

1. Price Transparency D-155.987

a) Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
b) Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
c) Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
d) Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
e) Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
f) Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
g) Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 20 – 2022

Introduced by: The Academy of Medicine of Lima and Allen County

Subject: Appropriate Physician Reimbursement to Cover Rising Expenses of Office Practice

Referred to: Resolutions Committee No. # 2

WHEREAS, the minimum wage in Ohio increases each year which is an increased cost for physicians who employ staff in their offices; and

WHEREAS, the cost of medical equipment and office supplies has increased each year; and

WHEREAS, the cost of health insurance and other benefits for office staff has increased each year; and

WHEREAS, reimbursement for hospitals has markedly increased over the past few years while physician reimbursement has stayed constant or minimally increased; and

WHEREAS, physicians in private practice are running small businesses which employ thousands of staff members across Ohio; and

WHEREAS, physicians are increasingly becoming hospital employees at least partially due to the costs and stress of running a private office; **therefore be it**

RESOLVED, that our Ohio State Medical Association (OSMA) advocate that physician reimbursement for all activities be increased to cover the expenses of running an office practice; and, **be if further**

RESOLVED, that our OSMA work with our Ohio State Legislature and Ohio Congressional delegation to improve physician reimbursement; and, **be if further**

RESOLVED, that the OSMA Delegation to the American Medical Association (AMA) take this resolution regarding improved physician reimbursement to the AMA House of Delegates for action.

Fiscal Note: $ 1,000 (Sponsor)
$ 25,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 21 – 2022

Introduced by: Kenneth Christman, MD

Subject: Health Plan Transparency

Referred to: Resolutions Committee No. # 2

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WHEREAS, Health Plans are increasingly and fraudulently altering CPT codes to avoid payment for medical care; and

WHEREAS, many Health Plans are completely disregarding some CPT codes, falsely claiming that they are part of medical care and thus not payable; and

WHEREAS, Health Plans are now attempting to avoid paying for medical care of their commercially insured subscribers by shifting the payment to Medicaid, at times improperly threatening physicians to accept Medicaid payment rates; and

WHEREAS, Health Plans are pre-authorizing medical care, but subsequently refusing to pay for such care; and

WHEREAS, Health Plans are increasingly abusing patients and physicians by demanding prior authorization for routine medical care, and refusing compensation for this time-consuming and expensive procedure; and

WHEREAS, Health Plans are using language that states the medical care is approved, but that “this is not a guarantee of payment”; and

WHEREAS, recently enacted state and federal Surprise Billing laws require physicians to anticipate the patient’s financial obligations in advance; and

WHEREAS, financial planning a disclosure is impossible without reliable commitments on the part of Health Plans; and

WHEREAS, some Health Plans are under the jurisdiction of the Ohio State Dept. of Insurance, while others are outside its jurisdiction and under federal jurisdiction; and

WHEREAS, Health Plans are increasingly denying needed medical care by making a distinction between “in-network” and “out-of-network”, causing many patients unnecessary delay and increased cost of medical care; and

WHEREAS, the introduction of Surprise Billing state and federal legislation will ultimately result in no financial distinction between being “in-network” or being “out-of-network, as those physicians outside the network will be forced to accept “in-network” restrictions; and

WHEREAS, Health Plans have become increasingly capricious about which physicians they "allow" in their networks, and physicians or groups they do not like or do not need are either not given contracts, or offered contracts on very unfavorable terms; and

WHEREAS, Health Plans are notoriously secretive about their contracted rates, offering some physicians or groups more lucrative contracts while discriminating against others; and

WHEREAS, some Health Plans have few, if any, specialists or subspecialists in geographic areas, thus forcing its subscribers to travel long distances unnecessarily; and

WHEREAS, Health Plans are insensitive to patient choice of physician or hospital by arbitrarily imposing their network system; **therefore be it**

RESOLVED, Ohio State Medical Association seek Ohio legislation that allows physicians and patients to abide by the transparency requirements by:

