OSMA 2026 Annual Meeting – Resolution Committee Two: Online Testimony – Preliminary Report

Res. #	Comment By:	Representing	Position
23	Dr. Susan Hubbell	District 3	Support R4 Oppose R 5 & R6
Speaking for District 3, we support item 4 and oppose 5 and 6.			
23	Dr. Hassan Aboumerhi	Self	Support R4 Oppose R 5 & R6
Also support item 4 and oppose 5 and 6.			
23	Dr. Kenneth Christman	Self	Oppose
Speaking for myself, I oppose this resolution. It is well-established that minors often regret these life-changing decisions, sometimes attempting to reverse a dreadfully wrong decision. Such situations can have very detrimental psychological consequences that may be irreversible. These treatments should be withheld from minors. Period.			
23	Dr. Philip Roholt		→Comment to Dr. Christman←
Please clarify Support or Oppose. I believe from your comment that you support this resolution, including items 4 and 5 restricting the treatment of gender dysphoria with hormones or surgery, unless part of a research study.			
23	Dr. Johnathon Ross	Self	Support R4 – I am not sure about R5 & R6
I know that the Europeans have slowed down on this problem. I would need to see more of that data before supporting a trial.			
23	Dr. Philip Roholt	District 6	Support
Speaking for District 6, we support this Resolution in its entirety, including items 5 and 6. Those resolves are the essence of this resolution #23, and it should be OSMA policy to ensure the safety of minors, to not be subject to hormonal sex change administration. The Cass report clearly speaks against this, in terms of dangers in treating minors. Other countries also take a more cautious approach to sex-change treatments, and we should follow their lead. The recent back-tracking of the AMA upon realizing that ASPS plastic surgeons reject gender altering surgery is compelling. Now lawsuits against doctors and hospitals are appearing, concerning this ill-advised treatment for minors. Ohio physicians who would follow OSMA policies concerning transgender treatments put themselves, and potentially OSMA, at risk. OSMA policy 15-2020 "The OSMA supports individualized, gender-affirming, evidence-based treatment and clinical practices in caring for transgender and gender minority patients." https://www.nytimes.com/2026/02/03/health/gender-surgery-malpractice-varian.html. In addition, Ohio HB 68 prohibits administering sex-change hormones and surgery for minors.			
23	Dr. Alexis Hill	Self	Support
My sentiments align with Dr. Phil Roholt's/District 6, please see his comment.			
23	Dr. Susan Payson	Self	Support
On behalf of myself.			
23	Dr. John Corker	Self	Support/w AMENDMENT
John Corker, D2 Delegate, speaking on behalf of myself in support of adding item #4 to existing policy, and deleting proffered items #5 and #6 as vague and poorly defined. All of our patients deserve adequate mental health and emotional support, regardless of the details of their health journey. However, as currently written and defined in the state of Ohio by HB 68, limitations on "gender affirming care" for minors can include limitations on puberty blockers. My wife is a fellowship trained pediatric endocrinologist at the Cincinnati Children's Hospital - the #1 pediatric endocrinology department in the world. Puberty blockers are nearly exclusively prescribed to minors to treat precocious puberty, a well-researched and evidence-based indication for their use. These safe, effective and established treatments do not need additional IRB-approved research trials in order to continue their use. This is just one example of why it is so important not to legislate blanket bans or limitations on broad categories of medical treatments. The OSMA has strong, long-standing policy in support of both evidence-based care AND leaving decisions regarding this care to physicians and their patients. Items #5 and #6 - like HB 68 before them - represent dangerous and unwelcome government intrusion into our exam rooms.			
23	Dr. Lester H. Hill, II	Self	Support
Speaking for myself I believe there is no situation that any hormonal or surgical intervention be performed in any setting on any pediatric patient below the age of 18. There is no study that indicates nothing but irreparable harm and these trans patients become more aggressive and violent the older they get. That is well documented as is borne out by all of the headlines from school and mass shootings. Many of those individuals were transgendered!			

Res. #	Comment By:	Representing	Position
23	Dr. Maria Phillis	ACOG	Oppose
Speaking on behalf of ACOG in opposition to items 5 and 6, though not opposed to item 4. Item 4 speaks to ensuring adequate mental health support for minors which is both already standard of care and not objectionable. Items 5 and 6 both withdraw support of any treatment outside of a research trial which is not in line with current guidelines of care from organizations that are the standard bearers of this care such as WPATH. Additionally while the resolution is clearly focused on gender dysphoria, the phrasing of it limits any gender affirming care for minors - the majority of which has nothing to do with dysphoria and includes readily acceptable treatments for precocious puberty or other standard care that does not require additional data.			
23	Dr. Engy Habashy	Self	Support
Speaking on behalf of myself. As an infertility specialist, I agree that any permanent sterilization (such as elective orchiectomy) on a minor who is unable to have a full understanding of a future fertility preservation conversation or procedure should be undertaken within the strictest of boundaries and within IRB-approved research protocols/studies. Sterilizing minors can have a lasting/irreversible/costly downstream effects. It is my belief that one needs to be a consenting adult to agree to sterilization. This would also legally protect the physician in the event of a buyer's remorse situation.			
23	Dr. Andrew Hill	Self & District 6	Support
On behalf of myself and district 6. If we can recognize that many non-medical restrictions are rightfully placed on minors given their lack of physical, emotional, and mental maturity (such as alcohol, tobacco, driving license, etc.) then it stands to reason that they should not be able to make decisions that permanently alter their bodies and minds before they are fully matured.			
23	Carson Hartlage	Self	Oppose
Speaking on behalf of myself, I oppose this resolution in its entirety. No new credible scientific evidence has emerged since passing the original policy to justify this proposed change. The Cass Review has been strongly criticized by experts in gender-affirming care (e.g., Aaron & Konnoth in NEJM, DOI: 10.1056/NEJMp2413747). It is also unclear whether relevant subject-matter experts were involved in the development of the HHS report, which originates from an administration who's shown repeated attempts at harming the trans community. On the other hand, the American Academy of Pediatrics, the leading organization for U.S. pediatricians, continues to support evidence-based gender-affirming care for youth, without the constraints of clinical trials. Additionally, the proposed clause 4 is already covered in the original clause 1. Mental health care and emotional support are part of evidence-based gender affirming care as defined by standards put out by organizations such as the World Professional Association for Transgender Health (WPATH). Finally, I am troubled by the inclusion of citations from organizations identified by GLAAD and the Southern Poverty Law Center as anti-trans hate groups (e.g., Gays Against Grooming, American College of Pediatricians). Reliance on such sources undermines the principles of rigorous, evidence-based policymaking and is inconsistent with the standards of respectful and constructive discourse expected among OSMA members.			
23	Dr. Tani Malhotra	Self	Oppose
Speaking as an individual in opposition to this resolution. Although many have been ok with 4, supporting 4 suggests that this is not already the standard of care - which it is. Oppose the rest for several reasons previously stated. We cannot ask for both patient autonomy and to not interfere in the patient-physician relationship AND make recommendations about the management of gender dysphoria in someone's child. Those decisions belong to the parents. The treatment provided does not need to be in the setting of research because research has already been conducted and treatment is supported by the experts - WPATH.			
23	Dr. Joseph Hellmann	Self	Support
Speaking for myself. R5 & R6 and would be more precise by altering the language to indicate "trans minors" This issue is divisive but at the heart of the issue is the young children who are struggling with figuring out who they are. These youth are being influenced through endless voices across the internet and even by physicians who allege standard of care which we can see by the recent 2 million award that there are inherent biases and power issues embedded within the medical community when addressing these youth. Detransitioning is increasing in frequency and the stories of these people who have suffered at the hands of the medical institutions should be listened to. Laura Perry Smalts and Chloe Cole are two that I have heard and these bring insight into personal stories which should make us all reconsider prior positions. How often do long term studies prove our short term studies wrong? There is no harm in IRB studies and Dr. Corker's concern is addressed by adjusting the R5 & R6 language to indicate TRANS minors.			

