2026 OSMA Annual Meeting
Resolution Committee One
Resolutions 1-22

#1 - Codifying Policy-1- 2025 in the OSMA Bylaws Assigning the Women, Senior, and International Medical Graduates Sections Seats on OSMA Council

#2 - Establish the OSMA Constitution and Bylaws Review Task Force as an OSMA Standing Committee

#3 – OSMA Task Force to Review and Modernize the Resolution Process

#4 - Advancing Health Equity and Cancer Prevention in Appalachian Ohio

#5 - Equitable Access to Healthcare Through Paid Time Off

#6 - Promoting Equity and Holistic Review in Ohio Graduate Medical Education

#7 - Supporting Implementation of Bilingual/Multingual Clinics in Ohio Residency Programs

#8 - Science in Medicine and Quality of Care

#9 - Limitations on Night and Weekend Call

#10 - Staffing Shortages

#11 - Opposing Criminalization of Drug Abuse During Pregnancy

#12 - Prohibiting the Inclusion of Medical Debt in Consumer Credit Reports

#13 - Advancing Structural Competency, Implicit Bias Training, and Protections for Healthcare Workers and Trainees in Ohio

#14 - Protection for Incarcerated Individuals

#15 - Surgical Consent

#16 - Protection for the Public From Micro Enterprises

#17 - Managed-Fee for Service Should Replace Ohio Medicaid Managed Care

#18 - Promote Monitoring of Private Equity Acquisitions and Advocate for Safeguarding Physician Clinical Autonomy

#19 - Make De-prescribing a Priority Especially as a Part of Care of Seniors

#20 – Immunization Re-Affirmation

#21 – Endorsing the Vaccine Schedule of the American Academy of Pediatrics

#22 – Immunization Informed Consent and Liability

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 1 – 2026

Introduced by: OSMA Council

Subject: Codifying Policy-1- 2025 in the OSMA Bylaws Assigning the Women, Senior, and International Medical Graduates Sections Seats on OSMA Council

Referred to: Resolutions Committee No. 1

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WHEREAS, the 2025 OSMA House of Delegates adopted Policy 1 – 2025 -- *Update of OSMA Bylaws to Include Representative Members from the Women Physician Section, Senior Physician Section, and International Medical Graduates Section on OSMA Council*, expressing the clear intent of the Association to include one (1) representative each from the Women Physicians Section, the Senior Physicians Section, and the International Medical Graduates Section on the OSMA Council, and to reduce the number of at-large Councilor positions from six (6) to four (4), in order to reflect the evolving composition and representation priorities of the Association; and

WHEREAS, Article VII of the OSMA Constitution establishes the composition of the OSMA Council, and Chapters 6 and 8 of the OSMA Bylaws govern the nomination, election, and duties of Councilors, and it is necessary to expressly amend those provisions to accurately codify the governance structure contemplated by Policy 1-2025, including the reduction of at-large Council seats from six (6) to four (4) and the formal inclusion of Council representatives from the Women Physicians Section, Senior Physicians Section, and International Medical Graduates Section; and

WHEREAS, Policy 1-2025 further reflects the House of Delegates' intent that the addition of designated section seats on the Council be subject to periodic reassessment, and incorporating an express five-year review of such section representation into the Constitution and Bylaws promotes clarity, accountability, and ongoing evaluation of the Council's composition as the Association and its membership continue to evolve; now, therefore be it

RESOLVED, that the OSMA Bylaws shall be amended as follows:

ARTICLE VII
THE COUNCIL

The Board of Trustees (referred to herein as "the Council") shall consist of one (1) Councilor from each geographical councilor district, ~~six (6)~~ FOUR (4) At-Large Councilors, one (1) member from the Organized Medical Staff Section, one

(1) member from the Young Physician Section, one (1) member from the Resident and Fellows Section, one (1) Student Member from the Medical Student Section, ONE (1) MEMBER FROM THE INTERNATIONAL MEDICAL GRADUATES SECTION, ONE (1) MEMBER FROM THE SENIOR PHYSICIANS SECTION, ONE (1) MEMBER FROM THE WOMEN PHYSICIANS SECTION, and the other elected Officers of this Association. The Council shall be the executive body of this Association and shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

. . .

CHAPTER 6
NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. . . .

The ~~six~~ FOUR at-large council seats shall be elected by voting members in annual statewide direct elections. Each year the committee on nominations shall nominate at least ~~three~~ TWO candidates for the at-large seats to be filled; however, not more than ~~two~~ ONE at-large councilors can reside or practice in the same councilor geographic district. The nominating committee shall report to all OSMA voting members the slate of candidates for at-large councilor elections.

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CHAPTER 8
THE COUNCIL

. . .

Section 4. Individual Duties of Councilors. Councilor duties shall be outlined in a councilor handbook and updated annually.

The duties of the Councilor from the Organized Medical Staff Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Resident and Fellows Section shall be set forth in the Bylaws of said section, which shall be approved by the Council. The duties of the Councilor from the Young Physician Section shall be set forth in the bylaws of said section, which shall be approved by the Council. THE DUTIES OF THE COUNCILOR FROM THE INTERNATIONAL MEDICAL GRADUATE SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION, WHICH SHALL BE APPROVED BY THE COUNCIL. THE DUTIES OF THE COUNCILOR FROM THE SENIOR PHYSICIANS SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION, WHICH SHALL BE APPROVED BY THE COUNCIL. THE DUTIES OF THE COUNCILOR FROM THE WOMEN PHYSICIANS SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION, WHICH SHALL BE APPROVED BY THE COUNCIL.

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

References:

1. Ohio State Medical Association Constitution And Bylaws (Amended April 2025)

Relevant OSMA Policy:

Policy 1-2025 -- IMG, WPS, SPS Seats on Council

1. The OSMA Bylaws shall be updated so that the Council shall additionally include one (1) member of the Women Physician Section, one (1) member of the Senior Physician Section, and one (1) member of the International Medical Graduates Section. The bylaws of each of these sections shall be updated (according to established procedure) to define the process of electing their representative member to the Council.
2. The OSMA bylaws shall be updated so that the council shall include four (4) at-large councilors, rather than the current six (6) at-large councilors.
3. The OSMA bylaws shall be updated so that designated section seats on the OSMA council be reviewed every 5 years.

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 2 – 2026

Introduced by: OSMA Council

Subject: Establish the OSMA Constitution and Bylaws Review Task Force as an OSMA Standing Committee

Referred to: Resolutions Committee No. 1

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WHEREAS, the OSMA Constitution and Bylaws serve as the foundational documents governing the Association's structure, authority, and internal processes; and

WHEREAS, governance documents must be periodically evaluated to ensure they reflect current organizational operations, legal requirements, and best practices for nonprofit and professional associations; and

WHEREAS, OSMA has previously convened a Bylaws Task Force to review and assess the Constitution and Bylaws and to recommend amendments or clarifications as needed; and

WHEREAS, governance review is an ongoing function that benefits from regular meeting cadence, defined charge, and continuity of membership; and

WHEREAS, converting this function into a standing committee will provide a formal mechanism for sustained governance oversight and orderly consideration of recommended amendments for approval by the House of Delegates; and therefore be it

RESOLVED, that the OSMA Constitution and Bylaws be amended as follows:

CHAPTER 10
COMMITTEES

Section 1. Committees. The standing committees of this Association shall be the Committee on Auditing and Appropriations<u>,</u> ~~and~~ the Committee on Membership<u>, AND THE COMMITTEE ON CONSTITUTION AND BYLAWS</u>. All other committees and task forces of this Association shall be formed by the President.

Section 2. Appointment. The President with approval of Council shall appoint the chair and members of each committee and task force.

Section 3. Duties and Responsibilities of Committees and Task Forces. Each committee and task force shall consider all items referred to it by the House of Delegates and

the Council. The purpose(s) of each committee and task force shall be prescribed by the Council.

The actions of all committees and task forces shall be subject to the approval of the Council.

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

References:

1. OSMA Constitution and Bylaws, Updated April 2025

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 3 – 2026

Introduced by: District 3

Subject: OSMA Task Force to Review and Modernize the Resolution Process

Referred to: Resolutions Committee No. 1

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WHEREAS, the process of submitting, reviewing, evaluating, reporting and voting on resolutions in our HOD has not changed in many years; and

WHEREAS, for the past 2 years, all Delegations and Sections have met virtually and have been able to work asynchronously to discuss and vote on potential resolutions to submit to the OSMA HOD; and

WHEREAS, the ability to meet virtually and work asynchronously was enhanced during the pandemic to the point where it is potentially more efficient and convenient for Delegations and Sections; and

WHEREAS, the number of resolutions submitted has increased over the past few years to the point where the number is difficult for Delegates to review and discuss; and

WHEREAS, the number of resolutions requiring action by staff and Council has increased beyond the capacity of staff and Council to accomplish; therefore be it

RESOLVED, that an OSMA Task Force on the Resolution Process be formed to review the entire process of handling resolutions for our OSMA House of Delegates including deadlines for submission of resolutions by all delegations and sections, online resolutions committee process, processing and review of initial and final Resolution Committee Reports, use of virtual meetings, and the number of submitted resolutions; and be it further

RESOLVED that the OSMA Task Force on the Resolution Process report back to our OSMA HOD by annual 2027 with recommendations regarding the resolution process.

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

References:

1. None

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 4 – 2026

Introduced by: Medical Student Section

Subject: Advancing Health Equity and Cancer Prevention in Appalachian Ohio

Referred to: Resolutions Committee No. 1

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WHEREAS, residents of Appalachian and other rural U.S. communities report worse perceived access to care and lower satisfaction with convenience, information, and healthcare quality compared with non-Appalachian populations[1]; and

WHEREAS, shortages of primary-care and behavioral-health clinicians are well documented in Appalachian and rural regions and contribute to reduced access to preventive care and mental-health services[1]; and

WHEREAS, rural hospital closures are associated with increased travel times, disrupted services, community economic decline, and worsening patient outcomes[2,3]; and

WHEREAS, Ohio's Appalachian region experiences cancer mortality at a 15% higher rate than the national average and a 5% higher rate than non-Appalachian Ohio[4,5]; and

WHEREAS, 13.9% of individuals under age 65 in Appalachian Ohio are uninsured, compared with 12.9% in non-Appalachian Ohio[6]; and

WHEREAS, 58.5% of women aged 67–69 in Appalachian Ohio have had a recent mammogram, compared with 62.1% nationally and 60.4% in non-Appalachian Ohio[1]; and

WHEREAS, Years of Potential Life Lost (YPLL) are significantly higher in Appalachian Ohio, driven in part by later-stage cancer detection and limited access to timely screening and treatment[7]; and

WHEREAS, Appalachian residents in Ohio, Kentucky, Pennsylvania, Virginia, and West Virginia experience significantly higher rates of cancer incidence and mortality, particularly from lung, cervical, and colorectal cancers, with cervical cancer deaths elevated in Ohio's poorest Appalachian counties due to later-stage diagnoses and poorer outcomes[4,5,7]; and

WHEREAS, women in Appalachia report barriers to Pap testing including cost, lack of physician recommendation, embarrassment, and anxiety[8]; and

WHEREAS, mobile mammography programs significantly improve breast cancer screening participation among medically underserved women by reducing structural barriers such as transportation limitations, cost, and lack of access to fixed screening facilities[9]; and

WHEREAS, mobile mammography programs significantly improve breast cancer screening participation among medically underserved women by reducing structural barriers such as transportation limitations, cost, and lack of access to fixed screening facilities[9]; and

WHEREAS, transportation insecurity significantly reduces adherence to recommended breast, cervical, and colorectal cancer screening, and that interventions addressing transportation barriers and providing community support can improve screening participation and reduce disparities in cancer outcomes[10]; and

WHEREAS, rural Appalachian populations found that lack of transportation, cost, and lack of education are major barriers to cancer screening, and that interventions addressing transportation and providing education can improve screening rates and lead to earlier diagnosis and better outcomes[11]; therefore be it

RESOLVED, that OSMA supports policies to sustain rural hospitals; and be it further

RESOLVED, that the OSMA supports expansion of community-based prevention and chronic-disease management models such as school-based and mobile clinics; and be it further

RESOLVED, that OSMA supports expansion of cancer-screening outreach programs in Appalachian Ohio; and be it further

RESOLVED, that OSMA supports funding for mobile screening units and partnerships with local public health departments to address regions with the highest cancer mortality; and be it further

RESOLVED, that the OSMA supports efforts to reduce barriers to cancer screening in Appalachian Ohio by assisting with transportation, expanding access to free or reduced-cost screening services, supporting insurance enrollment, and promoting culturally appropriate cancer prevention education to address fear and misinformation.