1. Banning Health Plans from arbitrarily and fraudulently altering CPT codes
2. Banning Health Plans from arbitrarily deleting and refusing payment for legitimate and medically necessary CPT codes
3. Requiring Health Plans to pay for Prior Authorization, a medical procedure for which the AMA has provided a CPT code, and which is costly to physician offices
4. Requiring Health Plans to follow the AMA's CPT provisions and all its guidelines, without picking and choosing which ones to follow and which ones to disregard
5. Banning the practice of Health Plans simultaneously providing commercial medical insurance and Medicaid health coverage for the same person. This is a needless waste of Ohio's resources and offers Health Plans the corrupted opportunity to shift payment responsibilities onto the Ohio taxpayer rather than the entity collecting commercial insurance premiums. This practices simply enriches Health Plans
6. Requiring Health Plans to pay for services that are authorized, and to issue appropriate fines to Health Plans which authorize medical care but subsequently refuse payment for it. This is standard practice for all other businesses and health care should be no exception. Failure to follow through with payment will corrupt and confuse Surprise Medical Billing legislation
7. Requiring all Health Plans operating in Ohio to be under the jurisdiction of the Ohio State Dept. of Insurance, whether it be an ERISA plan or not. The U.S. Constitution does not allow for the Federal Government to control medical care nor to control insurance matters. Failure to allow for state jurisdiction of Health Plans will cause adherence to the transparency requirements of Surprise Medical Billing legislation to be difficult, if not impossible
8. Banning the distinction between "in-network" and "out-of-network" providers, as such is no longer necessary with the advent of Surprise Medical Billing legislation. Health Plans are simply to post its reimbursement rates for ALL of our AMA's CPT codes that apply to ALL patients and ALL physicians regardless of network status. Such transparency will make it possible for physicians and patients to comply with Surprise Medical Billing laws, and know in advance what the financial responsibilities are. Full transparency should be required by ALL entities in the health arena—hospitals and facilities, insurers, physicians, and patients. This will also eliminate the unfair burdens patients routinely experience in being forced to "in-network" facilities

Fiscal Note: $ 50,000 (Sponsor)
$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2022

Introduced by: Kenneth Christman, MD

Subject: Medicare and Medicaid Reimbursement

Referred to: Resolutions Committee No. # 2

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WHEREAS, the November, 2021 Consumer Price Index (CPI) surged by 6.8% on an annualized basis; and

WHEREAS, there is widespread expectation of continued large increases in the cost of living; and

WHEREAS, physician practices have been expected over the years to absorb the increased cost-of-living and increased office expense; and

WHEREAS, some states (Alaska and Montana) offer Medicaid reimbursement above Medicare rates, and numerous others offer Medicaid reimbursement at near-parity with Medicare; and

WHEREAS, Ohio Medicaid reimbursement is amongst the lowest at an average of 63% of Medicare reimbursement; and

WHEREAS, in the last quarter of a century, Ohio Medicaid offered a paltry 3% increase in physician Medicaid reimbursement, only to rescind it later; and

WHEREAS, the Ohio Medicaid program has enriched certain Medicaid Managed Care entities at the expense of physician reimbursement; and

WHEREAS, at least one Ohio Medicaid HMO has been so profitable that it has expanded into other states; and

WHEREAS, many Medicaid recipients have had their medical needs thwarted or denied, or had difficulty obtaining appropriate medical care because of abnormally low physician reimbursement; and

WHEREAS, Medicare physician reimbursement has lagged CPI increases for many years, with continual threats of decreasing physician reimbursement; and

WHEREAS, the advent of Medicare Advantage Plans have become costly to administer, and only serve to deny timely medical care to the elderly, and clearly depart from traditional Medicare's absence of networks; **therefore be it**

RESOLVED, that Ohio State Medical Association seek to introduce legislation which will bring Ohio Medicaid reimbursement up to parity with Medicare reimbursements; and, **be it further**

RESOLVED, that the Ohio delegation to our American Medical Association carry a resolution which calls for eradication of Medicare Advantage Plans, as they only serve to deny and thwart the timely delivery of medical care, and also to seek a 15% increase in Medicare physician reimbursement in order to compensate for the many years of stagnating fee schedules.

Fiscal Note: $ 25,000 (Sponsor)
$ 50,000 (Staff)

1919OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 23 – 2022

Introduced by: The Academy of Medicine of Lima and Allen County

Subject: Prohibit Reversal of Prior Authorization

Referred to: Resolutions Committee No. # 2

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WHEREAS, the process of obtaining prior authorization requires several steps that take significant physician and staff time; and

WHEREAS, after prior authorization is obtained, the insurance company sends a letter or other communication stating that the test, procedure, or medication is approved; and

WHEREAS, after receiving such communication, the physician will proceed with ordering the approved testing, scheduling the procedure, or giving the approved medication; and

WHEREAS, after the testing or procedure is scheduled or done or the medication is given, physicians and patients have received a second communication from the insurance company reversing the prior authorization and denying payment; and

WHEREAS, many of the prior authorization letters have a statement such as: “This notification is not an approval for claim payment. This is confirmation of referral/authorization only”; and

WHEREAS, this is unfair to the patient and physician who proceed in good faith to do the testing or procedure or provide the medication; **therefore be it**

RESOLVED, that once the physician’s office has received prior authorization for testing, a procedure, or a medication, the insurance company cannot refuse payment for that test or procedure or medication unless the patient is no longer insured by that company at the time the test or procedure is done or the medication is given; and, **be it further**

RESOLVED, that our Ohio State Medical Association (OSMA) seek legislation to prohibit retroactive denial of a previously prior approved medication, procedure, or test unless the patient is no longer insured by that company; and, **be it further**

RESOLVED, That our OSMA Delegation to the American Medical Association (AMA) take this resolution regarding reversal of prior authorization to the next AMA meeting for discussion at the House of Delegates.