Res. #	Comment By:	Representing	Position
23	Dr. Elizabeth McIntosh	Self	Support
I support the new (4) to provide mental health services, and (5) and (6) also, which I actually see as a compromise between the two extremes of permitting gender altering care in minors with minimal or no oversight, and completely opposing any such care on the other. Since Ohio and 26 other states have now passed laws completely banning gender altering care for minors, I see this resolution as trying to say that we don't have to completely ban it, but because of the increased complications and uncertainties of doing these treatments on minors, and the current paucity of data on long-term outcomes for these situations, we should make sure that any minors who do receive gender-altering care receive it in a closely monitored setting, such as an IRB-approved trial.			
23	Dr. Courtney Holbrook	RFS	Oppose
Speaking on behalf of the RFS in opposition of Resolution #23. Limiting access to gender affirming care for minors moves us further away from patient autonomy. The decision to seek gender affirming care should involve a patient, their parents, and their physician without political interference.			
23	Mallika Desai	MSS	Oppose
Opposing items 5 and 6 but not item 4, aligning with ACOG's comment. This resolution would place significant barriers between vulnerable patients and medically appropriate care. In practice, this means a teenager who has been evaluated over months by a multidisciplinary team, working with their family, and struggling with severe dysphoria could be told that the next step in their care is no longer available outside of a research trial. That is not policy change to protect children, it is a delay or denial of care. We already see what happens when access is restricted. Patients experience delays that prolong distress, families are forced to travel out of state for care, and some youth disengage from the healthcare system altogether. These are real downstream effects when care becomes inaccessible. This resolution also creates a standard that is not applied elsewhere in pediatrics. We do not require IRB-approved trials for treatments like antidepressants in adolescents, hormonal therapies for conditions like precocious puberty, or even major surgeries with lifelong implications. Instead, we rely on clinical guidelines, informed consent, and physician judgment. Physicians should be supported in providing individualized, evidence-based care, not constrained by policies that override clinical expertise. Opposing this resolution protects access, preserves physician judgment, and ensures that patients are not left without care when they need it most. Mallika Desai, on behalf of the OSMA-MSS.			
23	Dr. John C. Grecula	Self	Support
This resolution continues to respect the trans community while discouraging consequential treatment in minors that may be of uncertain benefit, I support this resolution.			
24	Dr. Susan Payson	Self	Oppose
OSMA should not advocate to violate existing law on this matter. I did a quick law review - I could not find state or federal law that exempts hospitals from law enforcement or ICE presence. Arrests by law enforcement can be with or without a warrant (if there is probable cause) and ICE can arrest with or without a warrant if they believe a person is removable/deportable and will escape before a warrant can be issued. Open to reading anything others may know about to help clarify. Thank you - I respect that this is a sensitive issue.			
24	Dr. David Mungo	Self	Oppose
We should've in the business of picking and choosing what laws should be enforced. We are a nation of laws. Period.			
24	Dr. Jeffrey Studebaker	Self	Oppose
I agree with Susan P. Our limited OSMAPAC funds can be better used elsewhere.			
24	Dr. Hassan Aboumerhi	Self	Support
Hospitals were "protected" areas until a DHS mandate in 1/2025. This has threatened not just the care of patients, but also the presence of healthcare professionals being detained or abducted based off profiling of their name or suspected language/ethnicity. They are now "sensitive" areas per DHS, which implies agents should generally avoid action, except under urgent circumstances, and judicial warrants (not probable cause) are required for private areas where patient care takes place. Urgent circumstances may vary based on the responsible ICE personnel. Unfortunately, this is no longer an issue of law, but one of racial profiling and due process (or lack thereof). This resolution supports the safety of patients and healthcare providers alike.			
24	Dr. Kenneth Christman	Self	Oppose
Speaking for myself, this resolution has nothing to do with medical care. OSMA should not be involved in divisive political questions.			

Res. #	Comment By:	Representing	Position
24	Dr. Stephen House	Self	Support w/AMENDMENT
Currently administrative warrants are legally used by ICE for enforcement for undocumented aliens instead of signed Judicial Warrants. If these illegal aliens needed only Signed Judicial Warrants the laws would need to be significantly changed. This may allow criminals convicted of civil crimes, the ability to avoid ICE and go free continuing to commit crimes without consequences. Therefore I have asked the reference committee to eliminate the last Resolve.			
24	Dr. Johnathon Ross	Self	Support
As representatives of the profession, we should ask ourselves if we want to uphold our Samaritan traditions. We dug Saddam Hussein out of his rat hole and our best Army doctors fixed him up just so we could hang him. I personally provided care to some of the best and the worst human beings as a PCP. If my human "patient" could "fog a mirror", I would do my best regardless of race or legal status. Many times I had to ask the officer at the side of the bed to un-cuff my patients on teaching rounds in my center city hospital. They all got the best of my abilities. Up until September of 2025, racial profiling in police work was not permitted. The case brought against ICE for using racial profiling in LA led to a federal court injunction which was then stayed on the Supreme Court's "emergency" docket. It is not an official law as this SCOTUS opinion on racial profiling by ICE has not been argued in open court or voted on by all the members. The LA injunction told ICE they could not use racial profiling based on prior Supreme Court decisions, including the Harvard admissions racial discrimination case. This from a discussion by legal experts on the LA ICE racial profiling case emergency stay in the Washington Monthly September 2025 issue. "Chief Justice Roberts writing for the majority (in the past officially decided cases) has said “the way to end racial discrimination is to stop discriminating by race.” And that quote captures this formalistic view of what it takes to create racial equality. We saw this resurface in Students for Fair Admissions v. Harvard as well. So the majority seems really wedded to that idea if race is being used to provide uplift, even in a relatively non-zero sum kind of situation... But now let’s say I’m standing at a street corner, wearing jeans and a work shirt. I have a lunch bag. So it looks like I’m not going to the Duquesne Club in Pittsburgh for my next business meeting. And I’m standing next to a brown-skinned, Spanish-speaking individual dressed identically with the same lunch bag. He could be stopped, but I would not be, and the only differentiation is race.....What happened to “the way to stop racial discrimination is to stop discriminating by race”? Suddenly, we don’t care because the people who are targeted are people whose interests we just don’t value. And the other thing to be said is that the Court is also not acknowledging how stigmatic this is. Now it’s kind of okay in the Court’s view, not just for ICE, but for anybody walking around to say, you know, it’s reasonable for me to suspect that the person walking across the street is actually an “illegal.” This is just an intolerably demeaning way of looking at one another that the Court is implicitly sanctioning....would like to have thought it was un-American." The September 2025 stay was written by Kavanaugh. Kavanaugh's appointment only passed in the Senate when Mike Pence broke the tie. During his appointment hearing he was clear about shielding presidents from legal liability for misdeeds in office. This is a position that potentially served Trump's interests, especially amidst his ongoing existing investigations and possibly future ones.			
24	Dr. Philip Roholt	Self	Oppose
Speaking for myself. I agree with Susan P. The defense of racial discrimination breaks down because of the invasion of illegal aliens allowed and promoted until 2024. ICE was not accused of profiling before this, and generally, with some exceptions, are following the law in their activities. They have the support of legal US citizens of all races. These are unusual circumstances, and ICE is protecting the interests of legal US citizens. Using hospitals for sanctuary and free medical care on the backs of dedicated physicians and taxpayers should not be allowed.			
24	Dr. Samantha Thomas	RFS	Support of R2
Samantha Thomas, speaking on behalf of the RFS in support of R2 in resolution 24 and for considering R2 in resolution 24 and all of resolution 25 together. This past year we have seen the impact ICE has had on our patient’s access to healthcare. Regardless of documentation status, people have the right to access healthcare and to do so without fear of incarceration. Furthermore, it is our duty as physicians to provide care to people who are in need of it. R2 in resolution 24 is important because if ICE agents show up to hospitals with administrative warrants and try to convince hospital staff to let them have access to patients, this is a violation of that patient’s due process rights along with that staff member being in violation of HIPPA. Hospital staff should not be giving law enforcement access to patients unless a warrant is signed by a judge as this would be breaking the law. Ensuring that the OSMA has policy on our books that protect physicians and patients is of paramount importance. Our profession would in fact be following the law, by supporting R2 in resolution 24. Furthermore, the OSMA should be vocal in opposing legislation such as Ohio House Bill 281 as state law cannot supersede federal laws such as the due process clause in the constitution along with HIPPA. Having a law like Bill 281 coded into statute would cause unnecessary confusion for hospital staff and patients and would directly affect patient care.			