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

References:

1. Appalachian Regional Commission. Health Disparities in Appalachia: Mortality Domain. ARC; 2021.
2. Chatterjee P. Causes and consequences of rural hospital closures. Am J Public

Health. 2022;112(8):1107-1109.
3. Mills CA, Yeager VA, Unroe KT, Holmes A, Blackburn J. Impact of rural hospital closures: systematic review. J Rural Health. 2024;40(2):238-248.
4. American College of Surgeons. Cancer diagnoses and deaths in Appalachia remain significantly higher compared to other U.S. regions. ACS; 2025.
5. National Cancer Institute. Paskett E. Addressing cancer disparities in Appalachia. NCI; 2023.
6. Appalachian Regional Commission. Ohio Health Disparities: Key Findings. ARC; 2020.
7. Reiter PL, Katz ML, Oliveri JM, et al. Disparities in cervical cancer incidence and late-stage diagnosis in Ohio. Prev Chronic Dis. 2018;15:E144.
8. Vanderpool RC, Jones MG, Stradtman L, et al. Barriers to Pap test use among Appalachian women. J Womens Health. 2016;25(10):1082-1091.
9. Vang S, Margolies LR, Jandorf L. Mobile mammography participation among medically underserved women: a systematic review. *Prev Chronic Dis.* 2018;15:E140.
10. Syed ST, Gerber BS, Sharp LK. Transportation insecurity and adherence to cancer screening recommendations. *JAMA Netw Open.* 2024;7(1):e245678.
11. Katz ML, Reiter PL, Kluhsman BC, et al. Barriers to colorectal cancer screening in rural Appalachian Ohio. *J Rural Health.* 2010;26(3):255-263

Relevant OSMA Policy:

Policy 30-1994 – Increase in Number of Primary Care Physicians

1. The OSMA supports positive incentives such as shifting of more subsidies to primary care medical education programs, increasing reimbursement levels, tax abatements and loan repayment programs to attract greater numbers of primary care and rural physicians.
2. The OSMA discourages the enactment of restrictive measures such as licensure limitations, quotas in medical education programs, or compulsory measures which are intended to influence the numbers of primary care physicians in Ohio.

Policy 06-2013 – Crafting Innovative Ways of Funding Graduate Medical Education

1. The OSMA supports legislation to convene a state based task force of key stakeholders to include representatives from private business enterprises such as health insurance companies, private practice physicians, members of the general public, and academic medical center employees to study current graduate medical education (GME) financing in Ohio and investigate creative alternatives for GME funding that rely less on federal resources.

Policy 08-2013 – Support for More Primary Care Physicians

1. The OSMA shall take steps to increase the number of medical students and residents going into primary care by calling for an increase in the number of residency positions in primary care.

Policy 06-2023 –Increased Access to Health Care

1. The OSMA continues to express its support for increased access to comprehensive, affordable, high-quality health care.
2. The OSMA rescinds current Policy 11 – 2010 – Promoting Free Market-Based Solutions to Health Care Reform.

Policy 27-2023 – Decrease Costs for Ohio Patients with Diabetes with Commercial Insurance

1. The OSMA will:
(1) encourage the Ohio Department of Insurance to investigate insulin pricing and market competition and take enforcement actions as appropriate;
(2) support initiatives that provide physician education regarding the cost-effectiveness of insulin therapies; and
(3) support state efforts to limit the ultimate expenses incurred by commercially insured patients for prescribed insulin and diabetic equipment and supplies.

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 5 – 2026

Introduced by: Medical Student Section

Subject: Equitable Access to Healthcare through Paid Time Off

Referred to: Resolutions Committee No. 1

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WHEREAS, the Centers for Disease Control (CDC) emphasizes those who take time off and attend physician appointments are less likely to spread infectious diseases which in turn promotes public safety by taking this simple preventative measure. Parents without paid sick days are more than twice as likely to send a sick child to school or daycare, increasing the risk of infection[1,2] ; and

WHEREAS, during the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) found that there was a 50% reduction in COVID-19 cases in association with paid sick leave provisions[3] ; and

WHEREAS, studies have shown that regular doctor appointments significantly improve chronic condition management, including a 1.5 times higher likelihood of managing hypertension, a 1% decrease in HbA1c levels leading to a 21% reduction in diabetes-related complications, and a 58% reduced risk for Type 2 diabetes with frequent healthcare visits combined with exercise[4, 5,6]; and

WHEREAS, regular health checkups facilitate early detection of chronic illnesses, as demonstrated by findings from the American Journal of Managed Care, which revealed that 2.9% of participants had undiagnosed diabetes, highlighting the importance of physical exams and blood work[7]; and

WHEREAS, patients who frequently miss appointments show nearly a three-fold increase in risk of all-cause mortality than those who do not regularly miss appointments[8]; and

WHEREAS, Preventive health screenings and regular primary care visits significantly improve life expectancy, especially for those aged 30 to 49. Routine check-ups enable doctors to monitor vital signs, detect early signs of chronic diseases like cancer, diabetes, or heart disease, and provide timely treatment to maintain health[9]; and

WHEREAS, national public health assessments identify inflexible work hours and the lack of employer provided time to attend medical appointments as major barriers to accessing primary care, which is typically available only during standard working hours[10]; and

WHEREAS, In 2022, about 15% of employed adults reported forgoing needed medical care because they could not take time off work due to fear of lost wages or job loss[11]; and

WHEREAS, as of 2023, 18 states have enacted laws mandating minimum paid sick leave for private employers, demonstrating a growing recognition of the importance of paid time off for public health and employee well-being[12]; and

WHEREAS, Ohio currently lacks legislation mandating paid sick leave for private employers, despite prior interest highlighted in a 2007 study that that highlighted the significant benefits of paid sick leave policies for employees and their families; however, no legislative action followed this research[13]; and

WHEREAS, Employees without access to paid leave were more than twice as likely to go without medical care because they could not afford to take unpaid time off (12 percent versus 5 percent of those with access to paid leave) or because they worried losing their job if they took paid or unpaid leave (7 percent against 3 percent of those with access to paid leave)[14]; and

WHEREAS, Approximately half of working parents report that they are not paid when they take time off to care for ill children. Three-quarters (76%) of working mothers with low incomes (less than 200% of the federal poverty threshold) report losing pay when they miss work to care for sick children, more than twice as many as those with higher incomes (38%)[15]; and

WHEREAS, 76% of Ohio workers lack access to paid leave, and only 15% of workers, including just 4% of low-wage workers have any form of paid leave, with Black and Latina women disproportionately affected, exacerbating racial and economic inequities[16]; and

WHEREAS, In Ohio, access to paid leave is more than two-and-a-half times higher among the highest-wage workers than among the lowest-wage workers, and a typical worker taking four weeks of unpaid leave can lose nearly $3,100 in income[17]; and

WHEREAS, Part-time and low-income workers are disproportionately affected by a lack of workplace support, such as paid sick leave, which makes it difficult for them to balance their healthcare needs with job security[15]; and

WHEREAS, Employees without paid leave are more likely to have material and financial difficulties than those with paid leave, such as being twice as likely to face food insecurity and more than twice as likely to be unable to pay for utilities or rent[18]; and

WHEREAS, Approximately 80.5 percent of workers in families with incomes four times or greater than the federal poverty level receive paid leave; and

WHEREAS only 31.5 percent of workers in households below the poverty line have access, with workers' access rates progressively declining as family income drops[18]; and therefore be it

RESOLVED, our OSMA will support guaranteeing employees, regardless of full-time or part-time status, access to at least 2 days of protected paid time off annually for scheduled medical appointments.

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

References:

1. de Perio M. Srivastav A. Razzaghi H. Laney S. Black C. Paid sick leave among U.S. healthcare personnel. Am J Prev Med. 2023. 65(3):521-527. https://stacks.cdc.gov/view/cdc/132212
2. Paid Sick Days Benefit Children's Health. Fact Sheet. Published on April 2013. Access on Jan 16, 2025. https://nationalpartnership.org/wp-content/uploads/2023/02/paid-sick-days-benefit-childrens-health.pdf
3. Congress Finalizes COVID-19 Coronavirus Response Act: Prepare To Provide Paid Sick Leave And FMLA. Fisher Phillips. Published on Mar 18, 2020. Accessed on Nov 3, 2024. https://www.fisherphillips.com/en/news-insights/congress-finalizes-covid-19-coronavirus-response-act-prepare-to-provide-paid-sick-leave-and-fmla.html
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5. Lifestyle changes, meds effective to prevent or delay Type 2 diabetes; no change in CVD. American Heart Association. Published on May 23, 2022. Accessed on Nov 3, 2024. https://newsroom.heart.org/news/lifestyle-changes-meds-effective-to-prevent-or-delay-type-2-diabetes-no-change-in-cvd
6. Peterson K. Carlin C. Solberg L. Normington J. Eric L. Care Management Processes Important for High-Quality Diabetes Care. Diabetes Care 1 October 2023; 46 (10): 1762–1769.
7. Fragala M. Shiffman D. Birse C. Population Health Screenings for the Prevention of Chronic Disease Progression. AJMC. 2019. 25(11). https://www.ajmc.com/view/population-health-screenings-for-the-prevention-of-chronic-disease-progression
8. McQueenie E. McConnachie A. Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Med 17, 2 (2019). https://doi.org/10.1186/s12916-018-1234-0
9. Preventative Care. Public Health. Published in 2023. Accessed on Dec 7, 2024. https://www.publichealth.org/public-awareness/preventive-care-schedule/
10. Access to primary care. Office of Disease Prevention and Health Promotion. Accessed on Dec 6, 2025. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

11. Lack of Paid Leave Hurts Americans' Health. Center for American Progress. Published on May 22, 2024. Accessed on Dec 6, 2025. https://www.americanprogress.org/article/lack-of-paid-leave-hurts-americans-health/
12. Mitchell S. State Paid Sick Leave Laws. Published in December 2024. Accessed on January 16, 2025.
13. Fair Economy. Policy Matters Ohio. Published in 2025. Accessed on January 16, 2025. https://www.policymattersohio.org/research-policy/fair-economy/work-wages
14. Boyens C. Karpman M. Smalligan J. Workers without Paid Leave Are More Likely to Forgo Needed Medical Care Because of Difficulty Taking Time off Work. Urban Institute. Published on August 22, 2023. Accessed on Dec 5, 2024. https://www.urban.org/research/publication/workers-without-paid-leave-are-more-likely-forgo-needed-medical-care
15. Ranji U. Long M. Frederiksen B. Diep K. Salgani. Workplace Benefits and Family Health Care Responsibilities: Key Findings from the 2022 KFF Women's Health Survey. Kaiser Family Foundation. Published Nov 16, 2022. Accessed on Dec 5, 2024. https://www.kff.org/womens-health-policy/issue-brief/workplace-benefits-and-family-health-care-responsibilities-key-findings-from-the-2022-kff-womens-health-survey/
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17. Tebban A. Analysis: Some workers still don't have paid sick time post-pandemic. Ohio Capital Journal. Published on Sept 30, 2022. Accessed on January 17, 2025. https://ohiocapitaljournal.com/briefs/analysis-some-workers-still-dont-have-paid-sick-time-post-pandemic/
18. Boyens C. Karpman M. Smalligan J. Access to Paid Leave Is Lowest among Workers with the Greatest Needs. Urban Institute. Published on July 2022. Accessed on Dec 5, 2024. https://www.urban.org/sites/default/files/2022-07/Access%20to%20Paid%20Leave%20Is%20Lowest%20among%20Workers%20with%20the%20Greatest%20Needs.pdf

Relevant OSMA Policy:

Policy 12 – 2024 Support for Paid Parental Leave

1. OSMA supports paid parental leave following the birth, adoption, or foster placement of a new child and following loss of pregnancy.

Relevant AMA Materials:

Paid Sick Leave H-440.823

1. Our American Medical Association recognizes the public health benefits of paid sick leave and other discretionary paid time off.
2. Our AMA supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.

3. Our AMA supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.
4. Our AMA advocates for federal and state policies that guarantee employee access to protected paid sick leave without unduly burdening small businesses.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 6 – 2026

Introduced by: Medical Student Section

Subject: Promoting Equity and Holistic Review in Ohio Graduate Medical Education

Referred to: Resolutions Committee No. 1

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WHEREAS, Ohio is currently facing a projected physician shortage of up to 3,100 physicians by 2038, with a significant impact on primary care and rural communities[1,2]; and

WHEREAS, The transition to a Single Accreditation System (SAS) for Graduate Medical Education (GME) was completed in 2020, unifying residency training for Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) graduates[3]; and

WHEREAS, Despite this unification, 29 percent of residency program directors never or seldom interview DO candidates, and 73 percent require the MD licensing exam in addition to the DO licensing exam[4]; and

WHEREAS, a 2022 concordance study analyzing over 2,000 osteopathic medical students demonstrated a strong correlation between COMLEX-USA Level 1 and USMLE Step 1 scores, indicating that performance on the USMLE can be reliably predicted from COMLEX-USA results[5]; and

WHEREAS, National Resident Matching Program (NRMP) data indicates that residency programs emphasize research experience in applicant selection criteria, with mean publication numbers of 4.3 among DO applicants and 10.2 among MD applicants, establishing research as a dominant factor in applicant ranking[6,7]; and

WHEREAS, Less than 0.1% of NIH funding is allocated to DO schools compared to 41% for MD schools according to the American Association of Colleges of Osteopathic Medicine, harming DO students who face significant barriers to research participation[8]; and

WHEREAS, emphasis on research volume in residency applications is contrary to evidence showing that metrics like meaningful clinical experience and longitudinal community service are stronger predictors of an applicant’s clinical skills, humanism, and likelihood of remaining in their training community to practice[9,10,11,12]; and

WHEREAS, The AAMC announced the ERAS Publication Section will transition to the Scholarly Works Section beginning for the 2027 match cycle, which no longer includes publications such as resolutions and policies authored[13]; and

WHEREAS, the American Medical Association in November 2025 adopted Resolution I-25-312, calling for holistic review of non-research based domains in light of recent changes to the ERAS residency application portal[14]; and

WHEREAS, Applicants will be greatly limited in their ability to showcase other published works, including resolutions and advocacy initiatives[13]; therefore, be it

RESOLVED, that our OSMA reaffirm Policy 08 – 2018 – quality for COMLEX and USMLE

RESOLVED, that our OSMA amend Policy 34-2021 by addition and deletion as follows:

> **Policy 34-2021 – Increasing Transparency of the Resident Physician Application Process**
> 1. The OSMA and interested stakeholders shall study options for improving transparency in the resident application process, which works towards a holistic review of residency applicants.
> 2. The Ohio Delegation to the AMA shall forward this resolution to the AMA.
> 3. THE OSMA ENCOURAGES OHIO RESIDENCY PROGRAMS TO ADOPTSELECTION CRITERIA THAT VALUES BROAD CLINICAL EXPERIENCE, LONGITUDINAL COMMUNITY SERVICE, AND ADVOCACY WITH EQUITABLE CONSIDERATION TO ACADEMIC METRICS, SUCH AS RESEARCH AND SCHOLARLY ACTIVITY.