Fiscal Note: $1,000 (Sponsor)
$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 24 – 2022

Introduced by: Kenneth Christman, MD

Subject: United Healthcare Subsidiary Knowingly Using False Data

Referred to: Resolutions Committee No. # 2

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WHEREAS, in 2008, Ingenix, a subsidiary of United Heathcare, reached a settlement of $400 million due to knowingly using falsified data in order to cause physicians to be underpaid for their services; and

WHEREAS, our American Medical Association (AMA) was instrumental in exposing this fraudulent activity; and

WHEREAS, this fraudulent data was further disseminated to other payors; and

WHEREAS, Ingenics subsequently morphed into Optum, which remains a subsidiary of United Healthcare; and

WHEREAS, a cursory examination of data base charges over the last 7 or 8 years seems to indicate minimal changes for more complex CPT codes, and in some instances even decreases in data base amounts, while less complex codes seem to carry larger increases in value; and

WHEREAS, United Healthcare subsidiaries have recently been ordered to pay $60 million in punitive damages to emergency room physicians in Nevada, purportedly for dropping payment from $528 to $249 in 2 or 3 years; and

WHEREAS, there seems to be a pattern of fraudulent activity with respect to United Healthcare and its subsidiaries; and

WHEREAS, the recently enacted Surprise Medical Billing state and federal legislation will likely allow United Healthcare to disseminate potentially false data; **therefore be it**

RESOLVED, that Ohio State Medical Association request that our AMA delegation carry a request for an AMA investigation into the United Healthcare data bases, especially with respect to Optum, in order to ascertain UNH's methodology and accuracy, and to take appropriate action, if indicated

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 25 – 2022

Introduced by: OSMA Medical Student Section

Subject: Opposition of Conscience Clause Extension and Support for Expansion of Antidiscrimination Definition to Include Sexual Orientation and Gender Identity or Expression

Referred to: Resolutions Committee No. # 2

WHEREAS, the federal government, through The Church Amendments, the Public Health Service Act 245, The Weldon Amendment, and The Affordable Care Act (ACA), robustly upholds conscience protections for physicians who "refuse to perform, accommodate, or assist with certain health care services on religious or moral grounds"[1]; and

WHEREAS, the American Medical Association (AMA) Code of Medical Ethics allows the declination of care when a physician "lacks the resources needed to provide safe, competent, respectful care for the individual,"[2] but asserts the ethical duty of physicians to uphold patient safety by transferring or referring patients to an able medical professional and providing care in cases of medical emergency[3]; and

WHEREAS, the AMA asserts physicians "must uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, or other personal or social characteristics that are not clinically relevant[2]," including discrimination against sexual orientation or gender identity as outlined by Section 1557 of the ACA[3]; and

WHEREAS, Section 1557 of the ACA prohibits discrimination against patients participating in a federally-funded or administered program or receiving coverage from a health insurance marketplace plan, with discriminative practices considered legal violations of a patient's federal civil rights[3]; and

WHEREAS, Ohio House Bill 110 Section 4743.10 extends conscience protections by allowing the "freedom to decline to perform, participate in, or pay for any health care service which violates the practitioner's, institution's, or payer's conscience as informed by the moral, ethical, or religious beliefs or principles,"[4]; and

WHEREAS, Ohio House Bill 110 Section 4742.10 removes legal liability in the ethical responsibility of a provider exercising conscience rights to attempt the transfer or referral of a patient to an able medical professional[5], which jeopardizes patient safety, does not fulfill the standard of care, and violates a patient's rights to continuity of care as defined by the AMA[2]; and

WHEREAS, OSMA further opposes the extension of conscience rights, "which would inhibit Ohioans from getting necessary health care services and give insurers[6] (despite not practicing medicine) the ability to refuse to fulfill a claim on broad, largely unobjectionable, and intrusive grounds irrespective to medical necessity as determined by a licensed physician or health care practitioner;"[7]; and

WHEREAS, the 2021 Transgender Advocacy Council Ohio Trans Needs Assessment found that of the 121 individuals surveyed, 64.5% experienced maltreatment in healthcare settings in their lifetime and 46.2% experienced maltreatment within the past year[8]; and

WHEREAS, the 2021 Transgender Advocacy Council Ohio Trans Needs Assessment revealed that of the 121 individuals surveyed, 49.6% had been discriminated against while trying to access healthcare[8]; and

WHEREAS, the 2015 United States Transgender Survey (USTS), which surveyed 27,715 transgender and non-binary individuals found that 25% of respondents experienced a problem with insurance coverage related to their being transgender, 33% reported not seeing a doctor due to health care costs, and 7% reported being denied routine care because of their transgender status[9]; and