Res. #	Comment By:	Representing	Position
24	Dr. Tani Malhotra	ACOG	Support
On behalf of ACOG in support of this resolution. The resolution does not speak to the legality of the work of ICE but rather to maintaining the sanctity of the healthcare environment. We start each meeting of OSMA with a recitation of the hippocratic oath. Nowhere in the oath do we swear to only care for people legally in the US. It is our responsibility, nay our oath, to care for all the sick and to work towards bettering their health and removing obstacles from their path in order for people to all obtain the human right that is healthcare. This resolution asks that OSMA support the sanctity of healthcare facilities as safe spaces so that patients may be able to seek healthcare without the fear of being arrested or detained or reported.			
24	Dr. Joseph Hellman	Self	Oppose
Speaking for myself. A nation is not a nation without laws. Law enforcement protects me every time I enter the homeless shelter, meal ministry, prisons. Why are they there? They are there to protect and serve the community because not every person we care for has sanctity for life be it your life, my life, their own life, etc. I can and will take care of the life of the person in front of me who needs it and I can know what the laws say and act appropriately. As a physician it is not my place to restrict law enforcement for if I do then I have become a criminal. Without respect for our law enforcement we devolve into a nation without law no matter how honorable or virtuous our intent. A further concern is what happens when all healthcare facilities become not only a sensitive place but a protected place. The word protected suggests a place where all persons who are fleeing from ICE can come to hide. This doesn't assist orderly treatment it creates more confusion and results in unnecessary, possibly faked, medical scenarios. Also 'healthcare facility' is a broad term that should be clarified since every doctor's office, therapy site, medical dispensary could be considered healthcare facilities. This is not a discrimination issue. It is a criminal issue. Entering a country illegally brings consequences. Reforming the migration system makes sense. Treating ALL people in emergent need makes sense. Having knowledge of immigration law makes sense but there are few of these and we cannot be trained to the extent they are. Obstructing any authority of law does not make sense and is a criminal act. All that said, I love all people and care for them all where they are be it an office, hospital, Sport environment, homeless shelter, meal ministry, prison, on the street, in Peru, in Guatemala, in Puerto Rico... Every place I go be it in America or another country I am expected to follow the laws and respect the authorities. This is a foundational principle worldwide and should be respected in America as well.			
24	Dr. Shannon Trotter	District 2	Oppose
On behalf of D2, oppose.			
24	Dr. Maria Phillis	YPS	Support
Speaking on behalf of YPS in support of the resolution. This is a response designed to ensure that people can access healthcare without fear and to prevent the disruption of health care delivery for all people.			
25	Dr. Kenneth Christman	Self	Oppose
This resolution has nothing to do with medical care, and speaking for myself, I oppose it. Let the politicians and courts sort this out. Keep physicians out of such divisiveness.			
25	Dr. Johnathon Ross	Self	Support
See my comments made about resolution 24. I support the Samaritan traditions of our profession. There is no room for discrimination or cruelty in our profession.			
25	Dr. Philip Roholt	Self	Oppose
Speaking for myself, same argument as #24. The US taxpayer is not obligated to provide medical care for illegal aliens who don't enter the country through the proper channels. Compassionate physicians who desire to provide these services can, and have, opened free clinics and performed mission trips. However they must be aware that if they are treating undocumented aliens, patients are subject to arrest and deportation, and the clinic harboring these people after treatment could be subject to legal action. If physicians would like to volunteer their services in a detention center, that is their prerogative but don't ask taxpayers to provide this!			
25	Dr. John Corker	District 2	Support
John Corker, D2 delegate, speaking on behalf of D2 in support of this resolution. This well-written, common sense policy allows for adequate medical care for all of our patients without interference from or interfering with lawful immigration enforcement.			
25	Dr. Tani Malhotra	ACOG	Support
On behalf of ACOG - in support. Please see comments from #24.			

Res. #	Comment By:	Representing	Position
25	Dr. Samantha Thomas	RFS	Support
Samantha Thomas, speaking on behalf of the RFS in support of resolution 25 and for considering R2 in resolution 24 and all of resolution 25 together. I would like to point to my comments under resolution 24 for the importance of R2 in resolution 24. Resolution 25 points to common sense principles that most of us as physicians have programmed into us. That is to ensure that people have access to healthcare. Regardless of documentation status, people deserve the right to healthcare.			
25	Dr. Joseph Hellmann	Self	Oppose
Speaking for myself. Strike R1 as per my argument in res 24 Strike R3 - Such policy leaves room to protect potential criminals by claiming medical treatment and interferes with the execution of our 'serve and protect' authorities that we would be overrun without. Support R2.			
25	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support in lieu of 24.			
25	Dr. Maria Phillis	YPS	Support
Speaking on behalf of the authors YPS in support of our resolution. This resolution was crafted narrowly and specifically to ensure access to healthcare not be disrupted or interfered with and to prevent the destabilization of the health care system by immigration enforcement actions that may interfere with persons receiving care.			
26	Dr. Susan Payson	Self	Support
Speaking on behalf of myself.			
26	Dr. Susan Hubbell	District 3	Support w/AMENDMENT
Speaking for District 3 we support this with amended language in the first resolved clause to say "referring physician".			
26	Dr. Mary LaPlante	Self	Support
Agree with rewording to reflect that a referral be acceptable from any referring physician.			
26	Dr. Kenneth Christman	Self	Support
Speaking for myself, I strongly support this resolution. Several years ago, this House of Delegates passed a resolution that called for legislative action to cause physician reimbursement for prior authorizations. There already exists an appropriate CPT code for this purpose and it is well known that insurers are costing physician practices huge amounts in administrative expenses that are not reimbursed. If action had been taken by OSMA on that resolution, prior authorizations would have dried up because of the cost being transferred to the insurers! However, since that was never accomplished, I suppose physicians will be suffering with these denials well into eternity.			
26	Dr. Johnathon Ross	Self	Support
We need to remove the insurance provider from our medical decisions once and for all.			
26	Dr. Elizabeth McIntosh	YPS	Support & AMENDMENT
On behalf of the YPS, we support this resolution. Consider also changing to "based solely on the referring physician OR PHYSICIAN's SPECIALTY." In primary care I've come across multiple instances where the prior auth is denied solely because I am not a specific specialist, regardless of my knowledge or comfort in prescribing a medication. For example, Hep C drugs were denied because I am not an to GI or ID specialists, or insulin pump supplies denied because I am not an endocrinologist. Sometimes patients can't get into these specialists in a timely manner or their specialist moves away, and it is ridiculous that the insurance does not allow the primary care physician to prescribe appropriate medications in those and other cases.			
26	Dr. John Corker	District 2	Support
John Corker, D2 Delegate, speaking on behalf of D2 in support of this resolution.			
26	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
27	Dr. Susan Payson	Self	Support
Speaking on behalf of myself.			
27	Dr. Susan Hubbell	District 3	Support
Speaking for District 3 in support of this resolution. When a patient changes insurance companies, physicians' offices frequently get messages that the tried and true medications that the patient has been taking are not covered by the new company. The physician is given no information as to why the medications are not covered and no list of substitute medications that are covered. The physician or staff then need to try to determine what medications are covered which wastes time and money. We feel that more of the burden should be placed on the insurance company in these situations.			