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

References:

1. Department of Health and Human Services. Health Resources and Services Administration. *Health Workforce Projections*. Accessed January 29, 2026. https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections
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Relevant OSMA Policy:

Policy 11-1997 Osteopathic and Allopathic Relations

1. The OSMA continues to investigate possibilities for increased integration with state and local osteopathic physician organizations and with individual osteopathic physicians with the goal toward developing mutually beneficial relationships to strengthen organized medicine statewide.

Policy 08 – 2013 – Support for More Primary Care Physicians

1. The OSMA shall take steps to increase the number of medical students and residents going into primary care by calling for an increase in the number of residency positions in primary care.

Policy 34 – 2021 – Increasing Transparency of the Resident Physician Application Process

1. The OSMA and interested stakeholders shall study options for improving transparency in the resident application process which works towards holistic review of residency applicants.
2. The Ohio Delegation to the AMA shall forward this resolution to the AMA.

Policy 8 – 1973 – Compulsory Formal Postgraduate Education

1. The OSMA is opposed to any discriminatory government rules and regulations regarding compulsory formal post-graduate education and re-examination for re-licensure.
2. The assessment of a physician's competence by his performance is a referable technique, and as a realistic goal of medicine, should be pursued.

Policy 27 – 1982 – Develop Within the MSS Programs Which Would Assist in Improving the Public Health

1. The OSMA encourages medical students and the Medical Student Section to participate in public service activities.

Policy 35-2025 Expanding Graduate Medical Education Funding to Address Ohio's Physician Workforce Needs

1. The Ohio State Medical Association (OSMA) reaffirm OSMA Policy 06-2013.
2. The OSMA advocate for increased state and federal funding for Graduate Medical Education (GME) programs to address Ohio's physician workforce shortages and ensure access to high-quality healthcare.
3. That GME funding prioritize:
    a. The establishment of new and expansion of currently existing funding for residency programs in rural and underserved communities;
    b. Support for training programs in primary care, mental health, and other specialties facing critical shortages; and
    c. Collaboration with medical schools, teaching hospitals, and community health systems to maximize the impact of GME investments.
4. The OSMA advocate for policies aimed at expanding GME resources, including innovative funding mechanisms such as public-private partnerships and matching fund initiatives.
5. The OSMA commit to annual advocacy efforts and collaboration with key stakeholders to monitor and evaluate GME funding levels and physician workforce outcomes, ensuring accountability, transparency, and alignment with Ohio's healthcare needs.

Policy 08-2018 – Equality for COMLEX and USMLE

1. 1. The OSMA promotes acceptance of the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) as equivalent by all Ohio residency programs.

Relevant AMA Materials:

AMA Policy H-310.908 - Graduate Medical Education Resident Selection Our AMA encourages residency programs to use a holistic review process for resident selection that includes a balanced assessment of metrics, experiences, and attributes.

AMA Policy H-295.866 Supporting Two-Interval Grading Systems for Medical Education Our American Medical Association will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

AMA Policy H-275.953 The Grading Policy for Medical Licensure Examinations

1. Our American Medical Association's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring:
    a. Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.)
    b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of their numerical scores.
    c. Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will:
    a. promote equal acceptance of the USMLE and COMLEX at all United States residency programs.
    b. work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores.
    c. work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 7 – 2026

Introduced by: Medical Student Section

Subject: Supporting Implementation of Bilingual/Multingual Clinics in Ohio Residency Programs

Referred to: Resolutions Committee No. 1

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WHEREAS, limited English proficiency (LEP) is defined by the U.S Department of Health and Human Services as "individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English"[1]; and

WHEREAS, among Ohio's foreign-born population, nearly 40% report speaking English less than "very well"[2], highlighting a high prevalence of LEP within this community; and

WHEREAS, individuals with LEP have significantly poorer access to care, are less likely to have a primary care provider, are more likely to delay or forgo needed care and preventative screenings[3]; and

WHEREAS, LEP is associated with worse communication, lower adherence, increased medical errors and worse health outcomes in comparison to English proficient populations[3,4]; and

WHEREAS, language-concordant encounters have been shown to improve communication quality, patient satisfaction, healthcare relationship trust and clinical outcomes compared with language-disconcordant encounters, even when professional interpreters are available[5,6]; and

WHEREAS, access to a language-concordant primary care physician is associated with greater routine primary care use and fewer avoidable emergency department or specialist visits, improving health outcomes and lowering system level costs[7]; and

WHEREAS, bilingual/multilingual continuity clinics at residency programs such as the University of Arizona, Johns Hopkins, and UCSF are an effective educational model, and have shown high resident satisfaction, improved cultural and linguistic competency, and enhanced understanding of the social barriers faced by LEP patients[8]; and

WHEREAS, Ohio is home to a substantial and growing immigrant population, including nearly 607,000 Latino/Hispanic residents (5.1% of the state population), with the largest concentrations in Franklin, Cuyahoga, Lucas, Hamilton, and Stark Counties; and

WHEREAS, from 2010 to 2021, more than 25,000 refugees were officially resettled in Ohio, with Somali and Bhutanese-Nepali individuals being among the most represented refugee groups[10]; and

WHEREAS, immigrants and refugees in Ohio experience disproportionate barriers to healthcare access due to LEP, lack of language-concordant clinicians, difficulty navigating the healthcare system, and cultural barriers, contributing to lower rates of preventative care and delays in treatment[11]; and

WHEREAS, local organizations have explicitly highlighted the need for more bilingual and culturally competent physicians to care for these populations; and

WHEREAS, GME programs in Columbus serving the larger Bhutanese-Nepali and Somali communities already recognize the challenges and opportunities of caring for multilingual refugee and immigrant populations, highlighting the importance of structured bilingual/multilingual training pathways for residents practicing in Ohio[12]; and therefore be it

RESOLVED, that our OSMA supports the development and implementation of bilingual and multilingual continuity clinics within Ohio residency programs and teaching hospitals.

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

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Care and Outcomes. Journal of General Internal Medicine. 2019;34(8):1591–1606. doi:10.1007/s11606-019-04847-5. PMCID: PMC6667611.
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12. Mount Carmel Health System. *Global Health — Family Medicine Residency Program*. Mount Carmel GME. Accessed December 4, 2025.

Relevant OSMA Policy:

Policy 63 – 1994 – Health-System Reform

1. The OSMA supports only those proposed changes in our health-care system that are in the best interest of patients and which assure that all Americans continue to receive high quality medical care.

Policy 25 – 2017 – Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

1. The OSMA encourages all medical education institutions in Ohio to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician's role in eliminating cultural health care disparities in medical treatment.

Policy 06 – 2019 – Increase Awareness of Disparities in Medical Access and Treatment in Ohio

1. The OSMA shall work with appropriate stakeholders to increase awareness of Ohio physicians, residents, and medical students of disparities in medical access and treatment in Ohio based on disability, race, ethnicity, geography, and other social and demographic factors through the utilization of existing resources.

Relevant AMA Materials:

Support of Multilingual Assessment Tools for Medical Professionals H-160.914

Our American Medical Association will encourage the publication and validation of standard patient assessment tools in multiple languages.

Enhancing the Cultural Competence of Physicians H-295.897

1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 8 – 2026

Introduced by: District 3

Subject: Science in Medicine and Quality of Care

Referred to: Resolutions Committee No. 1

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WHEREAS, recent announcements about vaccinations and other aspects of preventive care have not been based on well-established science; and

WHEREAS, the basis of medical care should be the art and science of medicine; and

WHEREAS, some recent decisions seem to be more politically motivated than based on scientific literature; and therefore be it

RESOLVED that our OSMA preserve, protect and enhance the quality of medical care in Ohio now and in the future by:

(1) advancing the art and science of medicine and the health of the public;
(2) advocating for patients, physicians and the public;
(3) enhancing the profile and priority within the OSMA of science as the basis of medicine; and
(4) bringing science advocacy to the forefront of advocacy and legislative initiatives.

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

References:

1. None

Relevant OSMA Policy:

Policy 07-2022- Addressing the Roles of Licensed Health Professionals in Preventing Public Health Misinformation

1. The OSMA opposes legislation that mandates licensed healthcare professionals provide non evidence-based healthcare information to patients.
2. The OSMA: 1) Will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and 2) will work with public health agencies and professional societies in an effort to establish relationships with journalists and news agencies to enhance the public

reach in disseminating accurate medical and public health information and address misinformation that undermines public health initiatives.

Relevant AMA Materials:

Science in Medicine and Quality of Care in Health System Reform H-450.945

It is a critical role of the AMA to preserve, protect and enhance the quality of medical care now and in the future by: (1) advancing the art and science of medicine and the health of the public; (2) advocating for patients, physicians and the public; (3) enhancing the profile and priority within the AMA of science as the basis of medicine; and (4) bringing science advocacy to the forefront of health system reform.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 9 – 2026

Introduced by: District 3

Subject: Limitations on Night and Weekend Call

Referred to: Resolutions Committee No. 1

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WHEREAS physician burnout and leaving medical practice early has become an increasing issue; and

WHEREAS, mandatory night and weekend call is required by most hospitals to maintain medical staff privileges; and

WHEREAS, for decades, we’ve accepted call as an unspoken obligation, a badge of honor, a rite of passage, and the price of wearing a white coat; and

WHEREAS, historically, when physicians owned their practices, call made sense. You covered your patients because your practice depended on it; and

WHEREAS, to remain on the medical staff, most physicians must take unassigned patient ER call and must accept responsibility for patients they have never met, often without additional pay; and

WHEREAS, fatigue is a patient safety issue; and

WHEREAS, pilots, airline crews, truck drivers, and virtually every other industry have regulated rest; and

WHEREAS, resident and medical student work hours have already been limited; and therefore be it

RESOLVED, that maintenance of hospital privileges should not require mandatory night and weekend call for all medical staff members; and be it further

RESOLVED, that if a physician voluntarily wants to be on night and weekend call to cover only their own patients, that choice should be honored by hospitals without penalty; and be it further

RESOLVED that mandatory call for uninsured patients should be reimbursed appropriately by the hospital or physician group, with time off post call if needed for rest and recovery.

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

References:

1. None

Relevant OSMA Policy:

Policy 17 – 2017 – Importance of OSMA Promoting Physician Well-Being by Addressing the Physician and Medical Student Burnout Issue

1. The OSMA shall work with medical schools, hospitals, residency programs, and physicians to address the issue of physician and medical student burnout.
2. The OSMA encourages physicians and medical students to utilize the AMA Steps Forward Program to learn more about preventing physician burnout.

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 10 – 2026

Introduced by: Young Physicians Section

Subject: Staffing Shortages

Referred to: Resolutions Committee No. 1

WHEREAS, In December 2025 the U.S Department of Health and Human Services repealed several regulations regarding Minimum Staffing Standards in Long-Term Care and Skilled Nursing Facilities, including the requirement to have at least one registered nurse on site at all times[1]; and

WHEREAS, Staffing shortages across healthcare facilities are associated with worsened clinical outcomes, including increased patient mortality, and decreased patient and provider satisfaction scores[2,3]; and

WHEREAS, a majority of nursing homes and hospitals report a shortage of staff members[4,5]; and

WHEREAS, the Joint Commission includes safe staffing as a performance goal when evaluating hospital performance[6]; and therefore be it

RESOLVED, That the Ohio State Medical Association supports efforts to ensure that healthcare facilities are adequately staffed with competent personnel to deliver safe, high-quality care to all patients; and be it further

RESOLVED, That the Ohio State Medical Association supports the recruitment and retention of qualified individuals to medical professions including nursing and other allied health professions.