WHEREAS, transgender and non-binary people are three times more likely to travel more than fifty miles for gender-affirming care than for routine care, because they have no options in network to receive this care[9]; and

WHEREAS, the extension of conscience rights creates barriers to care that will exacerbate existing healthcare inequities for Ohioans, especially for marginalized communities, including the estimated 40,000-70,000 transgender individuals in the state of Ohio[10]; **therefore be it**

RESOLVED, Our OSMA opposes efforts to implement conscience protections for physicians not already endorsed by current law[3] and the AMA[2]; and, **be it further**

RESOLVED, Our OSMA support legislative actions to extend the definition of discrimination on the basis of sex to include sexual orientation and gender identity or expression, as outlined in Ohio House Bill 208/Senate Bill 119, termed the "Ohio Fairness Act."[11]

Fiscal Note: $ (Sponsor)
$ 1000 (Staff)

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RELEVANT OSMA POLICY

Policy 22 – 2016 – Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection Laws

1. The OSMA supports the protection of Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals from discriminating practices and harassment.
2. The OSMA advocates for equal rights protections to all patient populations

Policy 15 – 2020 – Supporting Gender-Affirming Care for Transgender and Gender Minority Patients

1. The OSMA reaffirms existing Policy 23-2016 - Expanding Gender Identity Options on Physician Intake Forms.
2. The OSMA supports individualized, gender-affirming, evidence-based treatment and clinical practices in caring for transgender and gender minority patients.
3. The OSMA supports educational training to further educate healthcare providers on how to provide competent, respectful, evidence-based care to transgender and gender minority patients.

RELEVANT AMA AND AMA-MSS POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual

orientation or gender identity. (Res 501, A-07, Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18)

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (Res. 122 A-08; Modified: Res. 05, A-16)

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07;Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 26 – 2022

Introduced by: OSMA Medical Student Section

Subject: Quality Child Care to Improve Pediatric Population Health

Referred to: Resolutions Committee No. # 2

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WHEREAS, only 17% of Publicly Funded Child Care programs in Cincinnati, Ohio ensure that children receive annual comprehensive health and developmental screens, including vision, dental, hearing, blood lead levels, and growth evaluations[1]; and

WHEREAS, areas with a lesser degree of income disparity are more likely to have integrated comprehensive health screening within Publicly Funded Child Care, as well as requirements for annual referrals to community resources if families are unable to obtain said screening[2]; and

WHEREAS, Ohio Senate revision of the Ohio State Budget provided an insufficient increase in funding for Publicly Funded Child Care in the 2 year budget,[3] and eliminated their previous goal of increased requirements for health screenings in Publicly-Funded Child Care programs[4]; and

WHEREAS, Ohio House Bill 145, currently being deliberated in House Committee, seeks to increase the income eligibility for Publicly Funded Child Care to 200% of Federal Poverty Level, with support from numerous Ohio child care organizations[5,6]; and

WHEREAS, multiple child care arrangements or child care instability was found to be associated with increased asthma diagnoses in early childhood and risk for communicable illness, as well as a highly predictive risk factor for early childhood health problems such as increased rates of respiratory illness and otitis media[7,8]; and

WHEREAS, Sabot et al found that adolescents who had stable preschool child care arrangements during their preschool years had lower blood pressure than children who did not, as well as had lower measurements of morning cortisol levels as adolescents[9]; and

WHEREAS, Hong et al found that enrollment in a pre-Kindergarten publicly funded child care program with integrated health promotion increased the likelihood that a child would be diagnosed with asthma, hearing or vision problems, as well as increased likelihood that children would receive an immunization during their pre-Kindergarten year[10]; and

WHEREAS, Head Start is a program that promotes the school readiness of preschool age children, toddlers and infants from low-income families, and specifically focuses on health promotion by incorporating services such as health screenings, nutritional meals and the referral of families to medical, dental and mental health services[11]; and

WHEREAS, Anderson et al found that children who attended Head Start programs were less likely to smoke tobacco as a young adult than their siblings who had not attended Head

Start programs, and Thompson found that Head Start participants are 4.6% less likely to have a health limitation at age 40[12,13]; and

WHEREAS, in the State of Ohio, there are 281 Head Start programs that do not have a contract with Publicly Funded Child Care (PFCC), while there are only 235 Head Start programs that families who receive PFCC benefits are eligible for[14]; and

WHEREAS, in both Head Start and non-Head Start child care centers, employment of Child Care Health Consultants (CCHCs) significantly increases the likelihood of the child care center providing access to health care screenings and health-promoting assessments[15]; and

WHEREAS, Step Up to Quality (SUTQ) is a 5-star Quality Rating and Improvement system that is administered by the Ohio Department of Job and Family services, which evaluates and ranks child care and development programs that exceed quality, health and safety licensing regulations[16]; and