Res. #	Comment By:	Representing	Position
27	Dr. Norman Moser	Support	Support
Who gave the insurance the right to tell physicians what drug to use? Most of the time the people at the insurance company cannot even understand the mechanism of action of a drug. How can they make a decision like this? I feel that they are making medical decisions without a medical license. I am behind and support this resolution 200%. Even though a drug may be in the same therapeutic class, it may differ from a sister drug in its absorption rate or receptor affinity.			
27	Dr. Johnathon Ross	Self	Support
We need to remove the insurance provider once and for all from our medical decisions.			
27	Dr. Susan Hubbell	SPS	Support
Speaking for the Senior Physicians Section, we support this resolution.			
27	Dr. Chris Paprzycki	Self	Support
Speaking for myself, I support this resolution. The third resolve is reaffirmation, of both 20-2018 and 14-2019.			
27	Dr. Tani Malhotra	ACOG	Support
On behalf of ACOG in support.			
27	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
27	Dr. Maria Phillis	YPS	Support
Speaking on behalf of YPS in support of this resolution.			
28	Dr. Laurel Barr	Self & YPS	Support w/AMENDMENT
Speaking for myself and the Young Physician Section, we support this resolution as bad behavior by insurance companies frequently results in irreparable harm and insurance companies should be held accountable for these harms. However, we support the last resolve only with deletion of the last line. This line reads "This document should be included in every outpatient discharge/encounter summary." The last resolve shall then read "RESOLVED, that our OSMA create an official document that health care providers can download from the OSMA website that educates, describes and outlines the steps that patients can take to file a complaint with the Ohio Department of Insurance or how to contact the Ombudsman." We propose this change to decrease the regulatory burden on individual physicians.			
28	Dr. Norman Moser	Self & District 3	Support
Speaking for myself and district 3. Physicians are ultimately responsible for a patients care. We make medical decisions (with an appropriate license). Frequently our medical decision is circumvented by an insurance company who makes a medical decision to refuse our medical decision (without an appropriate license to practice medicine). If an insurance company makes a decision that has a poor outcome for the patient, THEY SHOULD BE HELD RESPONSIBLE FOR THEIR DECISION MAKING like physicians are.			
28	Dr. Kenneth Christman	Self	Support
Speaking for myself, I support this resolution. Unfortunately, however, my experience has been that the Ohio Dept. of Insurance does not advocate for either the patient or the physician.			
28	Dr. Norman Moser	Self	Support w/AMENDMENT
After presenting this resolution, I began interviewing various health care providers and patients about their experience with the Ohio Department of Insurance and the Insurance Ombudsman. Many did not even know of the existence of the department nor the ombudsman. That is why I suggested that the OSMA prepare a formal document to educate every HCP and patient of the existence of these entities. Some people commented that the Department of Insurance really does not do much (see above) testimony. However, we may have to edit the resolution such that the OSMA can address the department of insurance and the Ombudsman to "step up to the plate" and perform what their website states that they will perform. The Ohio Department of Insurance (ODI) Regulatory Ombudsman acts as a liaison to assist consumers whose insurance issues were not resolved satisfactorily through the standard consumer services division. At any rate, we as a group whose sole desire is to improve the quality of life and protect the life of the patient need to act to insure that we are able to perform our duties to the best of our abilities uninhibited by the insurance carriers. We have the knowledge and skills and medications to improve life (which will reduce overall health care costs), but are crippled by the insurance companies. Imagine how exhilarating it would be to be able to care for a patient using all of the tools that are available to us without being blocked by an insurance company. I would like to suggest that we leave the resolved statements as written and add a statement such as "Be it further resolved that OSMA work closely with the department of insurance and the insurance Ombudsman to insure that we are "doing the right thing" in caring for our patients.			

Res. #	Comment By:	Representing	Position
28	Dr. Charles Hickey	SPS	Support w/AMENDMENT
Speaking for the Senior Physicians Section we support deleting Resolves 1 and 3 as they exceed the scope of our OSMA's responsibilities and could place OSMA in an expensive fight with the insurance industry. We agree with the Young Physicians that the last sentence of Resolve 4 should be deleted to minimize physician administrative burden. We support the passage of Resolve 2 and Resolve 4 after the deletion of Resolve 4's final sentence.			
28	Dr. Johnathon Ross	Self	Support but...
As long as the insurers are in it for the money and not publicly accountable for their behavior the interference with appropriate medical care will continue. We need a unified, simple, affordable, publicly accountable insurance for all. Improved, expanded traditional Medicare for all comes closest to this goal in my opinion. As an A PCP I was never forced to deal with insurance bureaucrats interfering with my decisions that were in the best interest of my patients.			
28	Dr. Chris Paprzycki	Self	Overall in Support
Speaking for myself, I'm not sure a task force is the way to go here. How would you define/prove/demonstrate "harm" legally? Same standard as malpractice? Would this lower the bar for physician tort? Agree with second resolve, but only if injury occurs? Fourth resolve, we should also advocate that every insurance company should have to include this information with any denial letter.			
28	Dr. Engy Habashy	OMSS	Support w/AMENDMENT
On behalf of OMSS, we generally support. Recommend the removal of organizing a task force and including of a document in every discharge/encounter summary.			
28	Dr. Barbara Rogers	Self	Support w/Rewording
I agree that OSMA can have resources to assist physicians and patients find the appropriate resources and channels to mitigate harm from insurance company denials. This might be in the form of a pamphlet, or such that shows where to get assistance in each county.			
28	Dr. Shannon Trotter	District 2	Refer
On behalf of D2, refer.			
28	Dr. Maria Phillis	ACOG	Support
Speaking on behalf of ACOG in support of this resolution.			
29	Dr. Susan Hubbell	District 3 & OSPM&R	Support
Speaking on behalf of District 3 and the Ohio Society of PM&R in support of this resolution. For example, patients with lower limb amputations require prosthetic devices for normal ambulation. Those prostheses are not appropriate if the patient wants to participate in running, jumping, or other sports activities. If an athlete tears his/her anterior cruciate ligament, the insurance company will cover physician visits, orthopedic surgery, and post op physical therapy so the athlete can return to sports activities. The cost of that can be more than $50,000. to $100,000. It is not fair that that expense is covered but an adaptive prosthesis or orthosis which is significantly less costly is not covered. There is excellent data discussing the improvement in function and life span for patients with a disability who are able to exercise. A sports prosthesis is a covered item for Medicare and should be covered by all insurances.			
29	Dr. Norman Moser	Self & District 3	Support
Speaking for myself and district 3. If an insurance company makes the clinical decision to not pay for a specialty prosthetic, it will significantly decrease the patient's quality of life. I support this resolution.			