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

References:

1. CMS repeals minimum staffing requirements for skilled nursing, long-term care facilities. American Hospital Association. December 2, 2025. https://www.aha.org/news/headline/2025-12-02-cms-repeals-minimum-staffing-requirements-skilled-nursing-long-term-care-facilities
2. Impact of the Nursing Shortage on Patient Care. American Association of Colleges of Nursing. https://www.aacnnursing.org/news-data/nursing-faculty-shortage/impact-of-the-nursing-shortage-on-patient-care

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5. Leuchter RK, Delarmente BA, Sitaram Vangala, Tsugawa Y, Sarkisian CA. Health Care Staffing Shortages and Potential National Hospital Bed Shortage. JAMA Network Open. 2025;8(2):e2460645-e2460645. doi:https://doi.org/10.1001/jamanetworkopen.2024.60645
6. National Performance Goals Effective January 2026 for the Hospital Program. Joint Commission; 2025. https://www.jointcommission.org/en-us/standards/national-performance-goals

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

H-280.951 Quality of Care and Staffing in Nursing Homes

Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.

H-360.986 Professional Nurse Staffing in Hospitals

1. Our American Medical Association encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients.
2. Our AMA encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care.
3. Our AMA encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care.
4. Our AMA encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility.
5. Our AMA encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 11 – 2026

Introduced by: Medical Student Section

Subject: Opposing Criminalization of Drug Abuse During Pregnancy

Referred to: Resolutions Committee No. 1

WHEREAS, across the United States, a patchwork of state statutes and child-welfare policies criminalize or define prenatal substance exposure as child abuse or neglect, exposing pregnant individuals to prosecution, loss of parental rights, civil commitment, and other punitive consequences, including Ohio[1-4]; and

WHEREAS, in Ohio, prosecutors have attempted to apply Ohio Revised Code § 2925.02 ("corrupting another with drugs") beyond its intended purpose in order to criminalize pregnant individuals for self-directed drug use - as held by the Fifth District Court of Appeals in State v. Hollingshead (2023-Ohio-1714)[5]; and

WHEREAS, punitive legal responses are associated with reduced prenatal and postpartum care among people with substance use during pregnancy, without evidence of reduced drug use[6-8]; and

WHEREAS, a recent study found that states such as Alabama, South Carolina, and Tennessee explicitly criminalized prenatal drug use, which led to a reduction in the prevalence of any prenatal care, declines in first-trimester prenatal care initiation and facility-based births[9]; and

WHEREAS, in Tennessee, SB 1391 added substance use disorder (SUD) during pregnancy and children born addicted to a drug to their Fetal Assault Law, and within its first year enacted, 124 women were charged with offenses ranging from simple assault, aggravated assault, reckless endangerment[10]; and

WHEREAS, five states' (MN, ND, OK, SD, WI) statutes allow pregnant people dealing with SUD to be either held in criminal custody or involuntarily committed to a rehabilitation facility for SUD treatment[11]; and

WHEREAS, reports from The Marshall Project reveal that pregnant women in states such as Alabama and Oklahoma have been criminally prosecuted under child endangerment and neglect laws for alleged prenatal conduct, including substance abuse, even when the children were born healthy, therefore criminalizing substance use disorders during pregnancy[12]; and

WHEREAS, in Alabama there have been reports of women serving jail time for substance use during pregnancy during which addiction medicine treatment was not prioritized until patients were transported to a hospital[13]; and

WHEREAS, during 2022 in the state of Oklahoma, 26 mothers had child neglect charges filed against them for using medical marijuana during pregnancy, which is a crime that can carry up to life in prison in Oklahoma[14]; and

WHEREAS, adoption of punitive policies has been empirically linked to 10-18% increase in neonatal drug-withdrawal syndrome (neonatal abstinence syndrome) relative to pre-policy baselines, proving worsening infant outcomes[15]; and

WHEREAS, mandated-reporting and punitive drug-use policies during pregnancy impose administrative and financial burdens on child-welfare and public health systems, including caseloads of abuse/neglect investigations and foster care placements, diverting resources from prevention and support services[16]; and

WHEREAS, these policies disproportionately burden low-income communities and women of color, who are more likely to be reported to child protective services for prenatal drug exposure than similarly situated White women[2]; and

WHEREAS, major medical organizations, including the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA), oppose criminalization of pregnant patients and endorse non-punitive, treatment-focused approaches[17,18]; and

WHEREAS, substance use disorder is a chronic, treatable medical condition, and for opioid use disorder during pregnancy, evidence-based care includes medications for OUD (buprenorphine or methadone), counseling, harm reduction, and coordinated social supports to improve maternal-infant outcomes[6,19,20]; therefore be it

RESOLVED, that our OSMA amend Policy 28 – 2022 by addition:

Policy 28 – 2022 – Substance Use Disorder in Pregnant People

1. The OSMA opposes any efforts to assert that a diagnosis of substance use disorder in a pregnant person alone constitutes child abuse or inherent parental unfitness.
2. The OSMA supports prioritizing funding for the expansion of integrative mental health and substance use treatment programs explicitly for pregnant persons.
3. The OSMA opposes 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.
4. <u>THE OSMA OPPOSES CRIMINAL CHARGES, FINES, JAIL TIME, INVOLUNTARY COMMITMENT TO DRUG REHABILITATION TREATMENT, OR ANY OTHER PUNITIVE CHARGES THAT</u>

EFFECTIVELY PENALIZE PREGNANT PERSONS FOR BEING DIAGNOSED WITH SUBSTANCE USE DISORDER.

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

References:

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2. Pregnancy Justice. 2023.
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4. Substance Use During Pregnancy and Child Abuse or Neglect: Summary of State Laws. *Legislative Analysis And Public Policy Association.* June 2024.
5. State v. Hollingshead, 2023-Ohio-1714 (Ohio Ct. App.).
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13. Newman, A. (2017, March 16). 3 reasons why criminalizing pregnant women for drug use is a bad idea. Our Bodies Ourselves.
14. Adlin, B. (2024, October 4). Hundreds prosecuted for drug use during pregnancy in year after Dobbs. FilterMag.
15. Meinhofer A, Witman A, Maclean JC, Bao Y. Prenatal substance use policies and newborn health. Health Econ. 2022 Jul;31(7):1452-1467. doi: 10.1002/hec.4518. Epub 2022 Apr 20. PMID: 35445500; PMCID: PMC9177792.

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17. ACOG. Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period. 2020.
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Relevant OSMA Policy:

Policy 16 – 2023 -- Opposition to Criminalization of Pregnancy Loss

1. The OSMA will advocate (1) that pregnancy loss shall not be criminalized for physicians or patients, and (2) that physicians and patients should not be held civilly and/or criminally liable for pregnancy loss as a result of medical care.

Policy 28 – 2022 – Substance Use Disorder in Pregnant People

1. The OSMA opposes any efforts to assert that a diagnosis of substance use disorder in a pregnant person alone constitutes child abuse or inherent parental unfitness.
2. The OSMA supports prioritizing funding for the expansion of integrative mental health and substance use treatment programs explicitly for pregnant persons.
3. The OSMA opposes 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.

Relevant AMA Materials:

Perinatal Addiction - Issues in Care and Prevention H-420.962

1. Our American Medical Association adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability.
2. Our AMA 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 people wherever possible.
3. Our AMA urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding people, 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. Our AMA 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.

5. Our AMA, 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.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 12 – 2026

Introduced by: Medical Student Section

Subject: Prohibiting the Inclusion of Medical Debt in Consumer Credit Reports

Referred to: Resolutions Committee No. 1

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WHEREAS, recent national survey data show that about 36% of United States households carry medical debt, including 21% with past due medical bills and 23% who are paying medical bills over time[1,13]; and

WHEREAS, medical debt disproportionately burdens vulnerable populations, including individuals with lower incomes, people of color, individuals with chronic illness, and those who lack comprehensive insurance coverage[1,5,7,9]; and

WHEREAS, medical debt often arises from expenses related to unexpected illness, emergency care, insurance billing complexity, or surprise out-of-network charges, leaving patients with little ability to anticipate or avoid these costs[1,6,9]; and

WHEREAS, well-documented examples of medical billing errors include incorrect coding, duplicate charges, billing for services not received, and improper application of insurance coverage, resulting in patients being charged for amounts they do not legitimately owe[3,4,8]; and

WHEREAS, unlike other forms of consumer debt, medical debt typically arises from medically necessary care rather than discretionary spending or voluntary financial decision making, and therefore does not reflect personal risk-taking or borrowing behavior by patients[1,5,9]; and

WHEREAS, the complexity of medical billing systems and insurance adjudication processes limits many patients' ability to identify, contest, or resolve inaccurate medical bills on time[3,7,9]; and

WHEREAS, patients often lack consistent and accessible means of settling billing disputes with providers, especially when disputes involve coverage determinations, coding errors, or out-of-network charges[6,7]; and

WHEREAS, state-based, federally-established, and independent billing dispute resolution programs exist to encourage the resolution of billing disputes between insurers and health care providers[6]; and

WHEREAS, dispute resolution programs are primarily designed to resolve payment disagreements and do not prevent disputed or inaccurate bills from being billed to patients or referred to collections while the resolution process is ongoing[6,3]; and

WHEREAS, inaccurate medical bills are often referred to collections before errors are corrected or insurance appeals are resolved, which results in unverified medical debt entering the collections system and exposing patients to financial and credit-related harm[1,3,7]; and

WHEREAS, Ohio does not currently require uniform billing review, dispute resolution, or verification processes to be completed before medical debt may be referred to collections, resulting in inconsistent protections for patients across healthcare settings; and

WHEREAS, hospitals, health systems, and their affiliated billing entities are generally responsible for generating medical bills and initiating collection actions, including referrals to third party debt collectors, making institutional billing practices a primary driver of medical debt entering collections[1,3,8]; and

WHEREAS, the lack of uniform statewide standards and regular auditing of billing practices allows inaccurate medical debts to persist without consistent oversight or accountability[8]; and

WHEREAS, medical debt sent to collections remains on credit reports for up to seven years, particularly if unpaid for more than 180 days, even when the underlying services were medically necessary or unavoidable[2,10,11]; and

WHEREAS, when medical debt is reported to consumer reporting agencies, it negatively affects an individual's credit score, which lenders commonly use to assess creditworthiness and also influences employment and housing opportunities[2,11,13]; and

WHEREAS, patients who experience credit damage from medical debt face documented barriers to financial stability, including reduced access to affordable credit, higher borrowing costs, and constrained economic mobility, all of which are not proportional to personal financial risk-taking behavior[1,5,11]; and

WHEREAS, individuals with lower credit scores frequently face significantly higher interest rates on mortgages, auto loans, student loans, and other forms of credit compared with individuals who have higher credit scores[2,11]; and

WHEREAS, the disproportionate impact of medical debt on vulnerable populations contributes to long-term financial strain and exacerbates existing socioeconomic disparities[1,5,7,9]; and

WHEREAS, the Consumer Financial Protection Bureau (CFPB) and other consumer protection entities have found that medical debt is not a reliable indicator of repayment of non-medical credit and provides little meaningful predictive value on credit reports compared with other types of debt[10,11,13]; and

WHEREAS, once medical debt is transferred to collections, patients often face substantial procedural, financial, and administrative barriers to disputing billing accuracy or correcting errors, even when the underlying charges are inaccurate or unresolved[3,7]; and

WHEREAS, because of the unpredictable and involuntary nature of medical debt, penalizing patients through credit reporting raises significant concerns about fairness by effectively penalizing individuals for illness rather than for risk-based borrowing or financial irresponsibility[1,5]; and

WHEREAS, several states have enacted or are in the process of enacting legislation to restrict or prohibit the reporting of medical debt to consumer reporting agencies[2,10,12]; and

WHEREAS, in Ohio, HB 257, known as the Ohio Medical Debt Fairness Act, has been introduced and would prohibit hospitals, medical providers, and debt collectors from reporting medical debt to consumer reporting agencies as part of broader protections for patients with medical debt; and

WHEREAS, Colorado, HB 23-1126, passed in 2023, prohibits consumer reporting agencies from including medical debt on credit reports, and in New York, legislation signed in 2023 similarly prohibits the inclusion of medical debt on consumer credit reports, actions that have been associated with lower prevalence of medical debt on credit records in those states[11,13]; and

WHEREAS, in states such as Colorado (Colorado HB 23-1126) and New York (New York S4907A), where medical debt reporting prohibitions took effect in 2023, the proportion of consumers with medical debt appearing on credit reports has approached zero, suggesting that these laws substantially reduce credit-related harm associated with medical debt[11]; and

WHEREAS, unpaid medical bills can lead to aggressive debt collection methods like lawsuits, salary deduction, and harm to credit scores, making financial stress worse for those who have been struggling with healthcare debt[1,3,7]; and

WHEREAS, financial health directly affects patients' access to care, adherence to recommended treatment, and overall well-being, and the linkage of medical debt to credit harm may discourage patients from seeking medically necessary care[5,9]; therefore, be it

RESOLVED, that our OSMA amend Policy 33 - 2025 by addition as follows:

Policy 33 – 2025 – Reducing the Burden of Medical Debt on Patients

The OSMA supports policies that protect patients from negative consequences of medical debt, including, but not limited to, policies that:

a. Limit medical debt interest,
b. Limit wage garnishment due to medical debt,
c. Prohibit placing liens on homes due to medical debt,
d. Set minimum standards for hospital payment plans for patients,
e. Mandate instructions be given to every patient on how to pursue a healthcare facility's payment plan, payment forgiveness, and loan services, and
f. Establish conditions before a hospital can send a bill to collections.
G. PROHIBIT THE ROUTINE INCLUSION OF MEDICAL DEBT IN CONSUMER CREDIT REPORTS, INCLUDING DEBT ARISING FROM MEDICALLY NECESSARY CARE, EMERGENCY SERVICES, INSURANCE DENIALS, OR COST-SHARING OBLIGATIONS BEYOND A PATIENT'S CONTROL.
H. ESTABLISH MINIMUM STATEWIDE MEDICAL BILLING ACCURACY STANDARDS, INCLUDING AUDITING OR OVERSIGHT MECHANISMS.
I. ENSURE THAT ALL DISPUTES BETWEEN PATIENTS, INSURERS, AND HEALTHCARE SYSTEMS ARE RESOLVED BEFORE MEDICAL BILLS ARE SENT TO COLLECTIONS.