WHEREAS, only 4 and 5 star ratings of Step Up to Quality ratings require that centers ensure that each family has access to comprehensive health screenings, developmental screenings, health educational materials, and requirement for a referral process for families without health care access, while centers with lower ratings are not required to provide any of these resources[17,18]; and

WHEREAS, of PFCC-eligible programs in Ohio, only 23% have the Step Up to Quality rating of 4 or 5 stars, which require health and child developmental screenings, where 55% of PFCC-eligible programs have ratings of 0, 1, or 2 stars, with no such requirements for ensuring the health maintenance of children[17,18]; and

WHEREAS, despite standardized state-wide income eligibility requirements for Publicly Funded Child Care, Urban areas with high degree of income disparity have higher proportions of low-rated child care programs compared to non-urban areas with less income stratification, and therefore less access to health-promoting programs[19]; **therefore be it**

RESOLVED, that our Ohio State Medical Association (OSMA) support the expansion of Publicly-Funded Child Care to increase the stability of child care arrangements, bolster healthy development of Ohio children, and improve pediatric population health in the state of Ohio; and, **be it further**

RESOLVED, that our OSMA support improved funding for the evidence-based integration of Child Health Care Consultation services within Publicly Funded Child Care to teach and encourage long-term healthy behaviors; and, **be it further**

RESOLVED, that our OSMA support the implementation of state licensing requirements that are more adherent to the health promoting standards of the Ohio quality rating system, Step Up To Quality, to increase access to high-quality Child Care.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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RELEVANT AMA AND AMA-MSS POLICY

Providing Medical Services through School-Based Health Programs H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

Early Literacy Programs H-60.914
Our AMA encourages physicians to participate in early literacy programs to promote literacy development, educate parents on child development, and strengthen family interactions, so that these programs become a common part of child health care as a foundation for school readiness.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 27 – 2022

Introduced by: OSMA Medical Student Section

Subject: Recognition of Climate Change as a Threat to Ohio's Health

Referred to: Resolutions Committee No. # 2

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WHEREAS, there is overwhelming agreement among experts that humans have contributed to global warming, as well as significant evidence that this warming is a driver of climate change[1,2]; and

WHEREAS, over 200 medical journals recognize climate change as the single greatest threat to human health this century and encourage action to limit global temperature increases[3,4]; and

WHEREAS, climate change currently causes deleterious health effects in Ohio and regionally, including: worsened respiratory illness, lower birth weights, exposure to infectious disease, exposure to toxic pollution in water, increased risk of heat-related morbidity, and worsened mental health[5-9]; and

WHEREAS, the deleterious effects of climate change will disproportionately impact children, elders, minorities, the economically disadvantaged, and the medically fragile[10,11]; and

WHEREAS, climate change will meaningfully impact the future practice of Ohio's physicians and, therefore, should be included within the scope of medical education[12,13]; and

WHEREAS, the American Medical Association (AMA) recognizes that climate change impacts human health (H-135.938), supports educating the medical community about these effects (H-135.919), supports physician involvement in policy-making around this issue (H-135.923), encourages patient education on the topic, and supports physician involvement in public health and research efforts pertaining to climate change; and

WHEREAS, Our Ohio State Medical Association (OSMA0 has expressed support for the expansion of renewable energy at the state level (P09-2019); **therefore be it**

RESOLVED, That our OSMA recognizes climate change as a significant threat to Ohio's public health that will disproportionately hurt our children, elders, poor, minority, and medically fragile citizens the most; and, **be it further**

RESOLVED, That our OSMA adopts the following, which is partially adapted from AMA policy (H-135.938: Global Climate Change and Human Health).

1. That our OSMA encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health

2. That our OSMA encourages education of the broader Ohio medical community to the serious adverse health effects of climate change and local conditions of climate variation.

Fiscal Note: $ (Sponsor)
$ 1000 (Staff)

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RELEVANT OSMA POLICY

Policy 09 – 2019 – Impact of Climate Change on Human Health

1. That the Ohio State Medical Association supports efforts at the state level for expansion of renewable sources of energy.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 28 – 2022

Introduced by: OSMA Medical Student Section

Subject: Substance Use Disorder in Pregnant People

Referred to: Resolutions Committee No. # 2

- -

WHEREAS, Ohio had an estimated prevalence of Substance Use Disorder of 8.3% in citizens over 18 years old in the year 2016, including those with dependence on alcohol, opioids, cocaine, pain relievers, and marijuana[1]; and

WHEREAS, from the years 2006 to 2014, the total number of pregnant persons in Ohio who were diagnosed with substance use or substance dependence at the time of delivery increased by 110%[2]; and

WHEREAS, in the State of Ohio, policy dictates that Substance Use Disorder during pregnancy constitutes child abuse under civil law child-welfare statutes, and is grounds for termination of parental rights[3]; and