Res. #	Comment By:	Representing	Position
29	Dr. Zeeshan Tayeb	Self & District 1	Support
I am in support of this resolution, I speak for myself and district 1. For many patients living with limb loss, a prosthetic device is not merely a medical aid—it is the key to restoring independence, mobility, and long-term health. Yet for individuals who wish to remain active through athletics, the prosthetic devices necessary for sport participation are often classified by insurers as optional or recreational, and therefore excluded from coverage. This distinction overlooks the profound medical benefits of physical activity. Participation in sports promotes cardiovascular health, reduces obesity and diabetes risk, strengthens mental health, and improves overall quality of life. For amputees, adaptive athletics also plays a crucial role in rehabilitation, social reintegration, and long-term physical conditioning. Sports prosthetics are not luxury devices. They are specialized medical equipment designed to allow patients to safely engage in the same health-promoting activities recommended to all individuals. When private insurers deny coverage, these devices become financially inaccessible to many patients, limiting opportunities for recovery and wellness. This creates inequities in care and prevents physicians from fully supporting the health goals of their patients. As physicians and advocates for patient health, we should support policies that encourage insurers to recognize sports prosthetics as medically beneficial devices that facilitate physical activity and rehabilitation. Ensuring reasonable coverage will expand access, improve health outcomes, and affirm our commitment to patient-centered care.			
29	Dr. Johnathon Ross	Self	Support
Prosthetics that allow people to participate in normal human activities should be supported.			
29	Dr. Maria Phillis	YPS	Support
Speaking on behalf of YPS we support this resolution.			
30	Dr. Susan Hubbell	Self	Support
Speaking for myself, I support this resolution. The WISeR program was implemented with very little input from states and specialty societies. It started in Ohio in January. There needs to be oversight and review of the effects of the program with adjustments as needed to make sure that the program is not detrimental to patient safety and care.			
30	Dr. Susan Hubbell	District 3	Support
Speaking for District 3, we support this resolution as written.			
30	Dr. Kenneth Christman	Self	Oppose
Speaking for myself. Do we really need yet another prior authorization model? Do we really want to trust AI? Even if this "model" is useful so far (which I doubt), do we know what it might morph into?			
30	Dr. Susan Hubbell	SPS	Support
Speaking for the Senior Physician Section in support of this resolution. We definitely need to monitor this program which changes Medicare. The procedures requiring prior authorization or pre-payment review for Medicare patient are: 1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9) 2. Induced Lesions of Nerve Tracts (NCD 160.1) 3. Vagus Nerve Stimulation (NCD 160.18) 4. Phrenic Nerve Stimulators (NCD 160.19) 5. Electrical Nerve Stimulators (NCD 160.7) 6. Incontinence Control Devices (NCD 230.10) 7. Sacral Nerve Stimulators for Urinary Incontinence (NCD 230.18) 8. Diagnosis and Treatment of Impotence (NCD 230.4) 9. Percutaneous Vertebral Augmentation for Vertebral Compression Fracture (L34228, L38201, L35130) 10. Epidural Steroid Injections for Pain Management (L39015, L39240, L36920) 11. Cervical Fusion (L39741, L39758, L39793) 12. Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (L38307, L38310, L38385) 13. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041) and Wound Application of Cellular and/or Tissue Based Products (CTPs), Lower Extremities (L36690) NOTE: Two other procedures that were on the list were postponed due to lobbying by AMA and neurosurgery.			
30	Dr. Johnathon Ross	Self	Support
What evidence is there that preauthorization improves care and saves enough money to be worth the time and bother that we as clinicians face? Not much. See this KFF article. https://www.kff.org/from-drew-altman/are-the-tradeoffs-from-prior-authorization-worth-it/			
30	Dr. Elana Sitnik	RFS	Support
Elana Sitnik writing on behalf of the RFS in support of this timely resolution. Given the WISeR prior authorization model is currently being implemented in Ohio and federal legislation and has been introduced to prohibit the implementation of the WISeR model under the Medicare program, we agree that close monitoring and input from physician groups is necessary and needs to be a priority for the OSMA.			
30	Dr. John Corker	District 2	Support
John Corker, D2 Delegate, speaking on behalf of D2 in support of this resolution.			

Res. #	Comment By:	Representing	Position
30	Daniel Leonard	MSS	Support
Daniel Leonard commenting on behalf of the OSMA-MSS in support of this resolution. Careful oversight of the WISeR model is essential to protect timely access to medically necessary care. Expanding prior authorization, especially with the use of AI, risks increasing delays, denial, and administrative burden, all of which can negatively impact patient outcomes and physician capacity to deliver care. Monitoring its implementation will help ensure that cost-containment efforts do not come at the expense of clinical judgment, transparency, and patient safety, and will allow for adjustments if harmful effects on care access or quality are identified.			
30	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
31	Dr. Susan Payson	Self	Support
Speaking on behalf of myself.			
31	Dr. Susan Hubbell	Self	Support w/AMENDMENT
Speaking for myself, I support the concept of this resolution. However I feel that the first resolved clause needs to be amended so that the policy is written out. It should read something like "Our OSMA supports that "physicians should be referred to as physicians" " rather than saying we support an ACS policy.			
31	Dr. Jeffrey Studebaker	Self	
I agree with Susan H. *(In response to comment above ↑.)*			
31	Dr. Susan Hubbell	District 3	Support w/AMENDMENT
Speaking for District 3, we support the first resolved clause with amended language that states that "physicians should be referred to as physicians". We do not support the other resolved clauses.			
31	Dr. Laurel Barr	Self & YPS	Support w/AMENDMENT
Speaking for myself and the Young Physician Section, we support the intent of this resolution as we oppose any effort to confuse patients regarding the qualifications of those who care for them or to blur the distinction between physicians and other members of the health care team. However, we oppose the last resolve who reads "RESOLVED, that OSMA monitor implementation and report annually to the House of Delegates." as we feel this duty to report would cause undo burden to the OSMA and is less meaningful without annual reports from other regions.			
31	Dr. Johnathon Ross	Self	Support
Support and agree with this amendment. *(Dr. Barr/YPS amendment)*			
31	Dr. Stephen House	SPS	Support w/AMENDMENT
Speaking for SPS, we agree with comments from Susan H. 3/8 3/11 and Laurel B. comments from 3/11			
31	Dr. Chris Paprzycki	Self	Support w/AMENDMENT
Speaking for myself, I support the intent and concept of this resolution. I would request that the resolution committee extensively clean this language up though. First resolve does not specify what ACP policy they're referring to. Second resolve: is this an issue internally? I think OSMA staff does a great job at using our accurate titles. Third resolve: terminology of what? PHYSICIANS AND HEALTH CARE PROFESSIONALS. Fourth resolve: role titles of whom? PHYSICIANS AND HEALTH CARE PROFESSIONALS. Fifth resolve: oppose in current form, as too vague. Also not sure it's relevant to the topic of titles. Sixth resolve: oppose as unnecessary use of limited staff resources.			
31	Dr. Engy Habashy	OMSS	Support w/AMENDMENT
On behalf of OMSS, we recommend amending the first resolve to omit the support for the ACP policy as policies of other organizations may change. We recommend rephrasing that OSMA supports referring to physicians as such and not as providers. This would promote a culture of safety and transparency.			
31	Dr. Barbara Rogers	Self	Support w/Rewording
Physicians should be called physicians and not "providers". Each type of care team member and employee should have name tags that accurately say who they are and their role in the hospital or health care area. Nurses are called nurses, medical assistants are called medical assistants, etc. The term "provider" only increases patient confusion and lets healthcare systems mask their under staffing issues.			
31	Dr. Shannon Trotter	District 2	Refer
On behalf of D2, refer.			
32	Dr. Susan Hubbell	District 2	Support Resolve 2
Speaking for District 3, we support Resolved clause 2 and oppose Resolved clauses 1 and 3.			