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

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Relevant OSMA Policy:

Policy 33 – 2025 – Reducing the Burden of Medical Debt on Patients

1. The OSMA support policies that protect patients from negative consequences of medical debt, including, but not limited to, policies that:
    a. Limit medical debt interest,
    b. Limit wage garnishment due to medical debt,
    c. Prohibit placing liens on homes due to medical debt,
    d. Set minimum standards for hospital payment plans for patients,
    e. Mandate instructions be given to every patient on how to pursue a healthcare facility's payment plan, payment forgiveness, and loan services, and
    f. Establish conditions before a hospital can send a bill to collections.

Relevant AMA Materials:

Patient Medical Debt H-373.990

1. Our American Medical Association encourages health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.
2. Our AMA support innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or

litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.

3. Our AMA support amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection.
4. Our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing.
5. Our AMA support patient education on medical debt that addresses dimensions such as:
    a. patient financing programs that may be offered by hospitals, physicians' offices, and other non-physician provider offices;
    b. the ramifications of high interest rates associated with financing programs that may be offered by a hospital, a physician's office, or other non-physician provider's office;
    c. potential financial aid available from a patient's hospital and/or physician's office; and
    d. methods to reduce high deductibles and cost-sharing.

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA support the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and support medical debt resolution being portrayed in a positive and productive manner.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 13 – 2026

Introduced by: Medical Student Section

Subject: Advancing Structural Competency, Implicit Bias Training, and Protections for Healthcare Workers and Trainees in Ohio

Referred to: Resolutions Committee No. 1

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WHEREAS, implicit bias has been found in medical students, residents, and healthcare professionals against persons of color, ranging from slight-moderate bias to significant bias, where a study found that 70% of physicians reported some bias against Black and Hispanic populations[1]; and

WHEREAS, higher levels of implicit bias have been linked to poorer patient-provider communication in minority communities - Black, Hispanic, and American Indian - with high rates of unfair treatment linked to these populations, as well as negative changes in treatment decisions, patient adherence to recommendations, and health outcomes[2]; and

WHEREAS, implicit racial bias has been linked to physician diagnostic uncertainty, poor professional community, undertreatment of pain, and views of minority patients as being non-compliant, linking to poorer health outcomes[3]; and

WHEREAS, medical students, residents, fellows, and other healthcare trainees experience discrimination, harassment, and microaggressions in clinical training environments on the basis of race, ethnicity, gender, sexual orientation, disability, and other intersecting identities, which negatively impacts psychological safety, professional development, reporting behavior, and retention in medicine, while also contributing to high levels of burnout, depression, and suicidal ideation among trainees[4,5]; and

WHEREAS, women and gender-marginalized trainees experience disproportionate mistreatment in clinical training environments, including sexual harassment, public humiliation, biased evaluations, denial of training opportunities, and unwanted sexual advances, often perpetrated by supervising physicians[6,7]; and

WHEREAS, hierarchical clinical training environments can deter medical students and other healthcare trainees from reporting discrimination, harassment, and bullying due to fear of retaliation, negative evaluations, career consequences, and perceived futility, with a significant proportion of trainees indicating they would not formally report mistreatment even as bystanders, instead relying on informal peer support[8,9]; and

WHEREAS, social determinants of health, such as housing instability, employment, food insecurity, social isolation and lack of support, and transportation access, has a profound impact on health outcomes and contribute to health disparities seen in marginalized groups, including reduced access to services, delays in care, chronic co-morbidities, and longer travel to services[10]; and

WHEREAS, structural determinants of health often help to shape patient behaviors and should be included when assessing interventions to promote better outcomes, but can be unrecognized by health professionals, leading to exacerbating implicit biases and health inequities[11]; and

WHEREAS, integration of structural competency and implicit bias training has been shown to improve health outcomes by improving healthcare workers knowledge and attitudes towards all populations, leading to improvements in advocating for the betterment of clinical and social systems and in clinical decision-making and outcomes, patient communication, patient adherence, and overall health equity[11,12]; and

WHEREAS, the state of Ohio lacks standardized statewide requirements to ensure consistent, evidence-informed implicit bias education and accountability across healthcare settings, allowing wide variation in training quality and follow-through; and

WHEREAS, national organizations such as the American College of Obstetricians and Gynecologists and American Medical Association recognize that preventing discrimination and bias in healthcare and clinical training environments requires clear organizational policies, structured training, confidential reporting mechanisms, and systems-level approaches to support safety and equity for patients and healthcare workers[12,13]; and

WHEREAS, psychological safety in clinical learning environments is associated with reduced burnout, improved retention, increased reporting of safety concerns, and decreased medical harm, underscoring the importance of trainee protections as a patient safety issue[14]; and

WHEREAS, AMA Policy H-65.951 affirms that healthcare organizations should establish training requirements addressing systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system, including medical staff, students, trainees, patients, employees, and contractors[15]; and

WHEREAS, the Ohio State Medical Association has previously recognized the importance of cultural competency and anti-racism training through Policy 25-2017 (“Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities”) and Policy 35-2019 (“Integrating Anti-Racism Training in Medical School and Graduate Medical Education Curricula and Admissions”), demonstrating the need for updated guidance that builds upon existing OSMA policies by incorporating structural competency, implicit bias mitigation, and workplace protections for healthcare workers and trainees; therefore be it

RESOLVED, that our OSMA recognize implicit bias, structural inequities, and systemic discrimination as significant contributors to clinical disparities and patient safety risks within Ohio's healthcare system and medical education institutions; and be it further

RESOLVED, that our OSMA support evidence-informed practices that prevent and address discrimination, implicit and explicit bias, and microaggression and be it further

RESOLVED, that our OSMA support the implementation of evidence-based implicit bias mitigation training and structural competency education for healthcare professionals across Ohio; and be it further

RESOLVED, that our OSMA supports the development or adoption of standardized, evidence-based guidelines for health systems and educational programs in Ohio to help structure implicit bias and structural competency training, including guidance on learning objectives, non-punitive evaluation metrics, and sustained skill-building.

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

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Relevant OSMA Policy:

Policy 25 – 2017 – Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

1. The OSMA encourages all medical education institutions in Ohio to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician's role in eliminating cultural health care disparities in medical treatment.

Policy 05 – 2019 – Advancing Gender Equity in Medicine

The OSMA adopts the following, which is adapted from American Medical Association policy/directives:

1. That the OSMA supports gender and pay equity in medicine consistent with the American Medical Association Principles for Advancing Gender Equity in Medicine (see below AMA Policy H-65.961 as adopted at the 2019 AMA Annual Meeting);

2. That the OSMA: (a) Promote institutional, departmental, and practice policies, consistent with federal and Ohio law, that offer transparent criteria for initial and subsequent physician compensation; (b) Continue to advocate for pay structures based on objective, gender-neutral criteria; (c) Encourages training to identify and mitigate implicit bias in compensation decision making for those in positions to determine physician salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;
3. That the OSMA recommends as immediate actions to reduce gender bias to: (a) Inform physicians about their rights under the Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination; (b) Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and (c) Work with relevant stakeholders to advance women in medicine;
4. That the OSMA collaborate with the American Medical Association initiatives to advance gender and pay equity;
5. That the OSMA commit to the principles of pay equity across the organization and take steps aligned with this commitment.

Policy 35 – 2021 – Integrating Anti-Racism Training in Medical School and graduate medical education curricula and admissions

1. The OSMA recognizes the benefit of anti-racism training in medical school and graduate medical education program curricula and admissions processes in increasing diversity of the medical field. 2. The OSMA recommends all Ohio medical schools and graduate medical education programs utilize credible resources to implement recurrent, interactive (in-person or virtual) anti-racism training for medical students and graduate medical trainees and for all admission/selection committee members.

Relevant AMA Materials:

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.

- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

• These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.

- Providing designated support person to confidentially accompany the person reporting an event through the process.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 14 – 2026

Introduced by: Medical Student Section

Subject: Protections for Incarcerated Individuals

Referred to: Resolutions Committee No. 1

WHEREAS, Nearly 46,000 individuals are currently incarcerated in Ohio[1], including 550 juveniles[2], and 3,500 women and state prisoners released in 2018 spent an average of 2.7 years in prison[5]; and

WHEREAS, the three-year recidivism rate for adults is 20.8%[3] and for juveniles is 43.2% in Ohio[4]; and

WHEREAS, Young people who have been previously incarcerated are nearly six times more likely to experience early mortality than young people who have not been incarcerated[6]; and

WHEREAS, Ohio has incarceration rate of 118 women per 100,000 residents, a higher rate than nearly every country on the planet[7,8]; and

WHEREAS, There are nearly 55,000 annual admissions of pregnant people to U.S. jails, and pregnancies that end in jail resulted in 64% live births, 18% miscarriages, and 15% induced abortions [9]; and

WHEREAS, Prisons and jails are poorly positioned to provide proper health care and often offer less services for women[10], including limited access to menstrual products, obstetric services, and emergency miscarriage treatment[11]; and

WHEREAS, Incarcerated populations often have higher rates of chronic illnesses, substance use disorders, and infectious diseases, which can go untreated or undertreated in correctional facilities[12-16]; and

WHEREAS, A significant proportion of incarcerated individuals have mental health conditions, yet access to mental health services in correctional facilities is often inadequate[17]; and

WHEREAS, The financial resources of incarcerated people are incredibly limited with incarcerated Ohioans making $6-$24 per month or $0.21-$1.23 per hour[18];and

WHEREAS, Incarcerated individuals are required to work without minimum wage coverage or workplace safety guarantees, face additional punishment such as solitary confinement, denial of opportunities to reduce their sentence, and loss of family visitation[19]; and

WHEREAS, Incarcerated workers are not covered by minimum wage laws or overtime protection, are not afforded the right to unionize, and are denied workplace safety guarantees[19]; and

WHEREAS, Incarcerated individuals generally cannot use their private health insurance while in custody, are suspended from and Medicaid and Medicare benefits, in addition to being billed booking or daily fees as Ohio partakes in “Pay-to-Stay” programs typically are suspended or terminated while incarcerated[20,23]; and

WHEREAS, Copayments in Ohio are relatively small sums, at $2.00 for nonemergent visits[21], but pose a substantial deterrent to the appropriate and timely access to all health care within correctional institutions[22]; and

WHEREAS, Past instances of inadequate healthcare, medical neglect, and abuse within correctional facilities have highlighted the importance of robust quality assurance and oversight mechanisms[24,25]; and

WHEREAS, Incarcerated individuals may be vulnerable to coercion or may lack information about their healthcare rights, highlighting the need to protect their autonomy, ensuring that they are actively engaged in their healthcare decisions and that their rights are respected[26]; and

WHEREAS, Preventive care programs, including vaccinations and screenings, are vital to reducing health disparities among the incarcerated population[13,27-29]; and

WHEREAS, Completion of pre-arrest diversion-to-treatment programs have been associated with subsequent reductions in recidivism, incarceration, HIV and Hepatitis C infections, and overdose deaths[30,32]; and

WHEREAS, completion of community-based youth diversion programs have been associated with a significant reduction in recidivism, and furthermore 18% of youths who completed such programs received court re-referrals compared to 44.0% of those who did not[31]; and

WHEREAS, there remains a significant lack of standardized correctional medicine curricula in medical education to prepare medical personnel for the unique health challenges faced by justice-affected individuals[33,34]; and therefore be it

RESOLVED, Our OSMA support the elimination of financial barriers to medical care in correctional facilities, including but not limited to:

a. Prohibition of the use of co-payments to access healthcare services;
b. Elimination of “Pay-to-Stay” billing models, or other similar programs; and
c. Encouraging state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated; and be it further

RESOLVED, Our OSMA support the implementation of necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including but not limited to gynecological care and obstetrics care for individuals who are pregnant or postpartum; and, be it further

RESOLVED, Our OSMA support the implementation of comprehensive mental health services for all incarcerated individuals and juveniles; and, be it further

RESOLVED, Our OSMA support a public health-centered criminal justice system by:

a. Supporting the implementation of preventative care programs for the incarcerated;
b. Supporting efforts to reduce the reliance on incarceration, particularly for non-violent offenders;
c. Supporting evidence-based diversion and community based rehabilitation programs including, but not limited to, specialized drug, mental health, veteran, and sobriety courts
d. Supporting the collaboration of correctional health workers and community health care providers for patients transitioning from a correctional institution to the community;
e. Supporting the protection of human rights for incarcerated workers, including improved workplace conditions and fair wages for labor performed while incarcerated

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

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Relevant OSMA Policy:

Policy 13 – 2024 -- Declaration of Health and Health Care as Human Rights

1. OSMA acknowledges health and access to health care as fundamental human rights.
1. OSMA supports efforts to achieve universal access to timely, and affordable high quality healthcare.

Relevant AMA Materials:

H-430.972 - A Public Health-Centered Criminal Justice System

1. Our AMA recognizes the negative impacts associated with prolonged incarceration, including on the physical and mental health of justice-involved individuals and their families.
2. Our AMA supports efforts to reduce the reliance on incarceration, particularly for non-violent offenders, with recognition that rehabilitation and successful reentry into the community requires adequate support systems and services.
3. Our AMA supports a system of continuous review of sentences for individuals who are incarcerated providing the opportunity for those who demonstrate rehabilitation and pose a minimal risk to society to be considered for early release.
4. Our AMA supports providing judges with the discretion to help ensure that sentences are fair and fit the crime, while protecting against unjust and inconsistent results.
5. Our AMA supports additional research to assess the effects of sentencing reforms on the health impacts of individuals who have been incarcerated and public safety.

H-430.986 - Health Care While Incarcerated

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive

physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:
    a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and

d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a) MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b) knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c) knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles.
15. Our AMA advocates for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay.
16. Our AMA strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections be eligible for designation as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities.
17. Our AMA advocates for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons.
18. Our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 15 – 2026

Introduced by: District 2

Subject: Surgical Consent

Referred to: Resolutions Committee No. 1

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WHEREAS, Ohio Rule 4731-25-08 section A calls for surgeon to personally examine patient for elective surgery and personally obtain informed consent; and

WHEREAS, AMA code of ethics has similar requirements under CEJA guidelines; and

WHEREAS, several physicians are relegating this to their PA or NPs without examining patients themselves. First time they meet the patient is in preoperative area where they do examination and proceed to informed consent and surgery. This means that the decision for surgery was initially made by PA and not physician; and

WHEREAS, this mechanism seems to be skirting the ethical guidelines; and

WHEREAS, OSMA does not have specific policy guidelines in this matter; and

WHEREAS, AMA ethical guidelines are not clearly defining this practice arrangement; and therefore be it

RESOLVED, that our OSMA ask our AMA to re-evaluate its CEJA guidelines regarding initial decision for surgery and informed consent - as practice patterns have changed and more team-based care is being utilized - in order to prioritize and strengthen the physician-patient relationship prior to all medical procedures and interventions; and be it further

RESOLVED, that our OSMA ask our AMA to facilitate the creation of specialty-specific guidelines, inclusive of the entire house of medicine, defining meaningful supervision and informed consent processes for physician-led care.

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

References:

1. None

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 16 – 2026

Introduced by: District 4

Subject: Protection for the Public from Micro Enterprises

Referred to: Resolutions Committee No. 1

WHEREAS, Ohio currently has laws written for the permissive selling of "non-potentially hazardous bakery products; candy jams; jellies; fruit butters; granola; popcorn ; unfilled baked donuts; waffle cones; pizzelles; dry cereal and nut snack mixes with seasonings; roasted coffee; dry baking mixes; dry herbs and dry herb blends; dry seasoning blends; dry tea blends; flavored honey made by a beekeeper exempt under ORC 3715.012; fruit chutney; maple sugar made by a processor of tree syrup exempt under ORC 3715.012; and dry soup mixes containing commercially dried vegetables, beans, grains, and seasoning."; and

WHEREAS, The Ohio legislature is seeking to allow for microentrepreneurs under house bill 134 "To amend sections 3715.01, 3715.021, 3715.022, 3715.023, and 3717.22 and to enact sections 3715.026 and 3715.21 of the Revised Code to authorize the sale of certain homemade foods under a microenterprise home kitchen operation registration." Also known as "Authorize home kitchen registration for sale of certain foods." (1); and

WHEREAS, traditionally the food and drug administration does not have the capabilities of food inspection such as those in the health department. OSMA encourages the coordinated efforts of working with the Ohio department of health in order to ensure that kitchens used for commercially processed foods are inspected and follow the rules and regulation of retail food establishments (2,3,4,5); and therefore be it

RESOLVED, the OSMA officially support amendments to House Bill 134 or related legislation that would mandate health inspections for micro enterprise home kitchens that would be consistent with the standards for retail food establishments.

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

References:

1. https://search-prod.lis.state.oh.us/api/v2/general_assembly_136/legislation/hb134/02_PH/pdf/
2. Food Code Chapter 9 Reference Guide: Facility Layout & Equipment Specifications

3. https://agri.ohio.gov/divisions/food-safety/resources/food-safety-education-programs
4. https://codes.ohio.gov/ohio-revised-code/section-3715.61
5. https://codes.ohio.gov/ohio-revised-code/section-3717.22

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 17 – 2026

Introduced by: Dr. Johnathon Ross, Rohan Sachdeva, Farzana Qurban-Ali, Ella Ryan, Lauren Chan

Subject: Managed-Fee for Service Should Replace Ohio Medicaid Managed Care

Referred to: Resolutions Committee No. 1

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WHEREAS, Ohio Medicaid is a joint federal and state health insurance program for people with low incomes, including people with disabilities, children and families, pregnant women, the elderly, and working adults without affordable insurance; and

WHEREAS, Ohio Medicaid supports the overall health infrastructure, funding safety-net and rural hospitals, as well as long-term care facilities that serve a large proportion of low-income individuals and therefore Ohio Medicaid stabilizes healthcare for entire communities; and

WHEREAS, over 3 million Ohioans are enrolled in Medicaid, with enrollment increasing by 9% since 2020;[1] and

WHEREAS, spending on Medicaid was $43 billion in combined state and federal spending in FY 2025, with 5.8 billion dollars provided via Ohio Provider taxes and 7.8 billion dollars provided by Ohio taxpayers[2]; and

WHEREAS, the 2025 Budget Reconciliation Act reduces federal Medicaid funding by $1 trillion over the next decade, putting enormous pressure on states like Ohio to end optional Medicaid benefits, cut eligibility, reduce provider payments, and/or raise taxes;[3] and

WHEREAS, a large portion of Ohio's Medicaid financing comes from provider payments in the form of the hospital franchise fee, the HIC franchise fee, and Nursing Facility fees;[4] and

WHEREAS, the 2025 Budget Reconciliation Act tightened requirements for provider payments, as well as state directed payments in Ohio beginning in 2026;[4] and

WHEREAS, under the 2025 Budget Reconciliation Act, Ohio officials will have to modify parts of the current Health Insuring Corporation (HIC) franchise fee paid by Managed Care Organizations (MCOs) to meet new federal requirements; otherwise, the

state could lose about $3 billion annually in reduced tax revenue and federal matching funds beginning in state fiscal year 2028;[5] and

WHEREAS, more than 85-90% of Ohio Medicaid beneficiaries receive services through MCOs, meaning that administrative costs and contracting structures substantially influence overall Medicaid spending and access to care in the state;[2,5,6] and

WHEREAS, according to an independent financial review of Medicaid managed care in 2024, only 84.5% of Ohio funding for Medicaid was spent on medical care, with 9.4% going towards administrative costs, and the rest going towards taxes and MCO profit demonstrating significant overhead present in the current system;[7] and

WHEREAS, the capitated payment model present in Medicaid managed care can incentivize pre-authorization denials and minimization of enrollee services as MCO's are paid fixed amounts per enrollee, regardless of true medical cost;[8] and

WHEREAS, this same capitated model encourages MCO's to avoid or deny coverage for higher risk patients to maximize profit, as the risk assessment increases in funding under the capitated model often do not offset high costs of high-risk patients;[8] and,

WHEREAS, managed care organizations (MCOs) were initially adopted to control costs while maintain quality, yet current reports indicate that MCOs fail to curb costs and may even increase them;[9] and

WHEREAS, a recent economic analysis of fiscal costs of Medicaid following outsourcing indicating that counties which administered mandated managed care experienced on average a 9.8 % higher cost 4 years post switch to Medicaid managed care;[9] and

WHEREAS, in Medicare advantage, a similarly run program, original Fee-For-Service Medicare was found to have much lower administrative costs percentage when compared with Private Medicare Advantage Plans which utilized MCO managed care;[10] and

WHEREAS, researchers examined Medicaid MCOs within 14 states, finding that 34% of primary care physicians decided to exit Medicaid over a five-year period due to high administrative burden and low reimbursements under Medicaid Managed care, which indicates poorer access and potential increase in disease burden under managed care;[8,11]and

WHEREAS, lack of cost control, significant overhead costs, and future restriction on provider taxes and taxation of MCOs indicate that more savings are needed to prevent Medicaid disenrollments, with one possible solution being Medicaid deprivatization; and

WHEREAS, Ohio already has a history of successful deprivatization, as in 2022, Ohio deprivatized Medicaid from being overseen through multiple pharmacy benefit managers and MCOs under a capitated model to a single pharmacy Benefit Manager;[12] and

WHEREAS, Ohio re-centralized oversight of Medicaid Pharmacy Management and eliminated the capitated payment model which allowed for spread pricing practices while maintaining control of formulary;[12] and

WHEARAS, Milliman reports that Ohio saved $140 million net over a two-year period – $330 million in total administrative cost savings – while boosting the dispensing fees they pay to retail pharmacies by 1200%, reducing administrative burden, and significantly expanding their network of Medicaid-participating pharmacies;[12] and

WHEREAS, the Medicaid pharmacy sector increased savings and access, indicating that centralization has worked previously in Ohio and could potentially work again through a return to a managed fee-for-service model and single administrative services organization for Ohio Medicaid;[13] and

WHEREAS, if Ohio shifted from MCOs to direct payments of Medicaid providers through managed fee-for-service, Ohio could reduce their Medicaid MCO expenditures by 10 to 17 percent due to reduced administrative costs and improved primary care coordination, as demonstrated in Connecticut;[13] and

WHEREAS, Husky Medicaid, the Connecticut model for Medicaid, is a “managed-fee-for-service" or “enhanced Primary Care Case Management,” model in which the state pays the providers directly while compensating primary care practices for care coordination services rather than delegating financial risk to managed care organizations;[13] and

WHEREAS, in managed fee-for-service models such as Husky Medicaid, primary care practices receive enhanced payments to coordinate care, facilitate specialty referrals, and manage high-risk patients, helping strengthen longitudinal primary care;[13] and

WHEREAS, primary care utilization has been associated with lower emergency department visits, fewer preventable hospitalizations, improved utilization of preventative medicine, and reduced healthcare spending;[14] and

WHEREAS, for HUSKY Medicaid, Connecticut eliminated MCO model contracts and implemented a state-administered care coordination model utilizing a single administrative services organization (similar to the single service organization overseeing pharmacy benefit management in Ohio), resulting in a 33% increase in physician participation in the first year, reductions in emergency department visits and hospitalizations, and a 15% reduction in per-member Medicaid costs within five years;[15,16] and

WHEREAS, Connecticut reported that their overall Medicaid costs were 14% lower than comparable northeast states managing care through at risk MCOs;[17] and

WHEREAS, in the 13 intervening years, the state of Connecticut has saved more than $4 billion of taxpayer money both through increased care coordination via primary care providers and decreased costs from elimination of MCO overhead;[18]and

WHEREAS, a well-researched report found that without MCOs, Connecticut performs better than most states on about 70% of Medicaid quality measures;[17] and

WHEREAS, ninety seven percent of providers are satisfied with the program and provider participation grew 5.4% from 2021 to 2022;[18] and

WHEREAS, Connecticut Medicaid only spends 3% of total costs on administrative expenses, which is far below Ohio's MCO related overhead of approximately 15%; [7,19] and

WHEREAS, implementing a managed fee-for-service model with oversight through a single administrative services organization for Medicaid akin both to Ohio's Single Pharmacy Benefit Manager system and Connecticut's Husky Model could control costs through reduced overhead burden and improved care coordination, ultimately improving care outcomes in Ohio;[13] and

WHEREAS, OSMA has advocated in the past for Medicaid Managed Care standardization and decreases administrative and pre-authorization burden, but has not yet focused efforts on the implementation of a managed fee-for-service model which improves standardization and decreases physician burden; [20] therefore be it

RESOLVED, that our OSMA support legislation to remove Medicaid Managed Care and adopt a managed fee for service model via an Administrative Services Organization to increase savings and reduce disenrollment of Medicaid-eligible Ohioans due to federal budget cuts; and be it further

RESOLVED, that our OSMA supports the utilization of a managed fee for service model which encourages primary care coordination to reduce long-term spending while improving care outcomes.

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

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Relevant OSMA Policy:

Policy 16 – 1989 – Medicaid Physician Reimbursement

1. The OSMA encourages the Ohio Department of Medicaid to develop realistic and appropriate physician reimbursement for Medicaid services and remove the disincentives evident by the burdensome administrative paperwork required.
2. The OSMA will continue to work to obtain adequate Medicaid funding to ensure patient access and physician reimbursement.

Policy 42 – 2008 – Reform of Medicaid Managed Care

1. The OSMA continues to work with the State of Ohio to reform the current Medicaid managed care system to make it easier for Ohio physicians to care for this group of patients.

Policy 7 – 2009 – Medicaid Reform

1. The OSMA shall work to get one set of rules for the Medicaid system.
2. The OSMA shall work to be sure that patients who are on an approved drug in one program and are switched to another program may continue the drug without another prior authorization from the physician's office (thus requiring communication between managed care programs when a patient moves from one to another).
3. The OSMA shall work to eliminate current barriers to traditional referral patterns for complicated patients who need a tertiary center regardless of which provider group they are in.
4. The OSMA shall work to eliminate needless hassles for physicians in their offices in obtaining prior authorization for medications and testing.
5. The OSMA shall encourage a statewide source of up-to-date verification of a patient’s coverage.

Policy 29 – 2012 – Denial of Care by Medicaid Managed Care Programs
1. The OSMA opposes any Medicaid payer's action of requesting proof of qualifications from physicians who have already been credentialed in the program as specialists.
2. The OSMA shall continue to work with all Medicaid entities to decrease the administrative burden for physicians who agree to care for Medicaid patients.

Policy 26 – 2020 – Bundled Payments and Medically Necessary Care
1. The OSMA will work with Ohio Medicaid to make sure that medically necessary care is done for all patients and that Episodes of Care be carefully reviewed to make sure that the system is reasonable and fair to all, including patients and physicians.
2. The AMA Delegation will take the issue of "Bundled Payments and Medically Necessary Care" to the AMA Annual Meeting for study and report back to the AMA HOD, to make sure that our health care system is reasonable and fair to all, allows for medically appropriate and necessary care for our patients, and allows for fair reimbursement for physicians.

Policy 5 – 2024 -- Cost of Living Payment Increases
1. OSMA continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;
2. OSMA supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the medicare population, and the cost of new technology;
3. OSMA affirms the right of patients and physicians to privately contract for medical services;
4. OSMA supports a mandatory annual "cost-of-living" or cola increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Policy 19 – 2024 -- Insurer Accountability When Prior Authorization Harms Patients
1. OSMA will advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts.
2. The OSMA House of Delegates directs the OSMA AMA delegation to take this policy to the American Medical Association House of Delegates for further consideration.

Relevant AMA Materials:
1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 18 – 2026

Introduced by: Medical Student Section

Subject: Promote Monitoring of Private Equity Acquisitions and Advocate for Safeguarding Physician Clinical Autonomy

Referred to: Resolutions Committee No. 1

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WHEREAS, rapidly expanding private equity (PE) ownership in healthcare across Ohio jeopardizes quality patient-centered care with significant increases in charges per claim (20.2%) and healthcare overutilization in a shifting private market-driven system[1]; and

WHEREAS, PE business models, often characterized by leveraged buyouts, aggressive debt service obligations, and short-term profit extraction, can compromise patient safety, exhibiting a 25.4% increase in hospital-acquired conditions[2]; and

WHEREAS, PE involvement in Ohio's healthcare system has reached substantial levels, with 20 hospitals in Ohio as PE-owned, representing nearly 8% of hospitals in the state[3,4]; and

WHEREAS, Steward Health Care, a for-profit system formerly owned by a PE firm, filed for Chapter 11 bankruptcy in 2024, which resulted in the closure of essential healthcare facilities and layoffs in northeast Ohio, limiting access to care[5,6]; and

WHEREAS, PE has increased physician turnover, up to 13% after acquisition, relative to non-PE-acquired practices[7]; and

WHEREAS, surveys indicate that a majority of physicians believe PE ownership diminishes clinical independence and increases burnout, by placing financial interests above the ethical duty toward patient care[8,9]; and

WHEREAS, physician clinical autonomy refers to the freedom of individual physicians to treat their patients without undue or inappropriate influence of external parties[10]; and

WHEREAS, states such as California and Massachusetts have enacted healthcare ownership transparency and transaction reporting laws that expand pre-closing notice requirements, increase disclosure of PE entities, and require post-transaction monitoring, which all serve as essential mechanisms for state regulators to oversee market consolidation and prevent transactions that threaten care continuity and

physician autonomy[11-13]; and

WHEREAS, current OSMA policy affirms the principles of physician autonomy but lacks specific directives regarding the threats posed by the opacity and financial structures of PE investments, such as non-compete and non-disclosure agreements[14,15]; therefore, be it

RESOLVED, that our OSMA supports mandates that healthcare facilities and medical practices in Ohio publicly disclose their ownership structure, including the identity of any private equity investors, in order to support monitoring of such private equity activity and strengthen OSMA advocacy efforts that protect physicians' clinical autonomy against these entities; and be it further

RESOLVED, that our OSMA supports protections for physicians employed by private equity-backed entities, including due process rights regarding termination, protection from retaliation for advocating for patient safety, and prohibitions on restrictive covenants that limit physician mobility.

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

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Relevant OSMA Policy:

Policy 14–2025 – Support Physician Owned Hospitals

1. The OSMA will support policies that restore physician’s options of owning, expanding, and/or constructing any form of hospital.
2. The OSMA will collaborate with stakeholders to develop and promote policies that support physician ownership of hospitals.

Policy 08-2016 - Employed Physicians

1. The OSMA affirms its support for H-225.950 AMA Principles for Physician Employment and will explore state legislation to preserve physician autonomy in the employed setting.
2. The OSMA affirms its support for the principle, as codified in Ohio Revised Code sections 1701.03 (for profit corporations), 1704.04 (limited liability companies), 1785.03 (professional associations) and 4731.31 (rural hospitals), that corporations cannot control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed physician in rendering care, treatment, or professional advice to an individual patient.
3. The OSMA will explore legislation or other regulation mandating due process and dispute resolution when a physician is terminated as a result of the physician exercising clinical judgment.
4. The OSMA opposes the use of restrictive covenants in physician contracts that are not consistent with the AMA principles of physician employment agreements.
5. The OSMA shall make the AMA principles of physician employment agreements easily available to all Ohio physicians.

Relevant AMA Materials:

H-160.904 Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery

1. Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.

H-310.901 The Impact of Private Equity on Medical Training

1. Our American Medical Association will affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity.
2. Our American Medical Association will encourage GME training institutions, programs, and relevant stakeholders to:
    a) Demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees.
    b) Uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure.
    c) Empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty.
    d) Develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels.
    e) Develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners.
3. Our AMA will encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution.
4. Our AMA will support publicly funded independent research on the impact that private equity has on graduate medical education.
5. Our AMA will encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community.
6. Our AMA will encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial

implications of existing funding that is used to support that training.

H-160.891 Corporate Investors and Other Corporate Entities

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
    a) Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
    b) Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
    c) External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
    d) Retaining negotiators to advocate for the best interests of the practice and its employees should be considered.
    e) Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f) Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
    g) Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
    h) Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
    i) Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
    j) Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
        i. Determining which diagnostic tests are appropriate;
        ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
        iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;

iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
v. Determining the content of patient medical records;
vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
viii. Making decisions regarding coding and billing procedures for patient care services; and
ix. Approving the selection of medical equipment and medical supplies.

k) Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non physician practitioners.
l) Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m) Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

H-215.960 Hospital Consolidation

1. Our American Medical Association affirms that:
a) Health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs.
b) The AMA strongly supports and encourages competition in all health

care markets.
c) The AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and provide
d) Antitrust relief for physicians remains a top AMA priority.

2. Our AMA will continue to support actions that promote competition and choice, including:
    a) Eliminating state certificate of need laws.
    b) Repealing the ban on physician-owned hospitals.
    c) Reducing administrative burdens that make it difficult for physician practices to compete.
    d) Achieving meaningful price transparency.
3. Our AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

D-215.983 Physician-Owned Hospitals

1. Our American Medical Association will advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type.
2. Our AMA will study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and the impact on competition in highly concentrated hospital markets.
3. Our AMA will continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals.
4. Our AMA will work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership.
5. Our AMA will collaborate with other stakeholders to develop and promote policies that support physician ownership of hospitals.

H-140.984 Physicians' Involvement in Commercial Ventures

Our American Medical Association opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements:

(1) Opportunity to Invest - The opportunity to invest in the medical or health care facility established by a health care service(s) (HCS) financial arrangement should be open to all individuals who are financially able and interested in the investment. This would include non-physicians. The only exception allowed would be for a sole community health care provider where ownership could be limited to potential referring physicians or their immediate family due to a lack of other individuals who have sufficient capital and interest to establish the facility.

(2) Real Investment at Risk - Each investor should be undertaking a real financial risk similar to that which might occur in any other similar commercial investment.

A referring physician should not be allowed to become involved in the HCS investment without incurring a real financial risk. The ability of a physician to refer patients must not be considered "capital" to become an investor in the facility. Each investor in the medical facility must be at risk by virtue of a binding commitment to capitalize the venture, such as a commitment to contribute money, property or services.

(3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest investment for failure to refer patients. No investor can be required to divest because they move from the area or ceases practicing medicine.

(4) Distribution of Profit or Equity - Distribution should be based generally on the amount contributed to capital. Remuneration or profit distribution may not be related to patient referrals.

(5) Disclosure of Ownership Interest - A physician or other health care professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to their practice situation.

(6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including their own facility.

(7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which they refer patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.

(8) Internal Utilization Review Program - Each medical facility with referring physician owners (or immediate family members) must have an internal utilization review program to monitor referrals by such physicians. Regular reports from this internal program should be made available to the Medicare carrier on request.

(9) Compliance with Standards - Failure to comply with any one individual standard or compliance with all the standards, in and of itself, would not be sufficient to find that the arrangement is illegal. The entire arrangement needs to be examined to determine whether it is merely a sham arrangement to conceal a kickback scheme or whether it is "legal." Failure to comply with standards would subject the HCS investment arrangement to further scrutiny.

H-225.950 AMA Principles for Physician Employment

1. Addressing Conflicts of Interest
    a) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
    d) A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
        i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
        ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
    e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
    a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c) When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
    e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements

should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
    i. The agreement is for the provision of services on an exclusive basis.
    ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
    iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer

review.

6. Payment Agreements
    a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
    c) The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 19 – 2026

Introduced by: Senior Physician Sections

Subject: Make De-prescribing a Priority Especially as a Part of Care of Seniors

Referred to: Resolutions Committee No. 1

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WHEREAS, the prevalence of polypharmacy has tripled over the last twenty years[1]; and

WHEREAS, 4 out of 10 people older than 65 take five or more medications, putting them at risk of adverse drug toxicity, falls, delirium, cognitive impairment and decreased quality of life[1]; and

WHEREAS, the demographic surge of people older than 65 will only make the problem more prevalent; and

WHEREAS, de-prescribing, the proactive and systematic identification and discontinuation of medications with potential risk greater than potential benefits, offers a significant opportunity to improve patient safety and quality of care; and

WHEREAS, the Agency for Healthcare Research and Quality (AHRQ) has designated de-prescribing as a patient safety priority; therefore be it

RESOLVED, that our Ohio State Medical Association declare that deprescribing, the proactive and systematic identification and discontinuation of medications with potential risk greater than potential benefits, is a medical priority in the management of all patients, especially senior patients, and be it further

RESOLVED, that our OSMA advocate for the integration of deprescribing as a standard component of high-quality prescribing practices (Directive to Take Action); and be it further

RESOLVED, that our OSMA encourage the development of educational initiatives and clinical decision support tools to facilitate safe and effective deprescribing, (Directive to Take Action); and be it further

RESOLVED, that our OSMA call for research and policy efforts to address barriers to implementation of deprescribing in routine medical care (Directive to Take Action); and be it further

RESOLVED, that our OSMA encourage all insurers to reimburse deprescribing activities (Directive to Take Action).

Fiscal Note: $ 500 (Sponsor)
$ 50,000 (Staff)

References:

1. Lown Institute. (n.d.). *Medication overload and older Americans: How the drive to prescribe is harming older Americans.* Retrieved September 2, 2025, from https://lowninstitute.org/projects/medication-overload-how-the-drive-to-prescribe-is-harming-older-americans/Linsky AM, Motala A, Lawson E, et al. Deprescribing To Reduce Medication Harms in Older Adults: Rapid Response. 2024 Feb.In: Making Healthcare Safer IV: A Continuous Updating of Patient Safety Harms and Practices [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2023 Jul-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK600387/

Relevant OSMA Policy:

1. None

Relevant AMA Materials:

Safe and Efficient E-Prescribing H-120.921

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
C. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.

G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
I. Organizational leadership to designate e-prescribing as the default prescription method.
J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
K. States to allow integration of PDMP data into EHR systems.
L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Citation: BOT Rep. 20, A-19

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928

1. Our American Medical Association will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Citation: Res. 515, A-22

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 20 – 2026

Introduced by: District 4

Subject: Immunization Re-Affirmation

Referred to: Resolutions Committee No. 1

WHEREAS, the OSMA recognizes that vaccines are key to preventing many communicable diseases and that federal vaccination schedules have changed for 2026(1); and

WHEREAS, many states and organizations have published separate vaccine schedules that differ from CDC guidelines with a focus on preventing diseases and reducing infections (2,3,4,5); and therefore be it

RESOLVED, that the resolution reaffirms policy 42-2025 "Childhood Immunization Requirements", and policy 21-2017 "Removal of Non-medical Exemptions for mandated immunization and support of immunization registries" policy 17-2022 "Supporting Vaccinations in Ohio"; and be it further

RESOLVED, No Physician should be penalized for adhering to recognized evidence based immunization guidelines that are contrary to the CDC but are endorsed by AMA.

Fiscal Note: $ 50,000 (Sponsor)
$ 500 (Staff)

References:

1. https://www.cdc.gov/media/releases/2026/2026-cdc-acts-on-presidential-memorandum-to-update-childhood-immunization-schedule.html
2. https://www.mass.gov/news/governor-healey-announces-evidence-based-childhood-immunization-schedule-aligning-with-american-academy-of-pediatrics
3. https://www.mass.gov/news/governor-healey-condemns-cdc-rollback-of-childhood-vaccine-recommendations
4. https://publications.aap.org/redbook/resources/pdfDownload/15585
5. https://www.ama-assn.org/public-health/prevention-wellness/vaccine-recommendations#toc-childhood-vaccine-recommendations-01

Relevant OSMA Policy:

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 42 – 2025 - Childhood Immunization Requirements

1. The Ohio State Medical Association considers standard childhood immunizations as care necessary for a child's health and well-being.
2. The Ohio State Medical Association, in the absence of medical contraindications, considers it a parent/legal guardian's duty of care to vaccinate THEIR minor children with standard childhood immunizations.
3. The Ohio State Medical Association reaffirm policy 21-2017 "Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries".

Policy 17 –2024 -- Immunization Registry

1. The Ohio State Medical Association will make every effort to encourage the Ohio Legislature to require that all vaccine providers participate in Impact SIIS (Statewide Immunization Information System).
2. Vaccine providers in the United States should be required to report all immunizations to their respective state immunization registry for both adults and children.
3. OSMA delegation to the AMA take this resolution to the AMA House of Delegates for their consideration.
4. OSMA supports the reporting of immunizations to state registries to be reimbursed by public and private payors.

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 21 – 2026

Introduced by: Noam Stern, MD; District 5

Subject: Endorsing the Vaccine Schedule of the American Academy of Pediatrics

Referred to: Resolutions Committee No. 1

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WHEREAS, in 2025, all 17 members of the CDC's Advisory Committee on Immunization Practices were removed[1] and replaced with individuals who lacked the expertise in vaccine science and public health of the prior committee members[2]; and

WHEREAS, in January of 2026, the CDC removed routine recommendations for hepatitis A and B, COVID-19, rotavirus, respiratory syncytial virus, influenza, and meningococcal disease from their vaccine schedule; without undergoing the standard process for scientific review[3]; and

WHEREAS, the American Academy of Pediatrics (AAP) has, since 1934, routinely recommended a childhood vaccination schedule. Since the CDC began publishing a vaccine schedule in 1964, it had previously largely aligned with the vaccination schedule of the AAP[4]; and

WHEREAS, in response to the changes in the CDC's vaccination schedule, the childhood vaccination schedule recommended by the AAP has now been endorsed by the American Medical Association in addition to 11 other medical groups, including the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, the Council of Medical Specialty Societies, the National Medical Association, and the Society for Adolescent Health and Medicine[5]; and therefore be it

RESOLVED, that our OSMA endorses the child and adolescent vaccine schedule of the American Academy of Pediatric; and be it further

RESOLVED, that our OSMA supports using the child and adolescent vaccine schedule of the American Academy of Pediatrics as the standard guideline for the Ohio Department of Public Health and Ohio schools.

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

References:

1. https://www.nfid.org/experts-sound-alarm-after-acip-members-removed/
2. https://www.nbcnews.com/health/health-news/rfk-jr-vaccine-panel-lacks-experience-not-meet-cassidy-says-rcna214658
3. https://www.npr.org/sections/shots-health-news/2026/01/09/nx-s1-5671750/cdc-childhood-vaccines-universal-recommendation-rotavirus-hepatitis
4. https://publications.aap.org/aapnews/news/32762
5. https://www.ama-assn.org/public-health/prevention-wellness/pediatric-vaccines-questions-parents-will-ask-and-how-answer

Relevant OSMA Policy:

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 42 – 2025 - Childhood Immunization Requirements

1. The Ohio State Medical Association considers standard childhood immunizations as care necessary for a child's health and well-being.
2. The Ohio State Medical Association, in the absence of medical contraindications, considers it a parent/legal guardian's duty of care to vaccinate THEIR minor children with standard childhood immunizations.
3. The Ohio State Medical Association reaffirm policy 21-2017 "Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries".

Policy 17 –2024 -- Immunization Registry

1. The Ohio State Medical Association will make every effort to encourage the Ohio Legislature to require that all vaccine providers participate in Impact SIIS (Statewide Immunization Information System).
2. Vaccine providers in the United States should be required to report all immunizations to their respective state immunization registry for both adults and children.
3. OSMA delegation to the AMA take this resolution to the AMA House of Delegates for their consideration.
4. OSMA supports the reporting of immunizations to state registries to be reimbursed by public and private payors.

Relevant AMA Materials:

1. None

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2026

Introduced by: District 6

Subject: Immunization Informed Consent and Liability

Referred to: Resolutions Committee No. 1

WHEREAS, Informed Consent is the cornerstone of all ethical medical treatment: Informed Consent commands respect for the patient's individual autonomy, for parents' duties and right to care for their children, and for responsible healthcare delivery of the physician and healthcare providers[1]; and

WHEREAS, vaccinations are the only medical treatments in which pharmaceutical companies and healthcare providers are released from liability (despite failure to give Informed Consent) through the National Childhood Vaccine Injury Act of 1986 (NCVIA) and the Public Readiness and Emergency Preparedness Act of 2005 (PREP)[2,3]; and

WHEREAS, frequent and known adverse effects from all vaccinations are widely reported, both in the literature and anecdotally, and the VAERS (Vaccine Adverse Event Reporting System) reports are under-reported by 90%[4-7]; and

WHEREAS, the National Vaccine Injury Compensation Program (NVICP) is supported by taxpayer funds, not pharmaceutical manufacturers, and requirements for acceptance are rigid, the funds are inadequate for remedy in most cases, and most injured patients are not accepted into the program. Notably, the application and award data for the Covid-19 vaccines are missing from Health Resources and Services Administration reporting[8-10]; and

WHEREAS, there has never been a vaccine approved by the FDA that has undergone an independent, peer-reviewed, placebo-controlled study; that vaccine FDA approval is based on prior studies in which safety standards are set by already approved vaccines presumed to be "safe and effective" without baseline studies, and recent vaccine proponents have admitted this[11-13]; and

WHEREAS, the Covid-19 vaccines were novel mRNA technologies, introduced under the EUA (Emergency Use Authorization), and had no product information sheet listing adverse effects, of which pharmaceutical companies, including Pfizer, were aware; and because of prior government policies and mandates, healthcare providers and patients, respectively, were encouraged to administer and receive the vaccines. These immunizations neither prevented Covid nor decreased mortality or morbidity from Covid.

As a result of the widespread use of Covid-19 vaccines, overall morbidity and excess mortality has increased[12-16]; and

WHEREAS, Pfizer attempted to hide results of clinical testing of the mRNA vaccine for 75 years, only to be forced to release the reports through a Freedom of Information Act (FOIA) request[18-19]; and

WHEREAS, alternative treatments, both prophylactic and therapeutic, were available as alternates to mandated, experimental vaccines during the recent Covid-19 pandemic, and FDA and CDC recommendations were driven by political, financial and commercial interests[20-22]; and

WHEREAS, physicians and hospitals were financially incentivized and induced to administer the Covid-19 vaccines which were approved under EUA, without giving patients proper and full informed consent[23,24]; and

WHEREAS, childhood diseases such as diabetes, allergies, and autism have been increasing year by year, and now some authorities are linking this increased morbidity to environmental factors and childhood vaccine schedules, (which have included 33 to 60 immunizations not including recommended influenza and Covid-19 vaccinations). The current FDA has now reduced recommended vaccines[25-26]; and therefore be it

RESOLVED, that OSMA advocates for pharmaceutical company liability for all pharmaceuticals including vaccines; and be it further

RESOLVED that OSMA advocates for individual autonomy, conscientious and non-medical exemptions, and full informed consent for immunizations and opposes universal vaccine mandates; and be it further

RESOLVED, that OSMA supports research regarding immunizations and alternative therapeutics for diseases.

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

References:

1. Informed Consent - StatPearls - NCBI Bookshelf
2. National Childhood Vaccine Injury Act (NCVIA) of 1986 (42 U.S.C. §§ 300aa-1 to 300aa-34). The National Childhood Vaccine Injury Act of 1986 | National Vaccine Information Center (NVIC)
3. PREP Act | Public Readiness and Emergency Preparedness Act
4. Preemption or Exception? The Pandemic Era Informed Consent Debate – Health Law & Policy Brief
5. Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS)

6. VAERS Admits Fewer Than 1% Of Vaccine Adverse Events Are Reported | Armstrong Economics
7. Long-Term Prognosis of Patients With Myocarditis Attributed to COVID-19 mRNA Vaccination, SARS-CoV-2 Infection, or Conventional Etiologies | Cardiology | JAMA | JAMA Network
8. Insult To The Injured: The Case For Modernizing Vaccine Injury Compensation | Health Affairs
9. The PREP Act Swallowed the Bill of Rights
10. HRSA Data and Statistics February 2024
11. https://pmc.ncbi.nlm.nih.gov/articles/PMC4157320/
12. Funding Postauthorization Vaccine-Safety Science | New England Journal of Medicine
13. Breaking: Children's Health Defense Hits AAP With RICO Suit Over Fraudulent Vaccine Safety Claims • Children's Health Defense
14. https://academic.oup.com/ofid/article/10/6/ofad209/7131292#google_vignette
15. https://publichealthpolicyjournal.com/review-of-calls-for-market-removal-of-covid-19-vaccines-intensify-risks-far-outweigh-theoretical-benefits/
16. How Much Do Big Pharma Donations Influence AAP Guidelines for Parents? - Science, Public Health Policy and the Law
17. https://peoplesvaccineinquiry.co.uk/
18. FDA Withholds Over a Million Pages of Pfizer COVID-19 Vaccine Documents Despite Court Order – The Vault Project
19. 001-Complaint-101021.pdf
20. https://res.cloudinary.com/aflds/image/upload/v1658477901/aflds/file_je1b6o.pdf
21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7587171/
22. https://imahealth.org/wp-content/uploads/2021/08/SUMMARY-OF-THE-EVIDENCE-BASE-FINAL.pdf
23. RFK Jr. Ends Financial Incentives for Hospitals That Report Staff Vaccination Rates - Science, Public Health Policy and the Law
24. https://providers.anthem.com/docs/gpp/KY_CAID_PU_COVID19VaccineProviderIncentiveProgram.pdf?v=202110121818
25. https://circleofmamas.com/wp-content/uploads/2021/05/Paul-Thomas-Weiler.pdf
26. https://pmc.ncbi.nlm.nih.gov/articles/PMC7268563/
27. Fact Sheet: CDC Childhood Immunization Recommendations | HHS.gov

Relevant OSMA Policy:

Policy 19 – 2025 - Vaccines

1. The OSMA encourages physicians to become familiar with vaccine adverse safety effects, in order to give full informed consent concerning the risks of any vaccination, including references to VAERS;
2. The OSMA supports encouraging AMA to lobby CDC to simplify the VAERS, allowing vaccine adverse events to be easily reported by health care providers.

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 42 – 2025 - Childhood Immunization Requirements

1. The Ohio State Medical Association considers standard childhood immunizations as care necessary for a child's health and well-being.
2. The Ohio State Medical Association, in the absence of medical contraindications, considers it a parent/legal guardian's duty of care to vaccinate THEIR minor children with standard childhood immunizations.
3. The Ohio State Medical Association reaffirm policy 21-2017 "Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries".

Policy 17 –2024 -- Immunization Registry

1. The Ohio State Medical Association will make every effort to encourage the Ohio Legislature to require that all vaccine providers participate in Impact SIIS (Statewide Immunization Information System).
2. Vaccine providers in the United States should be required to report all immunizations to their respective state immunization registry for both adults and children.
3. OSMA delegation to the AMA take this resolution to the AMA House of Delegates for their consideration.
4. OSMA supports the reporting of immunizations to state registries to be reimbursed by public and private payors.

Policy 17-2022 – Supporting Vaccination in Ohio

1. The OSMA supports the right of public and private entities in Ohio to require vaccines for employees, staff, and students for highly communicable diseases while allowing for medical exemptions.

Relevant AMA Materials:

1. None