WHEREAS, in the Ohio State Supreme Court case *re Baby Boy Blackshear,* the Court ruled that a positive newborn drug test constitutes an abused child under the state's civil child abuse law, even though Section 2151.27 of the Revised Code makes no mention of prenatal drug use,[4,5]; and

WHEREAS, during the years 2009-2013, four women were prosecuted in Ohio for positive newborn toxicology screens secondary to Substance Use Disorder during pregnancy, under the felony charge of "corrupting another with drugs"[6,7]; and

WHEREAS, Section 2151.26 of the Title 21 Juvenile Court Chapter of the Ohio Revised Code details that a court complaint may be made against a pregnant person who enrolls in a Substance Use Disorder (SUD) program after 20 weeks of gestational age or who do not complete the program in its entirety, and also allows for complaints to be made against pregnant people who are not able to attend all the recommended prenatal care appointments[8,9]; and

WHEREAS, sections of Ohio Code that evaluate parental fitness must inherently rely on a premise that every mother in a region has equal access to prenatal healthcare or Medication-Assisted treatment programs, yet only 44% of zip codes in Ohio with an overdose death in the year 2017 have an Opioid Treatment Program located within 30-minute round trip[10]; and

WHEREAS, according to educational material from Ohio's Maternal Opioid Medical Supports (MOMS) program, the State has the right to use prenatal care truancy of a person with SUD as evidence in a Juvenile Court complaint, even if the incident was reported months before birth and a newborn toxicology screen is negative[11]; and

WHEREAS, there are no such specifications in the Ohio Revised Code for Juvenile Court complaints for prenatal care truancy in pregnant people who have other diseases with

unfavorable perinatal outcomes, such as Gestational Diabetes Mellitus and Prenatal Tobacco Use, or who are not experiencing SUD during pregnancy[12-14]; and

WHEREAS, Section 5119.17 of the Ohio Revised Code calls for describes programming that permits "continued monitoring of women who were addicted to a drug of abuse during their pregnancies, after the birth of their children," with such additional monitoring functioning as a contributor to disproportionately higher rates of criminal consequences among pregnant or recently pregnant persons with SUD[15]; and

WHEREAS, punitive and Reporting State Policies focus disproportionately on pregnant persons' use of illicit substances, with Paltrow et al finding that these approaches undermine maternal, fetal, and child health by deterring women from care, and these policies resulted in higher rates of Neonatal Abstinence Syndrome due to maternal fear of seeking prenatal care in any capacity[16-18]; and

WHEREAS, studies of pregnant substance-users report fear of losing custody of children and experiencing criminal justice consequences for their illicit substance use, and that women with SUD do not always see the supposed merciful distinction between prosecution for substance use in a Criminal Court, and losing custody of children in a Juvenile Court[19,20]; and

WHEREAS, in the Ohio State Supreme Court's 1992 decision the State of Ohio v. Gray, it was decided that "A parent may not be prosecuted for child endangerment… for substance abuse occurring before the birth of the child" under the decision that a mother did not have a duty of care or duty of protection to a fetus[21]; and

WHEREAS, removal of the child from parental custody in cases of SUD directly conflicts with the CDC recommendation of utilizing a family-centered approach to effectively address both the Adverse Childhood Event of the child and the Substance Use Disorder of the parent[22,23]; and

WHEREAS, an Ohioan experiencing SUD during pregnancy has become functionally synonymous with a parent being unfit to care for a child, in many situations where neglect has not proven, but rather assumed by public agencies or municipalities executing criminal charges[24]; and

WHEREAS, our Ohio State Medical Association (OSMA) "recognizes Substance Use Disorder as a medical condition, and recognizes that those suffering from this disease should be treated like any other patient with a serious illness and should thus have appropriate access to treatment"[25]; and

WHEREAS, the American Medical Association (AMA) "will oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse … oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation, and advocate for appropriate medical evaluation prior to the removal of a child"[26]; and

WHEREAS, Equating Substance Use Disorder with parental unfitness is incongruent with how other chronic illnesses are perceived and managed during pregnancy, reflecting a continued attitude of prenatal substance use and SUD as moral failures rather than medical conditions[27]; **therefore be it**

RESOLVED, Our OSMA oppose any efforts to assert that a diagnosis of Substance Use Disorder in a pregnant person alone constitutes child abuse or inherent parental unfitness; and, **be it further**

RESOLVED, Our OSMA support legislative actions to prioritize funding for the expansion of integrative mental health and substance use treatment programs explicitly for pregnant persons; and, **be it further**

RESOLVED, Our OSMA oppose the removal of a child based solely on a prenatal drug screen or positive newborn toxicology screening without a full safety evaluation of newborn care upon disposition.