Res. #	Comment By:	Representing	Position
32	Dr. Johnathon Ross	Self	Support
I was a primary care internist in a center city clinic for 40 years. After many years of asking for better psych and social work support, the health system decided to add a psychologist to our team of teaching PCPs. Being able to do a warm handoff of a distressed patient to a psychologist and to discuss the appropriate follow up and meds if needed was a blessing to me as much as to the patient. Where possible, adding a psych component to our PCP practices is very helpful for all concerned. I recognize that many smaller practices would not have the means to do so.			
32	Dr. Poojajeet Kaur Khaira	Self	Support
I am strongly supportive of Resolution #32 and am deeply passionate about expanding Ohio Medicaid reimbursement for the Collaborative Care Model (CoCM). As a psychiatry resident at a safety-net hospital who will soon be an attending in July, I see firsthand how the lack of Medicaid reimbursement for CoCM disproportionately impacts our most underserved patients. These are individuals who already face significant barriers to accessing mental health care, and without sustainable reimbursement, it becomes extremely difficult for health systems to implement and maintain integrated behavioral health services that are proven to improve outcomes. This gap also places a significant burden on our primary care physicians, who are often the first—and sometimes only—point of contact for patients with mental health conditions. Without the infrastructure and support that Collaborative Care provides, PCPs are left to manage increasingly complex psychiatric conditions without adequate resources, time, or specialist support. This contributes to burnout and limits their ability to provide comprehensive, high-quality care to their patients. This is not an issue isolated to one institution. In speaking with colleagues across multiple health systems in Ohio—including University Hospitals, Cleveland Clinic, OhioHealth, and the University of Cincinnati—I have heard consistent concerns about the challenges of sustaining Collaborative Care programs due to the absence of Medicaid reimbursement. As a result, this gap is directly affecting our ability to deliver timely, evidence-based mental health care to patients who need it most. I had the opportunity to attend the OSMA Primary Care and Mental Health Advocacy Committee meeting, where I raised this issue and received strong encouragement to submit a resolution. Despite the short timeline—just two days before the submission deadline—I felt it was critical to bring this forward given its direct impact on patient care across the state. Expanding Medicaid reimbursement for CoCM is a practical, evidence-based solution that not only improves access to mental health care for vulnerable populations, but also meaningfully supports primary care physicians in delivering high-quality, integrated care. I strongly urge support for this resolution.			
32	Dr. Shannon Trotter	District 2	Support w/AMENDMENT
On behalf of D2, support with Amend R2 "and payment of."			
32	Dr. Maria Phillis	YPS & ACOG	Support
Speaking on behalf of YPS and ACOG in support of this resolution.			
33	Dr. Jeffrey Studebaker	Self	Support
No further comment.			
33	Dr. Johnathon Ross	Self	Support but...
This is another area of complexity in the midst of the most complex and administratively burdensome sickness care non system on earth. The solution would be global budgets for facilities that would include the needed resources to allow physicians to be appropriately paid for the services they provide whether in their offices or in a facility. We need simplicity. Simplicity will save enough to improve affordability.			
33	Dr. John Corker	District 2	Support
John Corker, Author and D2 Delegate, speaking on behalf of D2 in support of this resolution. Enough is Enough. Independent physician practices are suffocating under overwhelming administrative burden and unceasing cuts to our reimbursement. Physician payment represents less than 9% of overall health care costs, yet remains the only sector of health care whose government reimbursement is not tied to the MEI. This long-standing discrimination does nothing to meaningfully reduce health care costs or government spending. It only services to further disenfranchise physicians and our patients - leading to further health care consolidation, increasing costs and poorer health outcomes for all.			
33	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
34	Dr. Susan Hubbell	District 3	Oppose
Speaking for District 3, we oppose this resolution as it is not the purview of OSMA.			

Res. #	Comment By:	Representing	Position
34	Dr. Jeffrey Studebaker	Self	Oppose
Speaking for myself, at most, I might support the third resolve as a standalone resolution. Overall, I agree with Susan H. that this is beyond OSMA's purview.			
34	Dr. Kenneth Christman	Self	Oppose
Speaking for myself, this is NOT a medical care issue and NOT an OSMA issue			
34	Dr. Johnathon Ross	Self	Oppose as Written
The list of problems with healthcare in Ohio is real. I doubt that changing the Ohio Treasurer's choices of investments will improve our sickness care non system. There are other equally inappropriate use of state funds out there like the use of unclaimed funds to build stadiums for billionaire team owners. A significant portion of the unclaimed funds are owed to public, tax supported entities like cities, towns, counties, libraries, etc. I would not doubt that there is insider dealings going on in the office of the Treasurer. Is the Public Health system that that improves the social determinants of health an important piece of an effective health care system? Absolutely. Should OSMA support better funding of evidence base public heath interventions to improve the overall health of Ohioans? Absolutely. Rewrite this resolution to focus on the cuts to Public Health efforts in Ohio and I believe it would get OSMA support.			
34	Dr. Brandon Francis	RFS	Oppose
Speaking on behalf of the RFS in opposition to this resolution. While the RFS supports improved funding of the state's public health infrastructure, we believe that the way the resolution is currently written remains outside the scope of the OSMA.			
34	Daniel Leonard	MSS	Support
Daniel Leonard commenting on behalf of authorship and the OSMA-MSS in support of this resolution. State investments that lock public funds in high-risk or illiquid foreign bonds limit the state's fiscal flexibility during periods of public health urgency or economic uncertainty. This directly affects the state's ability to fund prevention programs, treatment access, and other essential public health services. Opposing these investments is, therefore, within OSMA's scope, as it falls in line with OSMA's mission to advocate for policies that protect and improve the health of Ohioans. Compared to illiquid financial investments that are completely locked until maturity, public health funding produces measurable benefits through improved population health and decreased emergency care utilization. Ensuring that resources are allocated to maximize health outcomes aligns directly with OSMA's mandate. Supporting this resolution helps ensure that state funds are used to improve population health, equity, and overall well-being statewide.			
34	Dr. Shannon Trotter	District 2	Oppose R1 & R2 Support R3
On behalf of D2, oppose R1/R2, ok with R3.			
34	Dr. Maria Phillis	ACOG	Oppose
Speaking on behalf of ACOG in opposition to this resolution as outside the scope of OSMA.			
35	Dr. Susan Hubbell	District 3	Support
Speaking for District 3, we support this resolution.			
35	Dr. Laurel Barr	Self & YPS	Support
Speaking for myself and the Young Physician Section, we strongly support this resolution. No doctor went to medical school expecting to go to jail for caring for and advocating for their patients and for evidence based medicine. The threat of criminal charges for physicians who practice standard care and evidence based medicine is chilling and results in patient harm. We strongly oppose criminal charges for physicians for doing their jobs and strongly support this resolution.			
35	Dr. Hassan Aboumerhi	Self	Support
Support! *(In response to Dr. Barr/YPS comment)*			
35	Dr. Johnathon Ross	Self	Support
Physicians should be able to advocate for public's health even when it conflicts with their employers or other affiliated institutional interests.			
35	Dr. Tani Malhotra	ACOG	Support
On behalf of ACOG in support.			
35	Dr. Samantha Thomas	RFS	Oppose w/RECOMMENDATION TO REAFFIRM EXISTING POLICY
Samantha Thomas, speaking on behalf of the RFS in opposition to resolution 35. While we agree with the spirit of this resolution, there is already existing policy that covers this issue (Policy 18 - 2012 Criminalization of Medical Care) which was amended to read as, "The OSMA opposes any portion of proposed legislation or rule that criminalizes clinical practice that is the standard of care." Therefore, we recommend reaffirmation of this existing policy.			

Res. #	Comment By:	Representing	Position
35	Dr. Shannon Trotter	District 2	Refer
On behalf of D2, refer. Concerns with employer and you cannot misrepresent your organization.			
35	Mallika Desai	MSS	Support
We support this resolution. This resolution protects a core part of what it means to be a physician. Advocacy for medically appropriate care is not optional, it is part of our ethical duty. Without clear legal protections, physicians are placed in a position where doing the right thing for patients can carry professional risk. Beyond individual cases, this has broader implications for the physician workforce and training environment. When advocacy is discouraged or penalized, it shapes a culture where trainees and early-career physicians learn to stay silent rather than speak up for patients. Over time, this erodes clinical autonomy and weakens the physician's role as a patient advocate. Establishing explicit protections helps preserve that role. It signals that clinical judgment should not be overridden by non-clinical pressures and supports a healthcare system where physicians can act in the best interests of their patients without hesitation. Mallika Desai, on behalf of the OSMA-MSS.			
36	Ellena Privitera	Self	Support
Speaking on behalf of myself as a supporting author of the resolution that was previously submitted and now being amended by YPS. I strongly support the edits and additions offered.			
36	Dr. David Mungo	Self	Oppose
OSMA has better things to do than get involved in a political statement. Ohioans have FIVE weeks to vote before an election. Asking for an ID is not an impediment to anything else except cheating at voting. ID required for everything else in society and isn't an issue….			
36	Dr. Susan Hubbell	District 3	Oppose
Speaking for District 3, we oppose this resolution. Current policy is sufficient.			
36	Dr. Kenneth Christman	Self	Oppose
Speaking for myself, OSMA is a medical organization, and not a political one. While we encourage voting, its methods are best devised by others.			
36	Dr. Johnathon Ross	Self	Support
Are we a medical organization that supports our patients? If we are we should support their right to vote. We depend on our patients to vote for representatives who want support their constituents who are our patients. The wise regulation of insurance and medical practice depends on the wisdom of the representatives they support with their votes. We should encourage not suppress voting. Many of our older and disabled patients vote by mail or by sending their votes with relatives to drop boxes. Making it hard to vote is functionally a poll tax. This is an issue that affects the practice of medicine. After all, we actively lobby the legislature on issue that affect insurance and the practice of medicine. It is not true that we are not a political organization. We spend substantial dollars on lobbying our representatives to support legislation that supports the practice of medicine and our patients (i.e. the voters).			
36	Dr. Philip Roholt	Self	Oppose
Reasons for opposition already cited.			
36	Dr. Jessica Geddes Shea	Self & YPS	Support
I support this resolution on behalf of the Young Physicians Section and myself. We cannot separate medicine/health from social determinants of health such as voting. One of OSMA's stated values is access to high-quality, affordable health care, which is determined/regulated by the elected officials. The AMA has strong policy on this topic as cited, the OSMA should as well. For those that feel OSMA should not have policy related to voting methods but agree with encouraging voting and acknowledging it as a SDoH, please consider editorial changes/amendments rather than total opposition to this resolution.			
36	Dr. John Corker	Self	Support w/AMENDMENT
John Corker, D2 Delegate, speaking on behalf of myself in support of adding Item #1 to existing policy and deleting all other additions/changes recommended in this resolution. My bias and COI is that I am an author of existing policy 14 - 2024. Exercising our right and responsibility as citizens to vote is absolutely a social determinant of health, and the impact of voting on both individual and societal health is fundamental and far-reaching. However, while I support the important addition of item #1 to existing policy, it is my personal belief that the remainder of these recommended additions and changes stray too far from our medical expertise - potentially infringing on the expertise of our board of elections, and risking the credibility and standing of our OSMA at important decision-making tables across our state.			

Res. #	Comment By:	Representing	Position
36	Dr. Tani Malhotra	ACOG	Support
On behalf of ACOG in support. The AMA has previously endorsed that voting access is a social determinant of health. ACOG has run multiple campaigns to help get patients registered to vote. This is a non-partisan issue that support Americans in their constitutional rights.			
36	Dr. Joseph Hellman	Self	Oppose
Speaking for myself. Current policy is sufficient. I have yet to run across one someone at the homeless shelter, meal ministry, in my local hospitals, in any of my offices, in prison, or on the street who shared the stress of voting access with me.			
37	Dr. Susan Hubbell	District 3	Support w/AMENDMENT
Speaking for District 3, we support with amendment to Resolved clause 3 so that it reads: RESOLVED, that the OSMA supports THE CONCEPT that seeking mental health care, by itself, is not a basis for adverse action regarding hospital credentialing, provided the physician is able to practice medicine safely.			
37	Dr. Johnathon Ross	Self	Support
I was on the state medical board a couple decades ago and this issue of physician impairment whether by substance abuse or by mental health issues was carefully considered. We should support this policy as much as it aligns with state medical board policy.			
37	Dr. Chris Paprzycki	Self	Support
Speaking for myself, I support this resolution as originally written.			
37	Dr. Engy Habashy	OMSS	Support
On behalf of OMSS, in support.			
37	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
37	Dr. Maria Phillis	YPS & ACOG	Support
Speaking on behalf of YPS and ACOG in support of this resolution.			
38	Dr. Johnathon Ross	Self	Support
WE should seek to maximize the federal money that comes to Ohio for healthcare including mental health. The new federal budget has significant cuts in support for Medicare and Medicaid in it. These will trickle down to our patients and increase medical debt and the uninsured will increase. As higher income citizens, physicians will get thousands of dollars in tax cuts while the bottom half will get at most a few hundred according to Policy Matters Ohio reports. The inability of low income people to pay their medical bills will increase bankruptcies and ultimately fewer will be able to pay us. Physicians as providers of publicly funded health services will help to pay for millionaires tax breaks in the 10's of thousands of dollars.			
38	Mallika Desai	MSS	Support
This resolution addresses a gap we see in real time. The IMD exclusion is outdated and limits access to necessary inpatient psychiatric care, pushing patients into emergency departments and other settings that are not designed to treat serious mental illness. Section 1115 waivers are a practical and very reasonable way to expand access now. Evidence from Ohio and other states shows reduced emergency department utilization when broader mental health services are covered. Supporting this aligns policy with how care is actually delivered, improves patient outcomes, and reduces strain on already overburdened systems.			
38	Dr. Glen McClain	RFS	Support
Speaking on behalf of the RFS in support of Resolution #38. States are considered "laboratories of democracy", and Section 1115 waivers are a prime example of such legislative experimentation. In brief, they allow states more flexibility in the spending of Medicaid dollars, provided the policy is budget neutral, i.e. that the state recoups the associated costs in downstream savings. 17 states currently have Section 1115 waivers approved for mental health services, and Ohio would be leading by example if it were to pursue such a waiver.			
38	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
39	Dr. Johnathon Ross	Self	Support
I know that there was an effort to get PCPs to screen for depression with simple questions (PH-9). This is already recommended as part of routine pre and post-natal care by ACOG. Maybe OSMA should just be adopting ACOG policy?			