Fiscal Note: $ (Sponsor)
$ 25,000 (Staff)

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RELEVANT OSMA, AMA and AMA-MSS POLICY

Policy 27 – 2021 – Recognition of Substance Use Disorder (SUD) as a Disease, Advocate for Expansion of Safe Treatment

1. The OSMA recognizes Substance Use Disorder as a medical condition, and recognizes that those suffering from this disease should be treated like any other patient with a serious illness and should thus have appropriate access to treatment.
2. The OSMA supports affordable and accessible evidence-based prevention and treatment of Substance Use Disorder.

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA:

(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability;

(2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible;

(3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children;

(4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Improving Mental Health Services for Pregnancy and Postpartum Mothers H-420.953

Our AMA:

(1) supports improvements in current mental health services for women during pregnancy and postpartum;

(2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum;

(3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and

(4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 29 – 2022

Introduced by: OSMA Medical Student Section

Subject: Supporting Housing Initiatives to Improve Health of Homeless Individuals

Referred to: Resolutions Committee No. # 2

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WHEREAS, approximately one third of the estimated 580,466 persons experiencing homelessness in 2020 were unsheltered according to reports from the United States Department of Housing and Development and the Urban Institute[1]; and

WHEREAS, the National Healthcare for the Homeless Council reports up to 46,500 persons experiencing homelessness die each year in the United States, and this number is climbing[2]; and

WHEREAS, life expectancy for people living on the streets is estimated to be twelve years shorter than the national average, and chronic diseases and disabilities are abundant and exacerbated by life on the street[2-3]; and

WHEREAS, the COVID-19 pandemic resulted in an increased rate of persons experiencing homelessness, increased criminalization of homelessness, and increased death rates amongst people experiencing homelessness[2,4,5]; and

WHEREAS, 1.4 million unsheltered people access emergency shelter or transitional housing each year, placing them in congregative settings which pose tremendous risk for the spread of communicable diseases like COVID-19, with the New York City Department of Emergency Services reporting that COVID-19 mortality rates are 49 percent higher for sheltered homeless individuals[6]; and

WHEREAS, lack of access to health care services, limited autopsies, and the absence of housing status on death certificates and hospital records leads to a severe undercount of COVID-related cases and deaths among unsheltered individuals[7-8]; and

WHEREAS, rent prices have risen dramatically in recent years with cities implementing rent control policies still placing undue burden upon lower income households; and

WHEREAS, communities criminalize homelessness and make it illegal for people to sit, sleep, or eat in public places, thus creating arrest records that further prevent unsheltered people from obtaining jobs or housing[10]; and

WHEREAS, a report from the American Hospital Association showed that those experiencing homelessness are five times more likely to be admitted as inpatients into a hospital with longer hospital stays and that investing in the care of these patients will reduce this cost burden[11]; and

WHEREAS, unsheltered individuals have health care costs on average five times higher than the national average, largely due to their overreliance on Emergency Rooms; the majority do not have health insurance or a primary care doctor, and up to 80% of these Emergency Room visits are for ailments that could have been addressed preventatively[12-15]; and

WHEREAS, as of January 2020, Ohio had an estimated 10,655 people experiencing homelessness on any given day[16]; and

WHEREAS, the number of people experiencing homelessness in Ohio has continued to rise, increasing by 30.8% between 2012 and 2018, despite only a 1.3% increase in Ohio's general population;[16] and

WHEREAS, the increase in homelessness reflects, in part, the lack of affordable and available housing in Ohio, with an estimated shortage of 256,875 affordable units in 2018;[16] and

WHEREAS, states have employed a variety of innovative policies to address homelessness, including Medicaid waivers that allow them to expand their Medicaid programs to fund housing-related interventions, appropriating local funds to mitigate deficiencies in affordable housing, making voucher holders a protected class under state fair housing laws, and creating state-level tax incentives for constructing affordable housing;[17-19] and

WHEREAS, many of these state housing initiatives increased access to healthcare for housed individuals and decreased state costs[19]; and

WHEREAS, access to stable housing improves health outcomes for homeless patients, including better management of chronic conditions, and decreases healthcare costs by reducing emergency department visits, hospitalizations, and duration of stay; and

WHEREAS, our Ohio State Medical Association (OSMA) has acknowledged housing insecurity as a predictor of health outcomes and supported appropriate care of the homeless and chronically mentally ill, but has yet to support state and local affordable housing initiatives; **therefore be it**

RESOLVED, that our OSMA support the development of state and local policies that adequately protect the health of low-income and homeless individuals by promoting and funding housing initiatives.