Res. #	Comment By:	Representing	Position
39	Maya Dunson	MSS	Support
Commenting on behalf of authorship and the OSMA-MSS in support of this resolution. There is no current policy on perinatal and postpartum mental health access in screening within the OSMA, and there is also no policy that promotes access to expanded treatment for those who screen positive. Perinatal and postpartum screening and treatment has become an increasingly prevalent issue that has been supported by ACOG and other organizations, so we feel that it is important to bring awareness on this issue and add to policy for the OSMA.			
39	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
39	Dr. Maria Phillis	ACOG	Support
Speaking on behalf of ACOG in support of R2, and support of the overall concept of this resolution as the importance of perinatal mental health in saving and improving lives cannot be overlooked. We would emphasize that the most significant barriers to access to care are a lack of clinicians that offer mental health services in a timely manner such that increasing screening can only impact outcomes so much where there is a bottleneck. Improving recruitment, retention, training pathways and opportunities for growth of the clinical base of mental health services is crucial to improving outcomes and would suggest some modifications to R3 may serve to reflect those priorities.			
40	Dr. Susan Hubbell	District 3	Support
Speaking for District 3, we support this amendment to current policy.			
40	Dr. Mary LaPlante	Self	Support
Appropriate addition for current social media use.			
40	Dr. Johnathon Ross	Self	Support
Agree with other comments and support.			
40	Dr. Elana Sitnik	RFS	Support
Elana Sitnik writing on behalf of the RFS in support of this resolution. The suggested amendment modernizes and improves the existing OSMA policy.			
40	Maya Dunson	MSS	Support
Commenting on behalf of authorship and the OSMA-MSS in support of this resolution. Given the current day and age of social media and online use, the prevalence of sexual exploitation and related harassment has been on the rise, which has led to increased issues of safety and possible violence towards adolescents. This is why we feel that it is important to add this amendment to current policy, as it is now more needed to have education on digital safety to raise awareness to the adolescent population and have them prepare for possible sexual exploitation situations so that they can respond accordingly.			
40	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
40	Dr. Maria Phillis	YPS & ACOG	Support
Speaking on behalf of YPS and ACOG in support of this resolution.			
41	Dr. Johnathon Ross	Self	Support
I am on the local board of health and we have been doing billboards on STD's. Unfortunately the recent federal budget cuts have hit support for our women's health and STD clinic to the tune of $200,000 and we might need to do layoffs and reduce services. This is the last thing we should do when the incidence of STDs is increasing in Ohio. Key Findings on Ohio STI Trends: Syphilis Surge: Syphilis has been the fastest-growing STI, with cases in some Ohio regions increasing by over 200% between 2017 and 2021. Ohio Capital Journal Regional Concerns: Toledo and areas in Northeast Ohio (including Stark and Cuyahoga counties) are reporting high infection rates, with syphilis cases in Stark County rising significantly by late 2024. YouTube Congenital Syphilis: Ohio has seen a severe rise in congenital syphilis (passed from mother to baby), which increased by nearly 200% between 2017 and 2021. Centers for Disease Control and Prevention | CDC (.gov) Demographics: The rise in syphilis disproportionately affects men who have sex with men, but cases are spreading across all demographics. YouTube College Campus Spikes: Urgent care centers on Ohio college campuses have reported a 35% to 75% increase in STIs between 2023 and 2024, with gonorrhea and chlamydia being the most common. Cleveland 19 News			
41	Dr. John Corker	District 2	Support
John Corker, D2 delegate, speaking on behalf of D2 in support of this resolution.			
41	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			

Res. #	Comment By:	Representing	Position
41	Dr. Maria Phillis	YPS	Support
Speaking on behalf of YPS in support of this resolution.			
42	Dr. Susan Hubbell	District 3	Support
Speaking for District 3 we support this resolution.			
42	Dr. Johnathon Ross	Self	Support
See my comments on STD's from resolution 41. The same clinics that do STD's also do our HIV screenings and funding is being cut due to the federal funding cuts.			
42	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
42	Dr. Maria Phillis	ACOG	Support
Speaking on behalf of ACOG in support of this resolution.			
43	Dr. Susan Payson	Self	Support w/AMENDMENT
Commenting as myself. I support street/mobile unit medicine for people on the street including the homeless. There is significant need for this, and for mobile dental units. I see first-hand the need and the barriers to care in my volunteer work doing street outreach (non-medical/non-health care related) to sex trafficked women/at risk women. Often, we are also approached by vulnerable men on the street, who would benefit from mobile medical and dental care. Poor dental care has suggested links to systemic disease, making it in the scope of OSMA to recommend. Severe visible dental deterioration can be a barrier to accessing a job as well, which traps the person in poverty. Requested correction of one word on line 43: pregnant ' females' in place of pregnant 'people'.			
43	Dr. Susan Hubbell	District 3	Support w/Title Change
Speaking for District 3 we support the Resolved clauses but feel that the title should be changed by eliminating "homelessness" and changing it to "promoting public health through mobile health clinics". In our area, mobile health clinics go to rural communities which do not have a physician.			
43	Dr. Johnathon Ross	Self	Support
Agree with the other comments. Primary care especially needs support to reach these hard to reach populations. This needs to be a public/private cooperative effort and the funding needs to be there to do it. Cuts to Medicaid and to FQHCs are upon us due to the federal budget cuts and we need to think creatively. (See our resolution 17).			
43	Dr. Alexis Wybrecht	RFS	Support
Alexis Wybrecht writing on behalf of the RFS in support of resolution 43. The RFS supports the development of mobile preventative care clinics working in partnership with health care systems for aiding access to immunizations, disease screening, chronic disease monitoring, and health education.			
43	Dr. John Corker	District 2	Support
John Corker, D2 delegate, speaking on behalf of D2 in support of this resolution.			
43	Dr. Joseph Hellman	Self	Support & Supports Title Change
Agree with Susan H. regarding title change. Embedded within my homeless shelter, clothing and meal ministry is Lifecare which is already providing these services successfully being one city block from the sarta station. Mobile clinics are more relevant to rural regions.			
43	Dr. Shannon Trotter	District 2	Support & Supports Title Change
On behalf of D2, support and support title change to reflect resolve clauses.			
43	Dr. Maria Phillis	YPS & ACOG	Support
Speaking on behalf of YPS and ACOG in support of this resolution.			
44	Dr. Susan Hubbell	Self	Support
Speaking for myself I support this resolution. Adding fluoride to water has been shown to be very beneficial over many years and should be continued.			
44	Dr. Susan Hubbell	District 3	Support
Speaking for District 3, we support this resolution.			
44	Dr. Philip Roholt	Self	Oppose
Let's leave this one to the dentists. Too many other important issues, and, in addition, the known relationship of fluoride to neurotoxicity requires further review of this topic https://pmc.ncbi.nlm.nih.gov/articles/PMC6923889/			

Res. #	Comment By:	Representing	Position
44	Dr. Johnathon Ross	Self	Support
The need for water fluoridation has decreased since the introduction of fluoride toothpastes in 1975. While a minority of dentists raise concerns, the overwhelmingly mainstream dental opinion remains that water fluoridation is a vital public health measure. If dental care access was better and you could assure that every child received topical treatment this might be more expensive but slightly safer perhaps. American Dental Association			
44	Dr. Alexis Wybrecht	RFS	Support
Alexis Wybrecht writing on behalf of the RFS in support of resolution #44. The RFS support efforts by state and county health authorities to achieve and maintain fluoridation of public water supplies statewide.			
44	Dr. John Corker	District 2	Support
John Corker, D2 delegate, speaking on behalf of D2 in support of this resolution.			
44	Dr. Shannon Trotter	District 2	Support
On behalf of D2, support.			
44	Dr. Joseph Hellman	Self	Support
Speaking for myself and with the authority of my dental contacts they are interested in the 0.7 ppm as the target for minimizing dental decay.			
44	Dr. Maria Phillis	YPS & ACOG	Support
Speaking on behalf of YPS and ACOG in support of this resolution.			