Fiscal Note: $ (Sponsor)
$ 1000 (Staff)

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Relevant OSMA Policy:

Policy 43 – 1984 – Financial Support - Homeless and Chronically Mentally Ill

1. The OSMA supports adequate and appropriate support for the care of chronically mentally ill.

Policy 32 – 2021 – Implementing Free and Routine Infectious Disease Testing at Homeless Shelters Across Ohio

1. The OSMA supports efforts for access to prevention, testing and treatment of infectious diseases to patients residing in homeless shelters.

Policy 21 – 2016 – Addressing Food and Housing Insecurity for Patients

1. The OSMA shall recognize food and housing insecurity as a predictor of health outcomes.
2. The OSMA shall encourage the use of housing and food insecurity screening tools by physicians and healthcare staff, similar to the depression screening tools, and assist physicians in identifying appropriate resources and avenues of referral.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 30 – 2022

Introduced by: Jessica Geddes MD, PGY-1 University of Cincinnati Internal Medicine Program

Subject: Encourage Hospitals to Create Patient-Centered and Evidence-Based Visitation Policies

Referred to: Resolutions Committee No. # 2

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WHEREAS, during the COVID-19 Pandemic, healthcare providers must prioritize both the health of individual patients and the health of the community1; and

WHEREAS, in order to balance the benefits to the individual patient with the duty to reduce infectious exposures to visitors, other patients, the community and the healthcare team, many hospitals have implemented new visitor restriction policies in response to the COVID-19 Pandemic1,2; and

WHEREAS, studies have shown positive impacts on patient well-being and healthcare delivery when visitors are permitted, and also demonstrate minimal impacts on performance and disruptions to workflow 3,4; and

WHEREAS, current visitation policies across the state Ohio vary widely, with differences related to screening practices, number of visitors allowed, visitation hours, and exceptions or lack thereof for emergency care, end of life care, ICU patients, pediatric patients, and labor & delivery patients5-10; **therefore be it**

RESOLVED, that our Ohio State Medical Association (OSMA) encourage Hospitals and other Healthcare Facilities within the state of Ohio to create clear and easily accessible visitation policies that are patient-centered and evidence-based; and, **be if further**

RESOLVED, that our OSMA encourage hospitals to allow visitors for children, persons with disabilities, end-of-life care, and labor and delivery units; and, **be it further**

RESOLVED, that our OSMA encourage collaboration between Hospitals and other Healthcare Facilities within the state of Ohio to create consistent policies.

Fiscal Note: $ 500 (Sponsor)
$ (Staff)

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7. Wexner Medical Center Visitor Policy. The Ohio State University Wexner Medical Center. Wexnermedical.osu.edu.
8. Visiting Guidelines. Cincinnati Children's. Cincinnati Childrens.org.
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RELEVANT AMA AND OSMA POLICY

1. none found

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 31 – 2022

Introduced by: Jessica Geddes MD, PGY-1 University of Cincinnati Internal Medicine Program

Subject: Support for the *Stop the Bleed* Campaign and Increased Availability of Bleeding Control Supplies

Referred to: Resolutions Committee No. # 2

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WHEREAS, active shooter and other mass casualty events are a growing public health concern, affecting communities throughout the nation1; and

WHEREAS, uncontrolled bleeding is the number one cause of preventable death from trauma; an estimated 20% of people of have died from traumatic injuries could have survived with quick bleeding control2,3; and

WHEREAS, one way to save lives is through educating both lay public and professional responders on proper bleeding control techniques1,2,3,4; and

WHEREAS, *Stop the Bleed* is a national awareness campaign created in 2015 through collaboration between several highly respected government and medical groups, including Homeland Security and the American College of Surgeons, with the goal of encouraging civilians to become trained, equipped and empowered to help in a bleeding emergency 4,5 ; and

WHEREAS, over 1.5 million people have taken a *Stop the Bleed* course nationwide, and the training has already saved lives6,7,8,9; and

WHEREAS, *Stop the Bleed* training events and other *Stop the Bleed* resources are currently available online and in-person throughout Ohio10; and

WHEREAS, effective bystander intervention in medical emergencies is crucial in the state of Ohio, where approximately 20% of the population lives in rural areas11, which experience higher wait times for EMS personnel12; and

WHEREAS, current American Medical Association (AMA) Policy H-130.935 Support for Hemorrhage Control Training encourages state medical societies to promote bleeding control training as well as the availability of bleeding supplies1 0; **therefore be it**

RESOLVED, that our Ohio State Medical Association (OSMA) promote the national public health educational campaign *Stop the Bleed* within the state of Ohio; and, **be if further**

RESOLVED, that our OSMA support the increased availability of hemorrhage control supplies (including pressure bandages, hemostatic dressings, tourniquets and gloves) in schools, places of employment, and public buildings.

Fiscal Note: $ 500 (Sponsor)

$ (Staff)

References

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13. Support for Hemorrhage Control Training H-130.935. American Medical Association.

RELEVANT AMA AND OSMA POLICY

Support for Hemorrhage Control Training H-130.935

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings