



**2026 OSMA Annual Meeting
Resolution Committee Two
Resolutions 23-44**

- #23 - Reconsider OSMA Policy on Gender Dysphoria in Minors**
- #24 - In Support of Designating Hospitals as “Protected Areas” from Ice Surveillance/Action**
- #25 – Supporting Access to Healthcare During Immigration Enforcement**
- #26 - Oppose Denials Based on Referring Provider**
- #27 - Coverage for Physician Prescribed Medications/Products by the Patient’s New Insurance Company**
- #28 - Insurance Company Accountability**
- #29 - Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses**
- #30 - Supporting Safeguards for Physician Autonomy and Patient Access to Care in The CMS Wiser Prior Authorization Model**
- #31 - Promoting Accurate Professional Titles in Health Care Communications and Supporting the ACP Policy 'Physicians Are Not Providers'**
- #32 - Supporting Ohio Medicaid Reimbursement for the Collaborative Care Model (CoCM)**
- #33 - Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians**
- #34 Opposing the Use of State-Managed Public Funds for High-Risk, Illiquid Foreign Bonds and Supporting Reinvestment in Ohio’s Public Health Infrastructure**
- #35 - Legal Protections for Physicians Who Advocate for Medically Appropriate Health Care for Their Patients**
- #36 - Support for Safe and Equitable Access to Voting**
- #37 - Destigmatizing Mental Health**
- #38 - Strengthening Medicaid Mental Health Funding Through Section 1115 Waivers**
- #39 - Support for Perinatal Mental Health Access & Screening**

#40 - Modernizing OSMA Policy to Safeguard Comprehensive Sexual Health Education

#41 - Efforts to Decrease Sexually Transmitted Infections

#42 – Implementing Perinatal HIV Testing Guidelines

#43 – Promoting a Public Health Approach to Homelessness

#44 – Fluoridation of Water Sources for Public Health

47 **WHEREAS** there is not a single long-term study to demonstrate the safety and
48 efficacy of puberty blockers, cross-sex hormones, and surgery for restoring well-being in
49 transgender believing youth including the recent review on gender care in minors
50 released by the United States Department of Health and Human Services on May 6, and
51 November 19, 2025; and

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53 **WHEREAS**, To echo Hillary Cass, the former president of England’s Royal College
54 of Pediatric and Child Health Services and author of the Cass Review, the scientific
55 foundations for gender affirming care rest on “shaky ground”. (9) (10) (11) (12) (60); and

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57 **WHEREAS** gender incongruence is neither innate nor immutable and 61-98% of
58 incongruent identities ultimately align with their biological sex, usually by late
59 adolescence, with or without counseling. (15) (16) (17) (18) (19); and

60
61 **WHEREAS** 43-75% of incongruent youth have a significant and untreated mental
62 illness that pre-dated their gender incongruence, and many supposed gender non-
63 conforming teens confuse childhood trauma effects or anxiety, eating, mood, and autism
64 spectrum disorders with gender dysphoria. (20) (21) (22) (23); and

65
66 **WHEREAS** suppressing normally timed puberty is dangerous to youth as such
67 interventions have been associated with mental illness and other serious health
68 consequences. The package-insert for Lupron, the most prescribed puberty blocker lists
69 “emotional instability” as a side effect and warns prescribers to “monitor for development
70 or worsening of psychiatric symptoms during treatment”. (24) (25) (26)(27); and

71
72 **WHEREAS** temporary use of Lupron has been associated with serious permanent
73 side effects including osteoporosis, mood disorders, seizures, cognitive impairment, voice
74 change, and when combined with cross-sex hormones, sterility. Over 90% of adolescents
75 on blockers will go on to cross-sex hormones which brings youth increased risk of heart
76 attacks, stroke, diabetes, blood clots and cancers. (27) (28) (29) (30) (31) (32) (33) (51)
77 (57); and

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79 **WHEREAS** girls as young as age 13 are receiving double mastectomies, and boys
80 as young as 16 are receiving breast implants and being surgically castrated, undergoing
81 penectomies and having pelvic wounds created to simulate female vaginas. (53) (54)
82 (55); and

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84 **WHEREAS** gender affirming care in youth frequently fails to achieve the goal of
85 improving the life of the recipient, and the incidence of suicide is much higher in recipients
86 of gender affirming care than in the non-treated transgender population. (8) (10) (11) (15)
87 (31) (34) (36); and

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92 **WHEREAS** youth transition can still be considered experimental, questioning the
93 ability of providers to obtain and of parents or guardians to give informed consent, or of
94 minors to assent to such treatments. (13) (14) (49) (57) (58) (59); and
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96 **WHEREAS** OSMA has already adopted Policy 07-2019 “Female Genital Mutilation
97 Ban” which condemns the practice of female genital mutilation as defined by the World
98 Health Organization and considers female genital mutilation a form of child abuse; and
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100 **WHEREAS** many European nations have called a halt on gender affirming care
101 for minors including Norway, Sweden, Finland, Belgium, The Netherlands, France and
102 England, unless in some, such as England, treatment is part of a carefully crafted
103 controlled multicenter long term outcome study including thorough pre and long term post
104 psychological evaluation and follow-up .(10) (37) (38) (39); and
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106 **WHEREAS** there is appearing on the horizon potential legal jeopardy for parents,
107 guardians, providers and institutions from plaintiffs who feel that as transgender
108 individuals their lives were permanently altered in the name of gender affirming care.
109 Organizations espousing such treatments could potentially become targets of imaginative
110 attorneys. Note the recent policy statements of the American Society of Plastic Surgeons
111 and the AMA. (40) (41) (42) (61); and
112

113 **WHEREAS** the most truthful and compassionate approach toward children and
114 adolescents questioning their gender is to allow them to be themselves and develop
115 without undue attention and pressure related to culturally determined gender roles, while
116 having mental, emotional, and spiritual support services to help them through their unique
117 individual process of understanding who they are; and therefore be it
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119 **RESOLVED**, that OSMA amend Policy 15 – 2020 – Supporting Gender-Affirming
120 Care for Transgender and Gender Minority Patients by addition as follows:
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122 Policy 15 – 2020 – Supporting Gender-Affirming Care for Transgender and
123 Gender Minority Patients
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- 125 1. The OSMA reaffirms existing Policy 23-2016 - Expanding Gender Identity
126 Options on Physician Intake Forms.
- 127 2. The OSMA supports individualized, gender-affirming, evidence-based
128 treatment and clinical practices in caring for transgender and gender
129 minority patients.
- 130 3. The OSMA supports educational training to further educate healthcare
131 providers on how to provide competent, respectful, evidence-based care
132 to transgender and gender minority patients.
- 133 4. THAT THE OSMA ADOPT AS POLICY THAT MINORS STRUGGLING
134 WITH GENDER DYSPHORIA BE PROVIDED WITH APPROPRIATE
135 MENTAL HEALTH AND OTHER APPROPRIATE EMOTIONAL
136 SUPPORT SERVICES TO ASSIST THEM THROUGH THEIR UNIQUE,

- 137 INDIVIDUAL PROCESS OF UNDERSTANDING THEIR OWN
138 DEVELOPING GENDER IDENTITY.
139 5. THAT THE OSMA SUPPORTS THAT MEDICAL, HORMONAL, AND
140 SURGICAL GENDER-AFFIRMING TREATMENTS FOR MINORS UNDER
141 AGE 18 SHOULD ONLY BE DELIVERED AS PART OF A MULTICENTER
142 LONG TERM IRB-APPROVED RESEARCH TRIAL.
143 6. THAT THE OSMA ADVOCATES THAT OUR AMA ADOPT POLICY THAT
144 MEDICAL, HORMONAL, AND SURGICAL GENDER-AFFIRMING
145 TREATMENT FOR MINORS UNDER AGE 18 SHOULD ONLY BE
146 DELIVERED AS PART OF AN IRB-APPROVED RESEARCH TRIAL.
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148 **Fiscal Note:** \$ X (Sponsor)
149 \$ 500 (Staff)

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256 *Los Angeles and others in Superior Court of California in and for the County of Los*
257 *Angeles*. According to the NY Times, defendant Dr Olson-Kennedy who was a
258 pioneer in developing gender affirmation surgery and is founder and medical
259 director of the Center for Transyouth Health and Development, is also being sued
260 by a taxpayer group for withholding the results of a \$10 million taxpayer funded
261 study showing that puberty blockers did not improve the mental health of recipients.
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Relevant OSMA Policy:

Policy 5 -2023 Protection for Physician Administration of Gender Affirming Care

1. The OSMA opposes any efforts to ban the administration of evidence-based care to patients when determined to be clinically indicated by their physician.
2. The OSMA opposes legislative or regulatory actions that would penalize physicians, Allied Health professionals, or healthcare entities who administer evidence-based gender-affirming care to patients.
3. The OSMA reaffirms Policy 15-2020 – supporting gender-affirming care for transgender and gender minority patients.

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

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

Relevant AMA Materials:

1. None

47 born patients and public health broadly⁶; and

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49 **WHEREAS**, health-care facilities remain legally and ethically obligated
50 under the Emergency Medical Treatment and Labor Act (EMTALA) and other
51 federal laws to provide emergency and essential care without regard to immigration
52 status⁷; and

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54 **WHEREAS**, the absence of clear protections for health-care settings may
55 undermine patient trust and the physician-patient relationship, thereby threatening
56 access to care and community health; therefore be it

57

58 **RESOLVED**, that our OSMA:

- 59 1. Supports designation of healthcare facilities as sensitive, protected
60 locations;
- 61 2. Will work with appropriate stakeholders to educate medical providers on the
62 rights of undocumented patients while receiving medical care, and the
63 designation of healthcare facilities as sensitive locations where U.S. Immigration
64 and Customs Enforcement (ICE) enforcement actions should not occur;
- 65 3. Encourages healthcare facilities to clearly demonstrate and promote their
66 status as sensitive, protected locations; and
- 67 4. Opposes the presence of ICE enforcement at healthcare facilities; and be it
68 further

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70 **RESOLVED**, that our OSMA opposes any legislation that compels hospital staff
71 to comply with immigration enforcement in the absence of a signed judicial warrant.

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74 **Fiscal Note:** \$ X (Sponsor)
75 \$ 50,000 (Staff)

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95 **Relevant OSMA Policy:**

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97 **Policy 14 - 2018 - Protection of the Patient-Physician Relationship in**
98 **Controversial Legislation**

- 99 1. The OSMA actively oppose any legislation or rule that would negatively
100 impact the sanctity of the physician/patient relationship.

101
102 **Policy 18 - 2012 - Criminalization of Medical Care**

- 103 1. The OSMA opposes any portion of proposed legislation or rule that criminalizes
104 clinical practice that is the standard of care.

105
106 **Policy 13 - 2024 - Declaration of Health and Health Care as Human Rights**

- 107 1. OSMA acknowledges health and access to health care as fundamental human
108 rights.
109 2. OSMA supports efforts to achieve universal access to timely, and affordable high
110 quality healthcare.

111
112 **Policy 07 - 2020 - Legislative or Regulatory Interference in the Practice of**
113 **Medicine in the State of Ohio**

- 114 1. The OSMA actively works to ensure that the sanctity of the physician-patient
115 relationship is protected in all legislative and regulatory matters.

116
117 **Relevant AMA Materials:**

118
119 **Presence and Enforcement Actions of Immigration and Customs Enforcement**
120 **(ICE) in Healthcare D-160.921**

121 Our AMA: (1) advocates for and supports legislative efforts to designate healthcare
122 facilities as sensitive locations by law; (2) will work with appropriate stakeholders to
123 educate medical providers on the rights of undocumented patients while receiving
124 medical care, and the designation of healthcare facilities as sensitive locations where
125 U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not
126 occur; (3) encourages healthcare facilities to clearly demonstrate and promote their
127 status as sensitive locations; and (4) opposes the presence of ICE enforcement at
128 healthcare facilities.

1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

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3 Resolution No. 25 – 2026

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5 **Introduced by:** Young Physicians Section

6
7 **Subject:** Supporting Access to Healthcare During Immigration Enforcement

8
9 **Referred to:** Resolutions Committee No. 2

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13 **WHEREAS**, increased immigration enforcement has been demonstrated to
14 prevent and delay targeted immigrant and ethnically diverse communities from seeking
15 access to healthcare.^{1 2}; and

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17 **WHEREAS**, these policies do not just affect undocumented individuals accessing
18 care but also spill over to their family and community members resulting in a chilling effect
19 in accessing care and negatively impacting their health outcomes.^{3 4}; and

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21 **WHEREAS**, while previous federal policy limited immigration enforcement officers
22 from operating in sensitive areas including health care facilities to avoid disruption of care,
23 that guidance has since been rescinded.^{5 6}; and

24
25 **WHEREAS**, the uptick in activity of immigration enforcement officers and their
26 presence in healthcare facilities has worsened the crisis of targeted communities not
27 presenting for care.^{7 8 9}; and

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29 **WHEREAS**, despite constitutional protections ^{10 11} against immigration
30 enforcement officers accessing private patient waiting areas without appropriate judicial
31 warrants, there have been reports of agents accessing these areas in violation of these
32 protections.^{12 13}; and

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34 **WHEREAS**, there have been reports of inadequate medical care and inhumane
35 treatment at immigration detention centers.^{14 15 16}; and

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37 **WHEREAS**, there have been reports of encounters with immigration enforcement
38 officers outside of these locations in which emergency care was needed and not provided
39 by officers and/or denied and/or impeded by officers when offered by bystanders and
40 emergency personnel.^{17 18 19}; and

41
42 **WHEREAS**, preventing the rendering of emergency aid is directly contrary to both
43 immigration enforcement officer policies²⁰ and medical ethics.^{21 22}; and therefore be it

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45 **RESOLVED**, The OSMA supports legislative efforts to designate healthcare
46 facilities as protected areas by law; and be it further

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RESOLVED, The OSMA supports efforts to ensure adequate health care access at all immigrant detention facilities; and be it further

RESOLVED, The OSMA opposes interference by immigration enforcement officers with health care rendered outside of healthcare facilities.

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

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137 **Relevant OSMA Policy:**

138 **Policy 14 - 2018 - Protection of the Patient-Physician Relationship in**

139 **Controversial Legislation**

140 1. The OSMA actively oppose any legislation or rule that would negatively
141 impact the sanctity of the physician/patient relationship.

142

143 **Policy 18 - 2012 - Criminalization of Medical Care**

144 1. The OSMA opposes any portion of proposed legislation or rule that criminalizes
145 clinical practice that is the standard of care.

146

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

148 1. OSMA acknowledges health and access to health care as fundamental human
149 rights.

150 2. OSMA supports efforts to achieve universal access to timely, and affordable high
151 quality healthcare.

152

153 **Policy 07 - 2020 - Legislative or Regulatory Interference in the Practice of
154 Medicine in the State of Ohio**

155 1. The OSMA actively works to ensure that the sanctity of the physician-patient
156 relationship is protected in all legislative and regulatory matters.

157

158 **Relevant AMA Materials:**

159 **Presence and Enforcement Actions of Immigration and Customs Enforcement
160 (ICE) in Healthcare D-160.921**

161 1. Our American Medical Association advocates for and supports legislative efforts to
162 designate healthcare facilities as protected areas by law.

163 2. Our AMA will work with appropriate stakeholders to educate medical providers on the
164 rights of undocumented patients while receiving medical care, and the designation of
165 healthcare facilities as protected areas where U.S. Immigration and Customs
166 Enforcement (ICE) enforcement actions should not occur.

167 3. Our AMA encourages healthcare facilities to clearly demonstrate and promote their
168 status as protected areas.

169 4. Our AMA opposes the presence of ICE enforcement at healthcare facilities.

170 **Improving Medical Care in Immigrant Detention Centers D-350.983**

171 Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs
172 Enforcement Office of Detention Oversight to (a) revise its medical standards governing
173 the conditions of confinement at detention facilities to meet those set by the National
174 Commission on Correctional Health Care, (b) take necessary steps to achieve full
175 compliance with these standards, and (c) track complaints related to substandard
176 healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement
177 refrain from partnerships with private institutions whose facilities do not meet the
178 standards of medical, mental, and dental care as guided by the National Commission on
179 Correctional Health Care; and (3) advocate for access to health care for individuals in
180 immigration detention.

181 **Patient and Physician Rights Regarding Immigration Status H-315.966**

- 182 1. Our American Medical Association supports protections that prohibit U.S. Immigration
183 and Customs Enforcement, U.S. Customs and Border Protection, or other law
184 enforcement agencies from utilizing information from medical records, Medicaid,
185 Children’s Health Insurance Program (CHIP), or other health program data, including but
186 not limited to Emergency Medicaid and related immigrant-specific programs, for
187 immigration enforcement purposes.
- 188 2. Our AMA supports efforts by interested parties to educate physicians, medical
189 students, and patients about existing privacy protections to safeguard confidential health
190 information, and to help ensure that this information reaches immigrant and mixed-status
191 families.

192 **Care of Women and Children in Family Immigration Detention H-350.955**

- 193 1. Our AMA recognizes the negative health consequences of the detention of families
194 seeking safe haven.
- 195 2. Due to the negative health consequences of detention, our AMA opposes the
196 expansion of family immigration detention in the United States.
- 197 3. Our AMA opposes the separation of parents from their children who are detained while
198 seeking safe haven.
- 199 4. Our AMA will advocate for access to health care for women and children in immigration
200 detention.
- 201 5. Our AMA will advocate for the preferential use of alternatives to detention programs
202 that respect the human dignity of immigrants, migrants, and asylum seekers who are in
203 the custody of federal agencies.
- 204 6. Our AMA advocates for the implementation of evidence-based, child-centered, and
205 trauma-informed policies across all detention centers, ensuring detained minors have
206 access to developmentally appropriate socioemotional care, including physical contact,
207 and for all detained people, free, unfettered communication access including regular in-
208 person communication, phone calls, and letters.
- 209 7. Our AMA supports efforts to address and mitigate concerns and accusations of child
210 abuse and neglect in detention centers.

47 \$ 50,000 (Staff)

48

49 **References:**

50 1. None

51

52 **Relevant OSMA Policy:**

53 1. None

54

55 **Relevant AMA Materials:**

56 1. None

47 that patients can take to file a complaint with the Ohio Department of Insurance or how to
48 contact the Ombudsman. This document should be included in every outpatient
49 discharge/encounter summary.

50

51 **Fiscal Note:** \$ 5,000 (Sponsor)
52 \$ 50,000 (Staff)

53

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57

58 **Relevant OSMA Policy:**

59 **Policy 19 - 2024 - Insurer Accountability When Prior Authorization Harms Patients**

60

- 61 1. OSMA will advocate for increased legal accountability of insurers and other payers
62 when delay or denial of prior authorization leads to patient harm, including but not
63 limited to the prohibition of mandatory pre-dispute arbitration and limitation on
64 class action clauses in beneficiary contracts.
65 2. The OSMA House of Delegates directs the OSMA AMA delegation to take this policy
66 to the American Medical Association House of Delegates for further consideration.

67 **Relevant AMA Materials:**

- 68 1. None

47
48 **RESOLVED**, that our OSMA recognize activity-specific adaptive sports and
49 exercise equipment as assistive devices that are integral to the health maintenance of
50 persons with disabilities in accordance with national exercise guidelines; and be it further
51

52 **RESOLVED** that our OSMA recognize activity-specific adaptive sports and
53 exercise equipment, such as activity-specific prostheses and orthoses, as medical
54 devices that facilitate independence and community participation; and be it further
55

56 **RESOLVED** that our OSMA advocate for coverage by all private and public
57 insurance plans for activity-specific adaptive sports and exercise equipment for eligible
58 beneficiaries with disabilities in order to promote health maintenance and chronic disease
59 prevention.
60

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81 **Relevant OSMA Policy:**

- 82 1. None
83

84 **Relevant AMA Materials:**

85 **Promotion of Exercise Within Medicine and Society H-470.990**

- 86 1. Our American Medical Association supports education of the profession on
87 exercise, including instruction on the role of exercise prescription in medical practice
88 in its continuing education courses and conferences, whenever feasible and
89 appropriate.
90 2. Our AMA supports medical student instruction on the prescription of exercise.
91 3. Our AMA supports physical education instruction in the school system.

92 4. Our AMA supports education of the public on the benefits of exercise, through its
93 public relations program.

94
95 **Promotion of Exercise H-470.991**

96 1. Our American Medical Association:

97 a. supports the promotion of exercise, particularly exercise of significant
98 cardiovascular benefit.

99 b. encourages physicians to prescribe exercise to their patients and to shape
100 programs to meet each patient's capabilities and level of interest.

101 2. Our AMA supports National Bike to Work Day and encourages active
102 transportation whenever possible.

103
104 **Exercise Programs for the Elderly H-25.995**

105 The AMA recommends that physicians: (1) stress the importance of exercise for
106 older patients and explain its physiological and psychological benefits; (2) obtain a
107 complete medical history and perform a physical examination that includes exercise
108 testing for quantification of cardiovascular and physical fitness as appropriate, prior
109 to the specific exercise prescription; (3) provide appropriate follow-up of patients'
110 exercise programs; and (4) encourage all patients to establish a lifetime commitment
111 to an exercise program.

112
113 **Government to Support Community Exercise Venues H-470.952**

114 1. Our American Medical Association encourages towns, cities and counties across
115 the country to make recreational exercise more available by utilizing existing or
116 building walking paths, bicycle trails, swimming pools, beaches and community
117 recreational fitness facilities.

118 2. Our AMA encourages governmental incentives such as tax breaks and grants for
119 the development of community recreational fitness facilities.

120
121 **Exercise and Physical Fitness H-470.997**

122 1. Our American Medical Association encourages all physicians to utilize the health
123 potentialities of exercise for their patients as a most important part of health
124 promotion and rehabilitation and urges state and local medical societies to
125 emphasize through all available channels the need for physical activity. The AMA
126 encourages other organizations and agencies to join in promoting physical fitness
127 through all appropriate means.

128 2. Our AMA advocates for continued research towards development of structured
129 physical activity treatment plans for the specific diagnoses of anxiety and
130 depression, as well as longitudinal studies to examine the effects of physical activity
131 on health outcomes, particularly later in life.

132 3. Our AMA encourages the education of health care professionals on the role of
133 physical activity and/or structured exercise in treating and managing anxiety and
134 depression; the need to screen for levels of physical activity of patients; the need to
135 motivate and educate patients of all ages about the benefits of physical activity,
136 including positive mental health benefits.

- 137 4. Our AMA encourages the provision of coverage by health care payers and
138 employers for fitness club memberships and access to other physical activity
139 programs.
140 5. Our AMA encourages the implementation, trending, and utilization of evidenced-
141 based physical activity measures in the medical record for treatment prescription,
142 counseling, coaching, and follow up of physical activity for therapeutic use.
143

144 **Medical Care of Persons with Disabilities H-90.968**

- 145 1. Our American Medical Association encourages:
146 a. clinicians to learn and appreciate variable presentations of complex functioning
147 profiles in all persons with disabilities including but not limited to physical,
148 sensory, developmental, intellectual, learning, and psychiatric disabilities and
149 chronic illnesses.
150 b. medical schools and graduate medical education programs to acknowledge
151 the benefits of education on how aspects in the social model of disability (e.g.
152 ableism) can impact the physical and mental health of persons with disabilities.
153 c. medical schools and graduate medical education programs to acknowledge
154 the benefits of teaching about the nuances of uneven skill sets, often found in the
155 functioning profiles of persons with developmental disabilities, to improve quality
156 in clinical care.
157 d. education of physicians on how to provide and/or advocate for
158 developmentally appropriate and accessible medical, social and living support for
159 patients with disabilities so as to improve health outcomes.
160 e. medical schools and residency programs to encourage faculty and trainees to
161 appreciate the opportunities for exploring diagnostic and therapeutic challenges
162 while also accruing significant personal rewards when delivering care with
163 professionalism to persons with profound disabilities and multiple co-morbid
164 medical conditions in any setting.
165 f. medical schools and graduate medical education programs to establish and
166 encourage enrollment in elective rotations for medical students and residents at
167 health care facilities specializing in care for the disabled.
168 g. cooperation among physicians, health & human services professionals, and a
169 wide variety of adults with disabilities to implement priorities and quality
170 improvements for the care of persons with disabilities.
171 2. Our AMA seeks:
172 a. legislation to increase the funds available for training physicians in the care of
173 individuals with disabilities, and to increase the reimbursement for the health care
174 of these individuals.
175 b. insurance industry and government reimbursement that reflects the true cost
176 of health care of individuals with disabilities.
177 3. Our AMA entreats health care professionals, parents, and others participating in
178 decision-making to be guided by the following principles:
179 a. All people with disabilities, regardless of the degree of their disability, should
180 have access to appropriate and affordable medical and dental care throughout
181 their lives.

- 182 b. An individual's medical condition and welfare must be the basis of any medical
183 decision. Our AMA advocates for the highest quality medical care for persons
184 with profound disabilities; encourages support for health care facilities whose
185 primary mission is to meet the health care needs of persons with profound
186 disabilities; and informs physicians that when they are presented with an
187 opportunity to care for patients with profound disabilities, that there are resources
188 available to them.
- 189 4. Our AMA will collaborate with appropriate stakeholders to create a model general
190 curriculum/objective that
- 191 a. incorporates critical disability studies.
 - 192 b. includes people with disabilities as patient instructors in formal training
193 sessions and preclinical and clinical instruction.
- 194 5. Our AMA recognizes the importance of managing the health of children and adults
195 with developmental and intellectual disabilities as a part of overall patient care for
196 the entire community.
- 197 6. Our AMA supports efforts to educate physicians on health management of
198 children and adults with intellectual and developmental disabilities, as well as the
199 consequences of poor health management on mental and physical health for
200 people with intellectual and developmental disabilities.
- 201 7. Our AMA encourages the Liaison Committee on Medical Education, Commission
202 of Osteopathic College Accreditation, and allopathic and osteopathic medical
203 schools to develop and implement a curriculum on the care and treatment of
204 people with a range of disabilities.
- 205 8. Our AMA encourages the Accreditation Council for Graduate Medical Education
206 and graduate medical education programs to develop and implement curriculum
207 on providing appropriate and comprehensive health care to people with a range
208 of disabilities.
- 209 9. Our AMA encourages the Accreditation Council for Continuing Medical Education,
210 specialty boards, and other continuing medical education providers to develop
211 and implement continuing programs that focus on the care and treatment of
212 people with a range of disabilities.
- 213 10. Our AMA will advocate that the Health Resources and Services Administration
214 include persons with disabilities as a medically underserved population.
- 215 11. Specific to people with developmental and intellectual disabilities, a uniquely
216 underserved population, our AMA encourages:
- 217 a. Medical schools and graduate medical education programs to acknowledge
218 the benefits of teaching about the nuances of uneven skill sets, often found in the
219 functioning profiles of persons with developmental and intellectual disabilities, to
220 improve quality in clinical education.
 - 221 b. Medical schools and graduate medical education programs to establish and
222 encourage enrollment in elective rotations for medical students and residents at
223 health care facilities specializing in care for individuals with developmental and
224 intellectual disabilities.
 - 225 c. Cooperation among physicians, health and human services professionals, and
226 a wide variety of adults with intellectual and developmental disabilities to

227 implement priorities and quality improvements for the care of persons with
228 intellectual and developmental disabilities.

229
230 **Advocacy for Physicians and Medical Students with Disabilities D-615.977**

231 Our AMA will: (1) establish an advisory group composed of AMA members who
232 themselves have a disability to ensure additional opportunities for including physicians
233 and medical students with disabilities in all AMA activities; (2) promote and foster
234 educational and training opportunities for AMA members and the medical community at
235 large to better understand the role disabilities can play in the healthcare work
236 environment, including cultivating a rich understanding of so-called invisible disabilities
237 for which accommodations may not be immediately apparent; (3) develop and promote
238 tools for physicians with disabilities to advocate for themselves in their own workplaces,
239 including a deeper understanding of the legal options available to physicians and medical
240 students to manage their own disability-related needs in the workplace; and (4)
241 communicate to employers and medical staff leaders the importance of including within
242 personnel policies and medical staff bylaws protections and reasonable accommodations
243 for physicians and medical students with visible and invisible disabilities.

244
245 **Social Security Disability Medical Benefits D-330.961**

246 Our American Medical Association will continue to monitor future research and related
247 developments on Medicare benefits for Social Security disability recipients, and will report
248 and recommend further action to the House of Delegates as appropriate.

249
250 **Promoting Health Awareness and Preventive Screenings in Individuals with**
251 **Disabilities H-425.970**

252 Our American Medical Association will work closely with relevant stakeholders to
253 advocate for equitable access to health promotion and preventive screenings for
254 individuals with disabilities.

255
256 **Private and Public Insurance Coverage for Adaptive Sports Equipment Including**
257 **Prostheses and Orthoses H-90.961**

- 258 1. Our American Medical Association recognizes activity-specific adaptive sports
259 and exercise equipment as assistive devices that are integral to the health
260 maintenance of persons with disabilities in accordance with national exercise
261 guidelines.
- 262 2. Our AMA recognizes activity-specific adaptive sports and exercise equipment,
263 such as activity-specific prostheses and orthoses, as medical devices that facilitate
264 independence and community participation.
- 265 3. Our AMA advocates for coverage by all private and public insurance plans for
266 activity-specific adaptive sports and exercise equipment for eligible beneficiaries with
267 disabilities in order to promote health maintenance and chronic disease prevention.

268

47
48 **RESOLVED**, that our OSMA support ongoing efforts by relevant stakeholders to
49 reevaluate the WISeR model during its six performance years to remove barriers to
50 preserve high quality patient care.

51
52 **Fiscal Note:** \$ X (Sponsor)
53 \$ 500+ (Staff)
54

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87
88 **Relevant OSMA Policy:**

89 **Policy 7- 2009 - Medicaid Reform**

- 90 1. The OSMA shall work to get one set of rules for the Medicaid system.
- 91 2. The OSMA shall work to be sure that patients who are on an approved drug in
92 one program and are switched to another program may continue the drug without

93 another prior authorization from the physician's office (thus requiring communication
94 between managed care programs when a patient moves from one to another).

95 3. The OSMA shall work to eliminate current barriers to traditional referral patterns
96 for complicated patients who need a tertiary center regardless of which provider
97 group they are in.

98 4. The OSMA shall work to eliminate needless hassles for physicians in their offices
99 in obtaining prior authorization for medications and testing. 5. The OSMA shall
100 encourage a statewide source of up-to-date verification of a patient's coverage.

101
102 **Policy 14 - 2019 - Compensation for Prior Authorization Services**

103 1. The OSMA opposes pre-authorization as a requirement for patient care.

104 2. The OSMA shall seek legislation that provides for appropriate compensation
105 to physician offices for expenses incurred in obtaining prior authorizations for
106 patient care.

107
108 **Policy 25 – 2023 - Codifying Efforts for Legislative Action on Prior
109 Authorization**

110 1. The OSMA will seek legislative solutions to reduce the burden of prior
111 authorization requirements.

112 2. The OSMA advocacy team will report back annually to the House of Delegates on
113 the status of prior authorization advocacy efforts unless deemed unnecessary by
114 Council.

115
116 **Policy 19 - 2024 - Insurer Accountability When Prior Authorization Harms
117 Patients**

118 1. OSMA will advocate for increased legal accountability of insurers and other
119 payers when delay or denial of prior authorization leads to patient harm, including
120 but not limited to the prohibition of mandatory pre-dispute arbitration and
121 limitation on class action clauses in beneficiary contracts.

122 2. The OSMA House of Delegates directs the OSMA AMA delegation to take this
123 policy to the American Medical Association House of Delegates for further
124 consideration.

125
126 **Policy 20 - 2024 - Eliminate Unnecessary Prior Authorization**

127 1. It is the position of our OSMA that a signed physician's order or prescription should
128 be all that is necessary to validate medical necessity for a procedure, test, or
129 medication.

130
131 **Relevant AMA Materials:**

132 **Insurer Accountability When Prior Authorization Harms Patients D-320.974**

133 1. Our American Medical Association advocates for increased legal accountability
134 of insurers and other payers when delay or denial of prior authorization leads to
135 patient harm, including but not limited to the prohibition of mandatory pre-dispute
136 arbitration regarding prior authorization determinations and limitation on class
137 action clauses in beneficiary contracts.

138 2. Our American Medical Association advocates that low-cost noninvasive

139 procedures that meet existing standard Medicare guidelines should not require prior
140 authorization.

141 3. Our AMA supports that physicians be allowed to bill insurance companies for all
142 full time employee hours required to obtain prior authorization.

143 4. Our AMA supports that patients be allowed to sue insurance carriers which
144 preclude any and all clauses in signed contracts should there be an adverse outcome
145 as a result of an inordinate delay in care.

146

147 **Prior Authorization and Utilization Management Reform H-320.939**

148 1. Our American Medical Association will continue its widespread prior authorization
149 (PA) advocacy and outreach, including promotion and/or adoption of the Prior
150 Authorization and Utilization Management Reform Principles, AMA model legislation,
151 Prior Authorization Physician Survey and other PA research, and the AMA Prior
152 Authorization Toolkit, which is aimed at reducing PA administrative burdens and
153 improving patient access to care.

154 2. Our AMA will oppose health plan determinations on physician appeals based
155 solely on medical coding and advocate for such decisions to be based on the direct
156 review of a physician of the same medical specialty/subspecialty as the
157 prescribing/ordering physician.

158 3. Our AMA supports efforts to track and quantify the impact of health plans' prior
159 authorization and utilization management processes on patient access to necessary
160 care and patient clinical outcomes, including the extent to which these processes
161 contribute to patient harm.

162 4. Our AMA will advocate for health plans to minimize the burden on patients,
163 physicians, and medical centers when updates must be made to previously
164 approved and/or pending prior authorization requests.

165

166 **Required Clinical Qualifications in Determining Medical Diagnoses and Medical
167 Necessity D-320.975**

168 Our American Medical Association advocates for a change to existing public and private
169 processes including Utilization Management, Prior Authorization, Medicare and Medicaid
170 audits, Medicare and State Public Health surveys of clinical care settings, to only allow
171 physicians with adequate and commensurate training, scope of practice, and licensure
172 to determine accuracy of medical diagnoses and assess medical necessity.

47

48 **Relevant OSMA Policy:**

49 1. None

50

51 **Relevant AMA Materials:**

52 1. None

47 **WHEREAS**, lack of reimbursement limits the ability of healthcare systems,
48 community health centers, and safety-net clinics to expand access to integrated
49 behavioral health services for vulnerable populations while also limiting access to
50 specialty consultation and team-based support for primary care clinicians; and

51
52 **WHEREAS**, expanding access to evidence-based integrated behavioral health
53 services aligns with goals of improving population health, reducing healthcare disparities,
54 supporting the primary care workforce, and controlling healthcare expenditures; and
55 therefore be it

56
57 **RESOLVED**, that the Ohio State Medical Association advocate for Ohio Medicaid
58 to provide reimbursement for Collaborative Care Model services; and be it further

59
60 **RESOLVED**, that OSMA support policies and initiatives that promote the
61 implementation of evidence-based integrated behavioral health models within primary
62 care settings to improve access to mental health services for Medicaid beneficiaries and
63 to provide additional clinical support to primary care clinicians managing behavioral health
64 conditions; and be it further

65
66 **RESOLVED**, that OSMA collaborate with relevant parties, including the Ohio
67 Department of Medicaid, healthcare systems, and professional organizations, to advance
68 policies supporting sustainable financing for the Collaborative Care Model in Ohio.

69
70 **Fiscal Note:** \$ 500 (Sponsor)
71 \$ 50,000 (Staff)

72
73 **References:**
74 1. None

75
76 **Relevant OSMA Policy:**

77 **Policy 9 - 1998 - Access and Parity of Mental Health Coverage**
78 The OSMA supports access and parity of mental health coverage as reflected in the
79 following statements:

- 80 1. Treatment of mental health problems should be integrated as much as possible
81 into other aspects of general healthcare.
82 2. Primary care physicians should have ongoing consultation available from and
83 efficient referral access to expert mental health providers.
84 3. Health care coverage plans should include mental health benefits on parity with
85 other general medical conditions for medically necessary treatment performed
86 by accountable clinicians.
87 4. Health care plans that list providers will also list individual mental health care
88 providers so that referrals can be made as a collaborative effort involving
89 patients, referring physicians and mental health care clinicians.
90 5. Psychiatrists and non-psychiatrists be appropriately compensated for the
91 psychiatric services they provide.

92

93 **Policy 24 - 2018 - Implementation of Integrated Behavioral Healthcare Management**
94 **Services**

- 95 1. The OSMA support efforts to implement evidence-based, physician-led
96 integrated behavioral health care management models.
97

98 **Policy 22 - 2022 - Medicare and Medicaid Reimbursement**

- 99 1. The Ohio State Medical Association will seek to introduce legislation which will
100 bring Ohio Medicaid reimbursement up to parity with Medicare reimbursements.
101 2. The Ohio delegation to our American Medical Association shall carry a resolution
102 which calls for education of beneficiaries particularly in regard to the scope of benefit
103 coverage within Medicare Advantage Plans.
104 3. The Ohio Delegation will bring to the AMA a resolution seeking an increase in
105 Medicare reimbursement.
106

107 **Relevant AMA Materials:**

108 **Integrating Physical and Behavioral Health Care H-385.915**

109 Our American Medical Association: (1) encourages private health insurers to recognize
110 CPT codes that allow primary care physicians to bill and receive payment for physical
111 and behavioral health care services provided on the same day; (2) encourages all state
112 Medicaid programs to pay for physical and behavioral health care services provided on
113 the same day; (3) encourages state Medicaid programs to amend their state Medicaid
114 plans as needed to include payment for behavioral health care services in school settings;
115 (4) encourages practicing physicians to seek out continuing medical education
116 opportunities on integrated physical and behavioral health care; and (5) promotes the
117 development of sustainable payment models that would be used to fund the necessary
118 services inherent in integrating behavioral health care services into primary care settings.

119 **Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-**
120 **345.984**

- 121 1. Our American Medical Association encourages:
122 a. medical schools, primary care residencies, and other training programs as
123 appropriate to include the appropriate knowledge and skills to enable
124 graduates to recognize, diagnose, and treat depression and other mental
125 illnesses, either as the chief complaint or with another general medical
126 condition.
127 b. all physicians providing clinical care to acquire the same knowledge and skills.
128 c. additional research into the course and outcomes of patients with depression
129 and other mental illnesses who are seen in general medical settings and into
130 the development of clinical and systems approaches designed to improve
131 patient outcomes. Furthermore, any approaches designed to manage care by
132 reduction in the demand for services should be based on scientifically sound
133 outcomes research findings.
134 2. Our AMA will work with the National Institute on Mental Health and appropriate
135 medical specialty and mental health advocacy groups to increase public awareness
136 about depression and other mental illnesses, to reduce the stigma associated with

137 depression and other mental illnesses, and to increase patient access to quality care
138 for depression and other mental illnesses.

139 3. Our AMA:

140 1. will advocate for the incorporation of integrated services for general medical
141 care, mental health care, and substance use disorder care into existing psychiatry,
142 addiction medicine and primary care training programs' clinical settings.

143 2. encourages graduate medical education programs in primary care, psychiatry,
144 and addiction medicine to create and expand opportunities for residents and
145 fellows to obtain clinical experience working in an integrated behavioral health and
146 primary care model, such as the collaborative care model.

147 3. will advocate for appropriate reimbursement to support the practice of integrated
148 physical and mental health care in clinical care settings.

149 4. Our AMA recognizes the impact of violence and social determinants on women's
150 mental health.

151 **Integrating Care for Individuals Dually Eligible for Medicare and Medicaid H-290.956**

152 Our American Medical Association supports integrated care for individuals dually eligible
153 for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:

154 a. Care is grounded in the diversity of dually eligible enrollees and services are
155 tailored to individuals' needs and preferences.

156 b. Coverage of medical, behavioral health, and long-term services and supports is
157 aligned.

158 c. Medicare and Medicaid eligibility and enrollment processes are simplified, with
159 enrollment assistance made available as needed.

160 d. Enrollee choice of plan and physician is honored, allowing existing patient-
161 physician relationships to be maintained.

162 e. Services are easy to navigate and access, including in rural areas.

163 f. Care coordination is prioritized, with quality case management available as
164 appropriate.

165 g. Barriers to access, including inadequate networks of physicians and other
166 providers and prior authorizations, are minimized.

167 h. Administrative burdens on patients, physicians and other providers are minimized.

168 i. Educational materials are easy to read and emphasize that the ability and power
169 to opt in or out of integrated care resides solely with the patient.

170 j. Physician participation in Medicare or Medicaid is not mandated nor are eligible
171 physicians denied participation.

47 payment updates by linking these payments to the Medicare Economic Index (MEI); and
48 be it further
49

50 **RESOLVED**, that our OSMA Delegation to the AMA House of Delegates carry this
51 resolution forward and present it at A-26 for consideration.
52

53 **Fiscal Note:** \$ X (Sponsor)
54 \$ 500 (Staff)
55

56 **References:**

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58

59 **Relevant OSMA Policy:**

- 60 1. None
61

62 **Relevant AMA Materials:**

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WHEREAS, communities that implement evidence-based public health strategies—such as harm reduction, linkage to treatment, targeted education, and safety planning—have consistently demonstrated meaningful reductions in overdose mortality and improved long-term health outcomes¹⁰; and

WHEREAS, investment in public health infrastructure produces sustained economic benefits by preventing disease, reducing avoidable emergency and inpatient care, lowering long-term Medicaid and Medicare expenditures, strengthening workforce productivity, and improving overall population well-being¹¹; and

WHEREAS, unlike speculative or illiquid financial instruments, public health investments deliver direct, measurable, and durable returns to Ohio residents in the form of lives saved, healthcare costs avoided, and communities strengthened; and

WHEREAS, Ohio currently holds only one foreign bond that is purchased directly and explicitly reported by the Ohio Treasurer as a specific debt instrument issued by a foreign sovereign, whereas other international investments consist of pooled funds in which Ohio does not directly select individual securities¹²; and

WHEREAS, as of May 2024, the Ohio State Treasury held approximately \$262.5 million in these directly purchased foreign bonds, making Ohio one of the largest state-level holders of such bonds in the United States¹; and

WHEREAS, these foreign bonds are illiquid, non-marketable securities that lock public funds until maturity and cannot be resold, thereby limiting the state’s fiscal flexibility during periods of public health urgency or economic uncertainty²; and

WHEREAS, the issuing country’s sovereign credit rating has recently been downgraded, and yields on its government debt have risen above 5%, indicating increased financial risk that may not align with careful management of public funds²; and

WHEREAS, Ohio Treasurer Robert Sprague serves as general chair of an organization dedicated to promoting investment in these foreign bonds²; and

WHEREAS, ethics experts have stated that this level of involvement between foreign bond promotion and American state officials exceeds what is typically considered appropriate for public officials responsible for managing public funds³; therefore be it

RESOLVED, that our OSMA oppose the use of state-managed public funds to purchase foreign government bonds when such investments restrict the availability of resources needed to address Ohio’s critical public health priorities; and be it further

RESOLVED, that our OSMA support the discontinuation of future purchases of foreign government bonds by the State of Ohio; and be it further

93 **RESOLVED**, that our OSMA support future state investment allocations that
94 prioritize strengthening Ohio’s public health infrastructure, including prevention,
95 treatment access, health equity initiatives, and the public health workforce.
96

97 **Fiscal Note:** \$ X (Sponsor)
98 \$ 500 (Staff)
99

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146

147 **Relevant OSMA Policy:**

148 **Policy 54 - 1990 - Raise Revenue for Health-Care Needs**

149 The OSMA supports an increase in federal excise taxes for tobacco and alcohol which
150 would be allocated to health-care needs.

151

152 **Relevant AMA Materials:**

153 1. None

47 **WHEREAS**, California Business and Professions Code § 2056 provides a model
48 framework affirming that physicians who “advocate for medically appropriate health care
49 for their patients,” including through communications with patients and appeals to
50 insurers, shall not be retaliated against²; therefore be it

51
52 **RESOLVED**, that our OSMA support the establishment of legal protections against
53 retaliation for physicians who advocate in good faith for medically appropriate health care
54 for their patients; and be it further

55
56 **RESOLVED**, that our OSMA support legislation affirming:
57 a) That no licensed physician shall be retaliated against for advocating for
58 medically appropriate care;
59 b) That such advocacy includes communication with patients and actions taken
60 within clinical judgment;
61 c) That employers, health care institutions, and payers may not interfere with,
62 discourage, or penalize such advocacy.

63
64 **Fiscal Note:** \$ X (Sponsor)
65 \$ 500 (Staff)
66

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87

88 **Relevant OSMA Policy:**
89 1. None
90

91 **Relevant AMA Materials:**
92 1. None

- 47 RECEIVE A BALLOT BY MAIL AND OTHER CONSTRAINTS as a
48 requirement to participate in mail-in voting.
- 49 3. OSMA supports nonpartisan voter registration efforts in healthcare settings and
50 encourages medical schools and hospitals to provide appropriate
51 accommodations to students and employees for the purpose of voting in local,
52 state and national elections.
- 53 4. OSMA SUPPORTS THE IMPLEMENTATION OF AN ELECTRONIC
54 ALTERNATIVE TO BALLOT APPLICATIONS, INCLUDING EMERGENCY
55 ABSENTEE BALLOT APPLICATIONS FOR PATIENTS EXPERIENCING AN
56 UNEXPECTED MEDICAL ILLNESS.
- 57 5. OSMA SUPPORTS THE USE OF NON-FAMILY AUTHORIZED
58 MESSENGERS TO ASSIST IN THE TRANSPORT AND DELIVERY OF
59 EMERGENCY BALLOT APPLICATIONS AND ABSENTEE BALLOTS.
- 60 6. OSMA SUPPORTS MAIL-IN BALLOT POSTAGE THAT IS FREE OR PREPAID
61 BY THE GOVERNMENT.
- 62 7. OSMA SUPPORTS IMPROVED ACCESS TO DROP OFF LOCATIONS FOR
63 MAIL-IN OR EARLY BALLOTS.
- 64 8. OSMA OPPOSES UNNECESSARY REGULATORY BURDENS IN ORDER TO
65 VOTE.

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67
68 **Fiscal Note:** \$ 5000+ (Sponsor)
69 \$ 500 (Staff)

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Relevant OSMA Policy:

Policy 14 – 2024 -- Support for Safe and Equitable Access to Voting

1. OSMA opposes requirements for voters to obtain a doctor’s note or other attestation by a medical professional as a requirement to participate in mail-in voting.
2. OSMA supports nonpartisan voter registration efforts in healthcare settings and encourages medical schools and hospitals to provide appropriate accommodations to students and employees for the purpose of voting in local, state and national elections.

Relevant AMA Materials:

H-440.805 Support for Safe and Equitable Access to Voting

1. Our American Medical Association supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to:
 - a. extending polling hours
 - b. increasing the number of polling locations
 - c. extending early voting periods
 - d. mail-in ballot postage that is free or prepaid by the government
 - e. adequate resourcing of the United States Postal Service and election operational procedures
 - f. improved access to drop off locations for mail-in or early ballots
 - g. use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA:
 - a. acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric.
 - b. recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes.
 - c. will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

H-65.936 Supporting the Health of Our Democracy

1. Our American Medical Association supports policies that ensure safe and equitable access to voting and opposes the institutional barriers to the process of voter registration.
2. Our AMA encourages physicians and medical trainees to vote, eliminate barriers to their participation in the electoral process, and support their and other healthcare workers’ engagement in all voter registration efforts in healthcare

141 settings, including emergency absentee ballot procedures for qualifying patients,
142 visitors, and healthcare workers.
143 3. Our AMA supports the use of independent, nonpartisan commissions to draw
144 districts for both federal and state elections.

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51
52 **Relevant OSMA Policy:**

53
54 **Policy 10 - 2025 - Disclosures Policy for Medical Applicants**

55 The OSMA encourages Ohio medical schools to provide education to medical students
56 on the process of disclosures in residency applications, including mental health
57 conditions, physical conditions, chemical dependency conditions, and disabilities.

58
59 **Policy 11 - 2024 - Ohio Medical School Suicide Education**

60 The Ohio State Medical Association supports the education of faculty members,
61 fellows/residents, and medical students in recognizing signs and symptoms of burnout
62 and depression, as well as treatment of and prevention, in order to combat the occurrence
63 of suicide amongst medical students, physicians, and residents.

64
65 **Policy 08 - 2020 - Mental Health First Aid Training**

- 66 1. The OSMA encourages physicians, physician practices, allied healthcare
67 professionals, and medical communities to support access to learning evidence based
68 mental health programs for all interested members of the care team.
69 2. The OSMA supports the use of public funds to facilitate evidence based mental
70 health programs for all interested members of medical care teams.

71
72 **Policy 9 - 1998 - Access and Parity of Mental Health Coverage**

- 73 1. The OSMA supports access and parity of mental health coverage as reflected in
74 the following statements:
75 1) Treatment of mental health problems should be integrated as much as possible
76 into other aspects of general healthcare.
77 2) Primary care physicians should have ongoing consultation available from and
78 efficient referral access to expert mental health providers.
79 3) Health care coverage plans should include mental health benefits on parity with
80 other general medical conditions for medically necessary treatment performed
81 by accountable clinicians.
82 4) Health care plans that list providers will also list individual mental health care
83 providers so that referrals can be made as a collaborative effort involving
84 patients, referring physicians and mental health care clinicians.
85 5) Psychiatrists and non-psychiatrists be appropriately compensated for the
86 psychiatric services they provide.

87
88 **Policy 17 - 2017 - Importance of OSMA Promoting Physician Well-Being by**
89 **Addressing the Physician and Medical Student Burnout Issue**

- 90 1. The OSMA shall work with medical schools, hospitals, residency programs, and
91 physicians to address the issue of physician and medical student burnout.

92 2. The OSMA encourages physicians and medical students to utilize the AMA Steps
93 Forward Program to learn more about preventing physician burnout.

94
95 **Policy 35 - 1982 - Education Regarding Suicide Recognition, Prevention and**
96 **Treatment**

97 1. The OSMA encourages physicians to continue their education in the recognition,
98 treatment, and prevention of potential suicides and the management of survivors of
99 suicide attempts.

100
101 **Relevant AMA Materials:**

102
103 **Physicians, Psychotherapy and Mental Health Care H-345.996**

104 Our American Medical Association supports efforts to inform physicians, the public and
105 third party payers that physicians in the private sector are at the forefront of mental health
106 care in their office practices and provide significant amounts of direct and preventive
107 mental health services to the public.

108
109 **Medical and Mental Health Services for Medical Students and Resident and**
110 **Fellow Physicians H-345.973**

111 Our AMA promotes the availability of timely, confidential, accessible, and affordable
112 medical and mental health services for medical students and resident and fellow
113 physicians, to include needed diagnostic, preventive, and therapeutic services.
114 Information on where and how to access these services should be readily available at all
115 education/training sites, and these services should be provided at sites in reasonable
116 proximity to the sites where the education/training takes place.

117
118 **Access to Confidential Health Care Services for Physicians and Trainees D-**
119 **405.978**

120 1. Our AMA will advocate that: (a) physicians, medical students and all members of the
121 health care team (i) maintain self-care, (ii) are supported by their institutions in their self-
122 care efforts, and (iii) in order to maintain the confidentiality of care, have access to
123 affordable health care, including mental and physical health care, outside of their place
124 of work or education; and (b) employers support access to mental and physical health
125 care including but not limited to providing access to out-of-network in person and/or via
126 telemedicine, thereby reducing stigma, eliminating discrimination, and removing other
127 barriers to treatment.

128 2. Our AMA will advocate for best practices to ensure physicians, medical students and
129 all members of the health care teams have access to appropriate behavioral, mental,
130 primary, and specialty health care and addiction services.

131
132 **Protecting Physician Wellbeing on Applications for Board Certification D-275.946**

133 1. Our American Medical Association will work with physician board certifying
134 organizations to assure that physician wellbeing is a primary concern.

135 2. Our AMA will advocate that the focus of physician board certifying organizations on
136 physician wellbeing be demonstrated by the removal of intrusive questions regarding

137 physician physical or mental health (including substance misuse) or related treatments
138 on board certification applications.

139 3. Our AMA will advocate that any questions on physician board certifying applications
140 related to physician health be limited to only inquiries about current impairment.

141

142 **Mental Health Crisis D-345.972**

143 1. Our American Medical Association will work expediently with all interested national
144 medical organizations, national mental health organizations, and appropriate federal
145 government entities to convene a federally-sponsored blue ribbon panel and develop a
146 widely disseminated report on mental health treatment availability and suicide
147 prevention in order to:

148 a. Improve suicide prevention efforts, through support, payment and insurance
149 coverage for mental and behavioral health and suicide prevention services, including,
150 but not limited to, the National Suicide Prevention Lifeline.

151 b. Increase access to affordable and effective mental health care through expanding
152 and diversifying the mental and behavioral health workforce.

153 c. Expand research into the disparities in youth suicide prevention.

154 d. Address inequities in suicide risk and rate through education, policies and
155 development of suicide prevention programs that are culturally and linguistically
156 appropriate.

157 e. Develop and support resources and programs that foster and strengthen healthy
158 mental health development.

159 f. Develop best practices for minimizing emergency department delays in obtaining
160 appropriate mental health care for patients who are in mental health crisis.

161 2. Our AMA supports physician acquisition of emergency mental health response skills
162 by promoting education courses for physicians, fellows, residents, and medical students
163 including, but not limited to, mental health first aid training.

164 3. Our AMA along with other interested parties will advocate that children's mental
165 health and barriers to mental health care access for children represent a national
166 emergency that requires urgent attention from all interested parties.

167 4. Our AMA will join with other interested parties to advocate for efforts to increase the
168 mental health workforce to address the increasing shortfall in access to appropriate
169 mental health care for children.

170

171 **Access to Confidential Health Services for Medical Students and Physicians H-** 172 **295.858**

173 1. Our American Medical Association will ask the Liaison Committee on Medical
174 Education, Commission on Osteopathic College Accreditation, American
175 Osteopathic Association, and Accreditation Council for Graduate Medical
176 Education to encourage medical schools and residency/fellowship programs,
177 respectively, to:

178 a. provide or facilitate the immediate availability of urgent and emergent
179 access to low-cost, confidential health care, including mental health and
180 substance use disorder counseling services, that:

181 i. include appropriate follow-up;

182 ii. are outside the trainees' grading and evaluation pathways; and

- 183 iii. are available (based on patient preference and need for assurance
184 of confidentiality) in reasonable proximity to the education/training
185 site, at an external site, or through telemedicine or other virtual,
186 online means;
- 187 b. ensure that residency/fellowship programs are abiding by all duty hour
188 restrictions, as these regulations exist in part to ensure the mental and
189 physical health of trainees;
- 190 c. encourage and promote routine health screening among medical students
191 and resident/fellow physicians, and consider designating some segment of
192 already-allocated personal time off (if necessary, during scheduled work
193 hours) specifically for routine health screening and preventive services,
194 including physical, mental, and dental care; and
- 195 d. remind trainees and practicing physicians to avail themselves of any
196 needed resources, both within and external to their institution, to provide
197 for their mental and physical health and well-being, as a component of
198 their professional obligation to ensure their own fitness for duty and the
199 need to prioritize patient safety and quality of care by ensuring appropriate
200 self-care, not working when sick, and following generally accepted
201 guidelines for a healthy lifestyle.
- 202 2. Our AMA will urge state medical boards to refrain from asking applicants about
203 past history of mental health or substance use disorder diagnosis or treatment,
204 and only focus on current impairment by mental illness or addiction, and to
205 accept "safe haven" non-reporting for physicians seeking licensure or relicensure
206 who are undergoing treatment for mental health or addiction issues, to help
207 ensure confidentiality of such treatment for the individual physician while
208 providing assurance of patient safety.
- 209 3. Our AMA encourages undergraduate and graduate medical education programs
210 to create mental health substance use awareness and suicide
211 prevention screening programs that would:
- 212 a. be available to all medical students, residents, and fellows on an opt-out
213 basis;
- 214 b. ensure anonymity, confidentiality, and protection from administrative
215 action;
- 216 c. provide proactive intervention for identified at-risk students by mental
217 health and addiction professionals; and
- 218 d. inform students and faculty about personal mental health, substance use
219 and addiction, and other risk factors that may contribute to suicidal
220 ideation.
- 221 4. Our AMA:
- 222 a. encourages state medical boards to consider physical and mental
223 conditions similarly;
- 224 b. encourages state medical boards to recognize that the presence of a
225 mental health condition does not necessarily equate with an impaired
226 ability to practice medicine; and

- 227 c. encourages state medical societies to advocate that state medical boards
228 not sanction physicians based solely on the presence of a psychiatric
229 disease, irrespective of treatment or behavior.
- 230 5. Our AMA:
- 231 a. encourages study of medical student mental health, including but not
232 limited to rates and risk factors of depression and suicide;
- 233 b. encourages medical schools to confidentially gather and release
234 information regarding reporting rates of depression/suicide on an opt-out
235 basis from its students; and
- 236 c. will work with other interested parties to encourage research into
237 identifying and addressing modifiable risk factors for burnout, depression
238 and suicide across the continuum of medical education.
- 239 6. Our AMA encourages the development of alternative methods for dealing with
240 the problems of student-physician mental health among medical schools, such
241 as:
- 242 a. introduction to the concepts of physician impairment at orientation;
- 243 b. ongoing support groups, consisting of students and house staff in various
244 stages of their education;
- 245 c. journal clubs;
- 246 d. fraternities;
- 247 e. support of the concepts of physical and mental well-being by heads of
248 departments, as well as other faculty members; and/or
- 249 f. the opportunity for interested students and house staff to work with
250 students who are having difficulty. Our AMA supports making these
251 alternatives available to students at the earliest possible point in their
252 medical education.
- 253 7. Our AMA will engage with the appropriate organizations to facilitate the
254 development of educational resources and training related to suicide risk of
255 patients, medical students, residents/fellows, practicing physicians, and other
256 health care professionals, using an evidence-based multidisciplinary approach.
257

46 **WHEREAS**, Medicaid funding in some states, including Ohio, can currently
47 support short-term substance use treatment, but not other mental health treatment,
48 through Section 1115 waiver programs as a temporary method to increase funding for
49 this care⁸; and

50
51 **WHEREAS**, a 2024 analysis by the Ohio Department of Medicaid showed a
52 decrease in emergency department utilization and inpatient stays among patients with
53 SUD in Ohio after the adoption of a Section 1115 waiver increasing Medicaid
54 reimbursement for SUD treatment⁹; and

55
56 **WHEREAS**, 16 states and the District of Columbia have been approved for Section
57 1115 waivers allowing Medicaid to reimburse all mental health treatment beyond just
58 substance use disorder¹⁰; and

59
60 **WHEREAS**, an analysis from 2017 to 2021 showed that 12 of these states and the
61 District of Columbia saw decreases in mental health–related emergency department
62 visits, underscoring the benefit of covering all serious mental health treatment, not just
63 substance use disorder¹⁰; and

64
65 **WHEREAS**, an analysis of the Section 1115 waiver program adopted in Indiana in
66 2020 for treatment of serious mental illness (i.e. all mental health treatment) showed a
67 15.9% decrease in emergency department utilization in metro areas, a 19.1% decrease
68 in larger non-metro areas, a 17.9% decrease in smaller non-metro areas, and a 32.2%
69 decrease in rural areas among patients with a serious mental illness¹¹; and therefore be
70 it

71
72 **RESOLVED**, That our OSMA supports the use of Section 1115 waivers to
73 circumvent the restrictions of the Institution for Mental Diseases (IMD) exclusion and
74 increase Medicaid funding for treatment of all mental health disorders.

75
76 **Fiscal Note:** \$ X (Sponsor)
77 \$ 500+ (Staff)

78
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117
118 **Relevant OSMA Policy:**

119 **Policy 9 - 1998 - Access and Parity of Mental Health Coverage**

- 120 1. The OSMA supports access and parity of mental health coverage as reflected in
121 the following statements:
- 122 1) Treatment of mental health problems should be integrated as much as possible
123 into other aspects of general healthcare.
- 124 2) Primary care physicians should have ongoing consultation available from and
125 efficient referral access to expert mental health providers.
- 126 3) Health care coverage plans should include mental health benefits on parity with
127 other general medical conditions for medically necessary treatment performed by
128 accountable clinicians.
- 129 4) Health care plans that list providers will also list individual mental health care
130 providers so that referrals can be made as a collaborative effort involving patients,
131 referring physicians and mental health care clinicians.
- 132 5) Psychiatrists and non-psychiatrists be appropriately compensated for the
133 psychiatric services they provide.

134
135 **Policy 62 - 1989 - Care of the Chronically, Mentally III**

- 136 1. The OSMA encourages improvement of Ohio's mental health system.
137 2. The Ohio mental health system should provide up-to-date psychiatric treatment
138 to patients with acute and intermittent psychiatric conditions, as well as planning,
139 evaluation and treatment for those with chronic psychiatric conditions.
140 3. Decisions concerning access to and treatment in the Ohio mental health system
141 should be made by physicians.
142

143 **Relevant AMA Materials:**

144 **Support for Continuance of Section 1115 Medicaid Waivers and Demonstration**
145 **Projects D-290.971:** Our AMA supports the use of Medicaid Section 1115 waivers to
146 address health-related social needs through evidence-based and medically appropriate
147 interventions.
148

149 **Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978:** Our
150 AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric
151 services and the continuum of care for mental illness and substance use disorders,
152 ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for
153 the care of patients with mental illness.
154

155 **Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976:** Our American
156 Medical Association will monitor the Medicaid Emergency Psychiatric Demonstration
157 Project established by the Patient Protection and Affordable Care Act for consistency with
158 AMA policy, especially the impact on access to psychiatric care and treatment of
159 substance use disorders.
160

161 **Maintaining Mental Health Services by States H-345.975:** Our American Medical
162 Association supports maintaining essential mental health services at the state level, to
163 include maintaining state inpatient and outpatient mental hospitals, community mental
164 health centers, addiction treatment centers, and other state-supported psychiatric
165 services.

45 **WHEREAS**, untreated perinatal mental health conditions can lead to chronic or
46 recurrent depression, increased risk of substance misuse, and loss of employment or
47 caregiving capacity, compounding long-term maternal health risks⁸; and
48

49 **WHEREAS**, children of individuals with untreated postpartum depression face
50 higher rates of emotional and behavioral difficulties, impaired attachment, and
51 developmental delays that can persist into school age and beyond⁸; and
52

53 **WHEREAS**, postpartum depression and anxiety disproportionately affect Black,
54 Hispanic, and other marginalized populations due to systemic inequities, including
55 unequal access to care, provider bias, chronic stress from racism, and social
56 determinants of health; and the Ohio Pregnancy Assessment Survey reports that in 2022,
57 12.8% of non-Hispanic Black women experienced postpartum depressive symptoms
58 compared to 9.3% of non-Hispanic White women⁹; and
59

60 **WHEREAS**, limitations in insurance coverage, provider shortages, fragmented
61 systems (gaps in obstetric follow up and hand off post-delivery, limited communication
62 and referral pathways for mental health), and stigma further prevent timely identification
63 and treatment of perinatal mental health conditions^{10,11}; and
64

65 **WHEREAS**, as many as 40% of postpartum individuals do not attend a postpartum
66 visit, meaning that relying on a single screening encounter may miss individuals who
67 remain at risk; and¹²,
68

69 **WHEREAS**, evidence suggests that implementing maternal mental-health
70 screening at multiple postpartum touchpoints, including well-child (pediatric) visits, can
71 increase detection of postpartum mood and anxiety disorders and improve linkage to
72 care¹³; and
73

74 **WHEREAS**, the State of Ohio received an ‘F’ rating for maternal mental health
75 screening and reimbursement and a ‘C’ grade for providers and programs on the Policy
76 Center for Maternal Mental Health’s 2025 State Report Cards, reflecting gaps in state-
77 mandated screening systems, insurance reimbursement, provider availability, and
78 program development¹⁴; and
79

80 **WHEREAS**, Medicaid covers approximately 40% of all births in the United States,
81 making access to reimbursable perinatal mental health screening and treatment an
82 essential component of equitable maternal healthcare¹⁵; and
83

84 **WHEREAS**, early screening and treatment of perinatal mental health conditions
85 have been shown to reduce maternal morbidity and mortality, improve infant
86 developmental outcomes, and generate long-term healthcare and economic savings^{16,17};
87 and
88

89 **WHEREAS**, the American College of Obstetricians and Gynecologists (ACOG)
90 recommends universal screening for depression and anxiety during pregnancy and the

91 postpartum period using validated tools, and emphasizes that screening must be paired
92 with systems for diagnosis, treatment, follow-up, and timely access to evidence-based
93 psychotherapy and pharmacologic care when indicated^{18,19}; and
94

95 **WHEREAS**, the American Medical Association supports expanded access to
96 perinatal mental health services, insurance coverage for care through 12 months
97 postpartum, and integration of screening into routine care²⁰; and therefore be it
98

99 **RESOLVED**, that our OSMA supports policies that support postpartum mental-
100 health screening across the perinatal period, including at multiple points of care, and
101 promote the availability of clear and consistent follow-up support for individuals who
102 screen positive, including access to behavioral-health resources, to increase
103 opportunities for early identification and continuity of care; and be it further
104

105 **RESOLVED**, that our OSMA supports the implementation of universal screening
106 for perinatal mood and anxiety disorders as part of routine prenatal and postpartum care,
107 in order to improve early identification of those in need and facilitate timely referral for
108 treatment; and be it further
109

110 **RESOLVED**, that our OSMA supports expanded access to effective treatment and
111 support for individuals facing perinatal mental health challenges, including policies and
112 programs that improve insurance coverage and affordability of mental health services
113 during pregnancy and up to 12 months postpartum and the integration of mental health
114 services into obstetric settings.
115

116 **Fiscal Note:** \$ X (Sponsor)
117 \$ 500+ (Staff)
118

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190

191 **Relevant OSMA Policy:**

192 **Policy 28 - 2022 - Substance Use Disorder in Pregnant People**

- 193 1. The OSMA opposes any efforts to assert that a diagnosis of substance use disorder
194 in a pregnant person alone constitutes child abuse or inherent parental unfitness.
195 2. The OSMA supports prioritizing funding for the expansion of integrative mental
196 health and substance use treatment programs explicitly for pregnant persons.
197 3. The OSMA opposes the removal of a child based solely on a prenatal drug screen
198 or positive newborn toxicology screening without a full safety evaluation of
199 newborn care upon disposition.
200

201 **Policy 9 - 1998 - Access and Parity of Mental Health Coverage**

202 The OSMA supports access and parity of mental health coverage as reflected in the
203 following Statements:

- 204 1) Treatment of mental health problems should be integrated as much as possible
205 into other aspects of general healthcare.
206 2) Primary care physicians should have ongoing consultation available from and
207 efficient referral
208 access to expert mental health providers.
209 3) Health care coverage plans should include mental health benefits on parity with
210 other general medical conditions for medically necessary treatment performed
211 by accountable clinicians.
212 4) Health care plans that list providers will also list individual mental health care
213 providers so that referrals can be made as a collaborative effort involving
214 patients, referring physicians and mental health care clinicians.
215 5) Psychiatrists and non-psychiatrists be appropriately compensated for the
216 psychiatric services they provide.
217

218 **Relevant AMA Materials:**

219 **Improving Treatment and Diagnosis of Peripartum Depression Through Screening**
220 **and State-Based Care Coordination D-420.991**

- 221 1. Our American Medical Association will work with stakeholders to encourage the
222 implementation of a routine protocol for depression screening in pregnant and
223 postpartum people presenting alone or with their child during prenatal, postnatal,
224 pediatric, or emergency room visits.
225 2. Our AMA encourages the development of training materials related to peripartum
226 depression to advise providers on appropriate treatment and referral pathways.

- 227 3. Our AMA encourages the development of state-based care coordination
228 programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate
229 referral, treatment and access to follow-up peripartum mental health care.
230

231 **Improving Mental Health Services During Pregnancy and Postpartum H-420.953**

- 232 1. Our American Medical Association will support improvements in current mental
233 health services during pregnancy and postpartum periods.
234 2. Our AMA will support advocacy for inclusive insurance coverage of and sufficient
235 payment for mental health services during gestation, and extension of
236 postpartum mental health services coverage to one year postpartum.
237 3. Our AMA will support appropriate organizations working to improve awareness
238 and education among patients, families, and providers of the risks of mental
239 illness during gestation and postpartum.
240 4. Our AMA will continue to advocate for funding programs that address perinatal
241 and postpartum depression, anxiety and psychosis, and substance use disorder
242 through research, public awareness, and support programs.
243 5. Our AMA will advocate for evidence-based postpartum depression screening and
244 prevention services to be recognized as the standard of care for all federally-
245 funded health care programs for persons who are pregnant or in a postpartum
246 state.

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WHEREAS, medically-inaccurate reproductive and sexual health education, such as reproductive biology, development, and STI prevention can lead to spread of misinformation to populations, leading to reduced health outcomes, provider mistrust, delays in seeking necessary care, and riskier sexual behaviors⁴; and

WHEREAS, rates of STIs and teen pregnancy in the United States remain higher than in other developed countries⁵, with Ohio ranking in the bottom half of all US states¹³, and evidence demonstrates that abstinence-only education does not reduce sexual activity or STI risk, while comprehensive sexual health education is associated with reduced risk of teen pregnancy without increasing sexual activity⁵; and

WHEREAS, the American College of Obstetricians and Gynecologists (ACOG) supports comprehensive sexuality education that is medically accurate, evidence-based, age-appropriate, begins in early childhood, and includes contraception, STI prevention, healthy relationships, consent, dating violence prevention, and inclusive information on gender identity and sexual orientation⁶; and

WHEREAS, the American Academy of Pediatrics supports age-appropriate sexuality education that addresses the biological, sociocultural, psychological, and relational dimensions of sexuality, including sexual development, gender identity, intimacy, body image, and healthy relationships, and emphasizes the importance of inclusive education for children with disabilities and diverse cultural backgrounds⁷; and

WHEREAS, LGBTQIA+ young populations are more likely to experience sexual and intimate partner violence compared to heterosexual and cisgender populations (nearly 49% to 11%), and this is even higher for LGBTQIA+ persons of color, which leads to poorer mental health outcomes and higher rates of depression and suicide⁸; and

WHEREAS, sexual and gender minority youth often lack culturally appropriate sexual health education, leading to feelings of isolation and alienation, as well as hostile environments during education in school where discussions about their identity do not feel tolerated, leading to exacerbation of mental health conditions and higher rates of STIs, unplanned teen pregnancies, and abortions^{9,10}; and

WHEREAS, adolescents face increasing exposure to online sexual exploitation and abuse, and education on digital safety, consent, and online risk prevention can support adolescents and families in recognizing, preventing, and responding to exploitation^{11,12}; and

WHEREAS, adolescent dating violence is highly prevalent and is associated with adverse short- and long-term health outcomes including mental health conditions, substance misuse, STI risk, academic harm, and increased likelihood of continued violence, and education can promote healthy relationship skills and violence prevention^{11,12}; and

93 **WHEREAS**, despite existing OSMA and AMA policy (Policy 38-2021 Advocating
94 for the Adoption of Statewide Sexual Education Standard and H-170.968 Sexuality
95 Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in
96 Schools) supporting comprehensive, medically accurate sexual health education,
97 significant gaps remain in curriculum accuracy, gender and cultural inclusivity, and
98 protection from misinformation in Ohio, demonstrating the need for strengthened and
99 modernized OSMA policy in this area; therefore be it

100
101 **RESOLVED**, that our OSMA amend Policy 38-2021 by addition as follows:

102
103 **Policy 38-2021 Advocating for the Adoption of Statewide Sexual**
104 **Education Standards**

- 105 1. The OSMA supports age-appropriate, evidence-based, comprehensive
106 health education in schools beginning in early childhood.
- 107 2. The OSMA defines comprehensive sexual education as including, but
108 not limited to, the following subjects: normal reproductive development,
109 human sexuality (including intimate relationships), healthy sexual and
110 nonsexual relationships, gender identity and sexual orientation,
111 abstinence, contraception, DIGITAL SAFETY AND ONLINE SEXUAL
112 EXPLOITATION PREVENTION, prevention of sexually transmitted
113 infections, communication, consent, decision making, recognizing and
114 preventing sexual violence, and reproductive rights and
115 responsibilities.
- 116 3. The OSMA will advocate for the adoption of required, state-wide
117 sexual health education standards for K-12 schools that are in
118 accordance with this resolution and the policies of the OSMA.

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121 **Fiscal Note:** \$ X (Sponsor)
122 \$ 500 (Staff)

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173
174 **Relevant OSMA Policy:**

175 **Policy 38 - 2021 - Advocating for the Adoption of Statewide Sexual Education**
176 **Standards**

- 177 1. The OSMA supports age-appropriate, evidence-based, comprehensive health
178 education in schools beginning in early childhood.
- 179 2. The OSMA defines comprehensive sexual education as including, but not limited
180 to, the following subjects: normal reproductive development, human sexuality
181 (including intimate relationships), healthy sexual and nonsexual relationships,
182 gender identity and sexual orientation, abstinence, contraception, prevention
183 of sexually transmitted infections, communication, consent, decision making,

- 184 recognizing and preventing sexual violence, and reproductive rights and
185 responsibilities.
186 3. The OSMA will advocate for the adoption of required, state-wide sexual health
187 education standards for K-12 schools that are in accordance with this resolution
188 and the policies of the OSMA.
189

190 **Policy 29 - 2000 - Education to Prevent Teenage Pregnancy and Sexually**
191 **Transmissible Diseases**

192 1. The OSMA adopts as policy, AMA policy H-170.968 Sexuality Education, Sexual
193 Violence Prevention, Abstinence and Distribution of Condoms in Schools, which
194 states that the AMA supports responsible sex education which includes: information
195 on reproductive biology, accurate and understandable information on sexual
196 abstinence, sexual responsibility, availability and reliability of contraceptives including
197 condoms, alternatives in birth control, and other information aimed at prevention of
198 pregnancy and sexual transmission of diseases.
199

200 **Relevant AMA Materials:**

201 **H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and**
202 **Distribution of Condoms in Schools**

- 203 1. Our American Medical Association supports the concept of sexuality education in the
204 home, when possible, as well as developmentally appropriate sexuality education
205 programming in the schools at all levels, at local option and direction.
206 2. Our AMA urges schools at all education levels to implement comprehensive,
207 developmentally appropriate sexuality education programs that:
208 a. are based on rigorous, peer reviewed science;
209 b. incorporate sexual violence prevention;
210 c. show promise for delaying the onset of sexual activity and a reduction in sexual
211 behavior that puts adolescents at risk for contracting human immunodeficiency
212 virus (HIV) and other sexually transmitted diseases and for becoming pregnant;
213 d. include an integrated strategy for making condoms and other effective barrier
214 protection methods available to students and for providing both factual
215 information and skill-building related to reproductive biology, sexual abstinence,
216 sexual responsibility, contraceptives including condoms, alternatives in birth
217 control, and other issues aimed at prevention of pregnancy and sexual
218 transmission of diseases;
219 e. utilize classroom teachers and other professionals who have shown an aptitude
220 for working with young people and who have received special training that
221 includes addressing the needs of LGBTQ+ youth;
222 f. appropriately and comprehensively address the sexual behavior of all people,
223 inclusive of sexual and gender minorities;
224 g. include ample involvement of parents, health professionals, and other concerned
225 members of the community in the development of the program;
226 h. are part of an overall health education program; and
227 i. include culturally competent materials that are language-appropriate for Limited
228 English Proficiency (LEP) pupils;

- 229 3. Our AMA will continue to monitor future research findings related to emerging
230 initiatives that include abstinence-only, school-based sexuality education, and
231 consent communication to prevent dating violence while promoting healthy
232 relationships, and school-based condom availability programs that address sexually
233 transmitted diseases and pregnancy prevention for young people and report back to
234 the House of Delegates as appropriate.
- 235 4. Our AMA will work with the United States Surgeon General to design programs that
236 address communities of color and youth in high risk situations within the context of a
237 comprehensive school health education program.
- 238 5. Our AMA opposes the sole use of abstinence-only education, as defined by the
239 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school
240 systems.
- 241 6. Our AMA endorses comprehensive family life education in lieu of abstinence-only
242 education, unless research shows abstinence-only education to be superior in
243 preventing negative health outcomes.
- 244 7. Our AMA supports federal funding of comprehensive sex education programs that
245 stress the importance of preventing unwanted teenage pregnancy and sexually
246 transmitted infections via comprehensive education, including contraceptive choices,
247 abstinence, and safer sex, and opposes federal funding of community-based
248 programs that do not show evidence-based benefits.
- 249 8. Our AMA extends its support of comprehensive family-life education to community-
250 based programs promoting abstinence as the best method to prevent teenage
251 pregnancy and sexually-transmitted diseases while also discussing the roles of
252 condoms and birth control, as endorsed for school systems in this policy.
- 253 9. Our AMA supports the development of sexual education curriculum that integrates
254 dating violence prevention through lessons on healthy relationships, sexual health,
255 and conversations about consent.
- 256 10. Our AMA encourages physicians and all interested parties to develop best-practice,
257 evidence-based, guidelines for sexual education curricula that are developmentally
258 appropriate as well as medically, factually, and technically accurate.

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WHEREAS, Increasing the availability and insurance coverage of home-based STI testing kits can reduce disparities in access for adolescents, young adults, rural communities, and other underserved populations⁸; and

WHEREAS, Offering patients the option to self-collect samples for STI testing has been shown to increase testing uptake rates, and self-collected samples are equal or superior to clinician-collected samples in terms of sensitivity and specificity^{9,10}; and

WHEREAS, A national survey showed that adolescents and young adults would utilize STI self-collection kits but some respondents expressed concerns about accuracy of the tests^{11,12}; and

WHEREAS, As an example of a safety net clinic system, Planned Parenthood of Greater Ohio performed nearly 150,000 STI tests in 2023-2024, but has closed three clinic sites and significantly reduced staffing in 2025 due to budgetary cuts¹³; and

WHEREAS, Increased home-based STI testing (self-collected or DTC kits) can reduce clinic staff workload¹⁴; and

WHEREAS, Both patient- and provider-focused education and outreach strategies have been shown to effectively increase uptake of home-based screening for colorectal cancer¹⁵ suggesting that similar strategies would be effective for STI prevention; and

WHEREAS, Public-focused campaigns on STI testing and screening have been shown to increase knowledge about STIs and uptake of screening, but have short-lived effects due to rapidly changing media landscapes¹⁶; and therefore be it

RESOLVED, that our OSMA amend Policy 16 – 2011 by addition:

Policy 16 – 2011 – Sexually Transmitted Infections (STI) Education and Prevention Initiative

1. The OSMA requests that the AMA and other appropriate organizations promote a campaign or campaigns to educate the public about the adverse effects of high risk sexual behavior.
2. OSMA SUPPORTS MEASURES THAT INCREASE EDUCATION OF AND ACCESS TO CARE FOR SEXUALLY TRANSMITTED INFECTIONS (STIS), INCLUDING BUT NOT LIMITED TO PHYSICIAN UTILIZATION OF HOME-BASED STI TESTING KITS AND INSURANCE COVERAGE OF SUCH PROGRAMS.

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

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150

151 **Relevant OSMA Policy:**

152 **Policy 53 - 1991 - Prevention of Sexually Transmitted Human Papilloma Virus (HPV)**
153 **Infections**

- 154 1. The OSMA supports human papilloma virus infection awareness and prevention.
155

156 **Policy 29 - 2000 - Education to Prevent Teenage Pregnancy and Sexually**
157 **Transmissible Diseases**

- 158 1. The OSMA adopts as policy, AMA policy H-170.968 Sexuality Education, Sexual
159 Violence Prevention, Abstinence and Distribution of Condoms in Schools, which
160 states that the AMA supports responsible sex education which includes: information
161 on reproductive biology, accurate and understandable information on sexual
162 abstinence, sexual responsibility, availability and reliability of contraceptives including
163 condoms, alternatives in birth control, and other information aimed at prevention of
164 pregnancy and sexual transmission of diseases.
165

166 **Policy 16 - 2011 - Sexually Transmitted Infections (STI) Education and Prevention**
167 **Initiative**

- 168 1. The OSMA requests that the AMA and other appropriate organizations promote a
169 campaign or campaigns to educate the public about the adverse effects of high risk
170 sexual behavior.
171

172 **Policy 38 – 2021 - Advocating for the Adoption of Statewide Sexual Education**
173 **Standards**

- 174 1. The OSMA supports age-appropriate, evidence based, comprehensive health
175 education in schools beginning in early childhood.
176 2. The OSMA defines comprehensive sexual education as including, but not limited
177 to, the following subjects: normal reproductive development, human sexuality
178 (including intimate relationships), healthy sexual and nonsexual relationships, gender
179 identity and sexual orientation, abstinence, contraception, prevention of sexually
180 transmitted infections, communication, consent, decision making, recognizing and
181 preventing sexual violence, and reproductive rights and responsibilities.

182 3. The OSMA will advocate for the adoption of required, state-wide sexual health
183 education standards for K-12 schools that are in accordance with this resolution and
184 the policies of the OSMA.
185

186 **Policy 26 – 1995 – HIV Testing of Pregnant Women**

187 1. The OSMA recommends routine HIV counseling and testing of pregnant women as
188 a part of pre-natal care.
189

190 **Policy 41 – 1996 – More Routine HIV Testing**

191 1. The OSMA recommends more routine HIV testing especially young sexually active
192 people.
193

194 **Relevant AMA Materials:**

195 **H-440.983 Update on Sexually Transmitted Infections**

- 196 1. Our AMA urges medical students, primary care residents, and physicians in all
197 specialties to familiarize themselves with sexually transmitted infections (STI), so
198 that they will be better able to diagnose and treat them.
199 2. Our AMA encourages physicians to always include a sexual history as part of their
200 routine history and physical exam.
201 3. Our AMA encourages STI instruction, both didactic and clinical, in all medical school
202 and primary residency programs.
203 4. Our AMA encourages the establishment of STI fellowships by primary care
204 specialties in order to develop a pool of clinical and research expertise in the area.
205 5. Our AMA encourages state and local medical societies to promote STI public service
206 TV and radio announcements in their communities.
207 6. Our AMA supports continued communication of updated STI information regularly
208 through AMA publications.
209 7. Our AMA supports federal and state efforts to expand access to comprehensive
210 sexually transmitted infection (STI) screening, treatment, and prevention services for
211 persons with unstable or no housing.
212

213 **H-440.996 Sexually Transmitted Infection Control**

214 Our AMA

- 215 (1) supports continued action to assert appropriate leadership in a concerted program to
216 control sexually transmitted infection;
217 (2) urges physicians to take all appropriate measures to reverse the rise in sexually
218 transmitted infection and bring it under control;
219 (3) encourages constituent and component societies to support and initiate efforts to gain
220 public support for increased appropriations for public health departments to fund
221 research in development of practical methods for prevention and detection of sexually
222 transmitted infection, with particular emphasis on control of gonorrhea; and
223 (4) in those states where state consent laws have not been modified, encourages the
224 constituent associations to support enactment of statutes that permit physicians and
225 their co-workers to treat and search for sexually transmitted infection in minors legally
226 without the necessity of obtaining parental consent.
227

228 **H-440.979 Control of Sexually Transmitted Infections**

229 The AMA urges increased efforts at all levels of organized medicine to bring sexually
230 transmitted infections under control, through professional and public education, and
231 support of the efforts of state Departments of Health, the Centers for Disease Control and
232 Prevention, the National Institutes of Health, and other appropriate organizations.

46 and delivery, 12 states have laws for testing newborns, and 5 states have non-specific
47 perinatal HIV testing laws; Ohio has no laws⁹; and
48

49 **WHEREAS**, North Carolina regulations say that healthcare providers must offer
50 HIV counseling and testing to every pregnant client; in the 2 years after this mandate was
51 put in place, perinatal HIV testing increased from 87% to 96% and perinatal HIV treatment
52 went from 21% to 95%¹⁰; and
53

54 **WHEREAS**, in California, a passed bill mandated that all providers must offer and
55 document offer of a perinatal HIV test; in the resulting years, there was a statistically
56 significant increase in offers of perinatal HIV testing and a statistically significant increase
57 in offers of perinatal HIV treatment¹¹; and
58

59 **WHEREAS**, in Illinois, a statewide program of perinatal HIV testing caused an
60 increase in rapid testing and a nearly 100% rate of mothers and infants leaving the
61 hospital with a known HIV status¹²; and therefore be it
62

63 **RESOLVED**, The OSMA reaffirm Policy 26-1995.
64

65 **Fiscal Note:** \$ X (Sponsor)
66 \$ 500 (Staff)
67

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114 115 **Relevant OSMA Policy:**

116 **Policy 26 – 1995 – HIV Testing of Pregnant Women**

- 117 1. The OSMA recommends routine HIV counseling and testing of pregnant women as
118 a part of pre-natal care.

119 120 **Relevant AMA Materials:**

121 **Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV** 122 **Transmission H-20.918**

123 In view of the significance of the finding that treatment of HIV-infected pregnant people
124 with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their
125 infants, our AMA recommends the following statements:

- 126
127 (1) Given the prevalence and distribution of HIV infection among individuals in the United
128 States, the potential for effective early treatment of HIV infection, and the significant
129 reduction in perinatal HIV transmission with treatment of pregnant people with
130 appropriate antiretroviral therapy, routine education about HIV infection and testing
131 should be part of a comprehensive health care program for all individuals. The ideal
132 would be for all people to know their HIV status before considering pregnancy.
- 133 (2) Universal HIV testing of all pregnant people, with patient notification of the right of
134 refusal, should be a routine component of perinatal care. Basic counseling on HIV
135 prevention and treatment should also be provided to the patient, consistent with the
136 principles of informed consent.

- 137 (3) The final decision about accepting HIV testing is the responsibility of the patient. The
138 decision to consent to or refuse an HIV test should be voluntary. When the choice is
139 to reject testing, the patient's refusal should be recorded. Test results should be
140 confidential within the limits of existing law and the need to provide appropriate
141 medical care for patients and their infant.
- 142 (4) To assure that the intended results are being achieved, the proportion of pregnant
143 people who have accepted or rejected HIV testing and follow-up care should be
144 monitored and reviewed periodically at the appropriate practice, program or
145 institutional level. Programs in which the proportion of patients accepting HIV testing
146 is low should evaluate their methods to determine how they can achieve greater
147 success.
- 148 (5) Pregnant people who are not seen by a health care professional for prenatal care until
149 late in pregnancy or after the onset of labor should be offered HIV testing at the earliest
150 practical time, but not later than during the immediate postpartum period.
- 151 (6) When HIV infection is documented in a pregnant person, proper post-test counseling
152 should be provided. The patient should be given an appropriate medical evaluation of
153 the stage of infection and full information about the recommended management plan
154 for their own health. Information should be provided about the potential for reducing
155 the risk of perinatal transmission of HIV infection to the infant through the use of
156 antiretroviral therapy, and about the potential but unknown long-term risks to the
157 patient and the infant from the treatment course. The final decision to accept or reject
158 antiretroviral treatment recommended for the patient and their infant is the right and
159 responsibility of the patient. When the serostatus is either unknown or known to be
160 positive, appropriate counseling should also be given regarding the risks associated
161 with breastfeeding for both her own disease progression and disease transmission to
162 the infant.
- 163 (7) Appropriate medical treatment for HIV-infected pregnant people should be determined
164 on an individual basis using the latest published Centers for Disease Control and
165 Prevention recommendations. The most appropriate care should be available
166 regardless of the stage of HIV infection or the time during gestation at which the patient
167 presents for prenatal or intrapartum care.
- 168 (8) To facilitate optimal medical care for pregnant people and their infants, HIV test results
169 (both positive and negative) and associated management information should be
170 available to the physicians taking care of both individuals. Ideally, this information will
171 be included in the confidential medical records. Physicians providing care for a
172 pregnant person or their infant should obtain the appropriate consent and should notify
173 the other involved physicians of the HIV status of and management information about
174 the pregnant patient and their infant, consistent with applicable state law.
- 175 (9) Continued research into new interventions is essential to further reduce the perinatal
176 transmission of HIV, particularly the use of rapid HIV testing for patients presenting in
177 labor and those presenting in the prenatal setting who may not return for test results.
178 The long-term effects of antiretroviral therapy during pregnancy and the intrapartum
179 period for both pregnant patients and their infants also must be evaluated. For both
180 infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term
181 follow-up studies are needed to assess potential complications such as organ system

182 toxicity, neurodevelopmental problems, pubertal development problems, reproductive
183 capacity, and development of neoplasms.
184 (10) Health care professionals should be educated about the benefits of universal HIV
185 testing, with patient notification of the right of refusal, as a routine component of
186 prenatal care, and barriers that may prevent implementation of universal HIV testing
187 as a routine component of prenatal care should be addressed and removed. Federal
188 funding for efforts to prevent perinatal HIV transmission, including both prenatal
189 testing and appropriate care of HIV-infected pregnant people, should be maintained.

47 **WHEREAS**, children experiencing housing instability are more likely to have
48 significant behavioral and developmental challenges including disorders of nutrition and
49 growth^{8,9}; and
50

51 **WHEREAS**, individuals facing housing instability and limited financial resources
52 may prioritize food and shelter over healthcare needs, resulting in decreased access to
53 preventive and primary care and increased reliance on emergency departments and
54 inpatient services¹⁰; and
55

56 **WHEREAS**, criminalization and forced institutionalization of homelessness
57 disrupt continuity of care, increase justice system involvement, and exacerbate existing
58 behavioral health conditions¹¹; and
59

60 **WHEREAS**, punitive responses to homelessness disproportionately affect people
61 of color, LGBTQ+ youth, and individuals with serious mental illness, further entrenching
62 health inequities and social marginalization¹¹; and
63

64 **WHEREAS**, sharing of protected health information between healthcare systems
65 and law enforcement agencies for non-clinical purposes undermines trust in medical
66 institutions and deters people experiencing homelessness from seeking needed care^{12,13};
67 and
68

69 **WHEREAS**, the U.S. Community Preventive Services Task Force finds that,
70 compared to Treatment First Initiatives, Housing First programs, without preconditions
71 such as sobriety or treatment participation, are associated with greater housing stability,
72 reduced homelessness, improved quality of life, and decreased emergency department
73 use and hospitalizations, including among individuals living with HIV¹⁴; and
74

75 **WHEREAS**, Medicaid is a critical source of coverage for people experiencing
76 homelessness, and gaps in coverage are associated with increased emergency
77 department use, hospitalizations, and unmet mental health and substance use treatment
78 needs¹⁵⁻¹⁷; and
79

80 **WHEREAS**, Ohio and other states are pursuing or implementing Section 1115
81 waivers that impose work or community engagement requirements and other
82 administrative conditions for Medicaid eligibility among expansion adults¹⁸⁻²⁰; and
83

84 **WHEREAS**, implementing mobile clinics save patients from the financial burden
85 of emergency department visits; estimates that each mobile clinic results in an average
86 of 600 fewer emergency room visits per year, saving one-fifth the cost of care²¹; and
87

88 **WHEREAS**, according to a self-report by 291 mobile health clinics in 2021, 56%
89 of clinics specifically target uninsured patients, 55% target to serve low-income patients,
90 and 38% of mobile clinics target homeless patients, and 36% target rural patients²¹; and
91

92 **WHEREAS**, mobile health clinics can be especially valuable during public health
93 emergencies, pandemics, or when communities are displaced or underserved – offering
94 accessible rapid vaccinations and urgent care²²; and
95

96 **WHEREAS**, street medicine programs that bring interdisciplinary care directly to
97 encampments and unsheltered locations have demonstrated success in engaging people
98 who are otherwise disconnected from health and social services²³⁻²⁵; and
99

100 **WHEREAS**, medical respite (recuperative care) programs provide short-term,
101 medically supervised, residential care for people experiencing homelessness who are
102 too ill for streets or shelters but not ill enough to remain in the hospital, and have been
103 shown to reduce readmissions and improve health outcomes^{26,27}; and
104

105 **WHEREAS**, implementation of street medicine and medical respite care at scale
106 requires sustainable payment mechanisms (e.g., Medicaid, managed care, hospital
107 community benefit investments) and integration into local homelessness response
108 systems^{28,29}; and
109

110 **WHEREAS**, coverage loss among people experiencing homelessness is likely to
111 worsen health outcomes and increase uncompensated care and emergency utilization,
112 undermining the goals of both Medicaid and public health^{17,30}; therefore be it
113

114 **RESOLVED**, the OSMA supports the development of mobile preventative care
115 clinics - including but not limited to immunizations, disease screening, chronic disease
116 monitoring, and health education; and be it further
117

118 **RESOLVED**, the OSMA supports partnerships between health systems and
119 community health centers to establish and expand medical respite programs, street
120 medicine teams, and mobile preventative care clinics.
121

122 **Fiscal Note:** \$ X (Sponsor)
123 \$ 500 (Staff)
124

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214
215 **Relevant OSMA Policy:**

216 **Policy 32 - 2021 - Implementing Free and Routine Infectious Disease Testing at**
217 **Homeless Shelters Across Ohio**

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

220
221 **Policy 29 - 2022 - Supporting Housing Initiatives to Improve Health of Homeless**
222 **Individuals**

- 223 1. The OSMA supports the development of state and local policies that protect the
224 health of low income and homeless individuals by promoting and funding housing
225 initiatives.

226

227 **Policy 17 - 2025 - Ohio State Medical Association Medicaid Position on Medicaid**
228 **Cost-Sharing and Eligibility**

- 229 1. The Ohio State Medical Association opposes the instatement of premiums and out-
230 of-pocket cost sharing for Medicaid and the Children’s Health Insurance Program.
231 2. The Ohio State Medical Association oppose federal and state cuts to
232 Medicaid/CHIP funding, including via block grants, Federal Medical Assistance
233 Percentage (FMAP) reductions, changes to provider taxes, limits on covered services
234 and medications, and addition of prior authorizations as a means of maintaining
235 reimbursement rates and avoiding higher uncompensated care costs.
236 3. The Ohio State Medical Association oppose work requirements as a criterion for
237 Medicaid eligibility.
238 4. The Ohio State Medical Association advocate for maintained Medicaid payment
239 rates for hospitals, physicians, nursing homes, and other health care providers without
240 reduction in “optional benefits” including prescription drug coverage and clinic
241 services.
242 5. The Ohio State Medical Association oppose reductions in Medicaid/CHIP eligibility.
243

244 **Relevant AMA Materials:**

245 **Housing Insecure Individuals with Mental Illness H-160.978**

- 246 1. Our American Medical Association believes that public policy initiatives directed
247 to the homeless, including the homeless mentally ill population, should include
248 the following components:
249 a. Access to care (e.g., integrated, comprehensive services that permit flexible,
250 individualized treatment; more humane commitment laws that ensure active
251 inpatient treatment; and revisions in government funding laws to ensure
252 eligibility for homeless persons).
253 b. Clinical concerns (e.g., promoting diagnostic and treatment programs that
254 address common health problems of the homeless population and promoting
255 care that is sensitive to the overriding needs of this population for food,
256 clothing, and residential facilities).
257 c. Program development (e.g., advocating emergency shelters for the homeless;
258 supporting a full range of supervised residential placements; developing
259 specific programs for multiproblem patients, women, children, and
260 adolescents; supporting the development of a clearinghouse; and promoting
261 coalition development).
262 d. educational needs;
263 e. housing needs; and
264 f. research needs.
265 g. Our AMA encourages medical schools and residency training programs to
266 develop model curricula and to incorporate in teaching programs content
267 on health problems of the homeless population, including experiential
268 community-based learning experiences.
269 h. Our AMA urges specialty societies to design interdisciplinary continuing
270 medical education training programs that include the special treatment
271 needs of the homeless population.
272

273 **Eradicating Homelessness H-160.903**

- 274 1. Our American Medical Association supports improving the health outcomes and
275 decreasing the health care costs of treating the chronically homeless through
276 clinically proven, high quality, and cost effective approaches which recognize the
277 positive impact of stable and affordable housing coupled with social services.
- 278 2. Our AMA recognizes that stable, affordable housing as a first priority, without
279 mandated therapy or services compliance, is effective in improving housing
280 stability and quality of life among individuals who are chronically-homeless.
- 281 3. Our AMA recognizes adaptive strategies based on regional variations,
282 community characteristics and state and local resources are necessary to
283 address this societal problem on a long-term basis.
- 284 4. Our AMA supports the use of physician-led, team-based street medicine
285 programs, which travel to individuals who are unhoused or unsheltered and
286 provide healthcare and social services, as well as funds, including Medicaid and
287 other public insurance reimbursement, for their maintenance.
- 288 5. Our AMA recognizes the need for an effective, evidence-based national plan to
289 eradicate homelessness.
- 290 6. Our AMA encourages the National Health Care for the Homeless Council to
291 study the funding, implementation, and standardized evaluation of Medical
292 Respite Care for homeless persons.
- 293 7. Our AMA will partner with relevant stakeholders to educate physicians about the
294 unique healthcare and social needs of homeless patients and the importance of
295 holistic, cost-effective, evidence-based discharge planning, and physicians' role
296 therein, in addressing these needs.
- 297 8. Our AMA encourages the development of holistic, cost-effective, evidence-based
298 discharge plans for homeless patients who present to the emergency department
299 but are not admitted to the hospital.
- 300 9. Our AMA encourages the collaborative efforts of communities, physicians,
301 hospitals, health systems, insurers, social service organizations, government,
302 and other stakeholders to develop comprehensive homelessness policies and
303 plans that address the healthcare and social needs of homeless patients.
- 304 10. Our AMA:
- 305 a. supports laws protecting the civil and human rights of individuals experiencing
306 homelessness, and
- 307 b. opposes laws and policies that criminalize individuals experiencing
308 homelessness for carrying out life-sustaining activities conducted in public
309 spaces that would otherwise be considered non-criminal activity (i.e., eating,
310 sitting, or sleeping) when there is no alternative private space available.
- 311 11. Our AMA recognizes that stable, affordable housing is essential to the health of
312 individuals, families, and communities, and supports policies that preserve and
313 expand affordable housing across all neighborhoods.
- 314 12. Our AMA:
- 315 a. supports training to understand the needs of housing insecure individuals for
316 those who encounter this vulnerable population through their professional
317 duties;

- 318 b. supports the establishment of multidisciplinary mobile homeless outreach teams
319 trained in issues specific to housing insecure individuals; and
320 c. will make available existing educational resources from federal agencies and
321 other stakeholders related to the needs of housing-insecure individuals.
322 13. Our AMA encourages medical schools to implement physician-led, team-based
323 Street Medicine programs with student involvement.
324

325 **Increased Access to Identification Cards for the Homeless Population H 160.894**

326 Our AMA: (1) recognizes that among the homeless population, lack of identification
327 serves as a barrier to accessing medical care and fundamental services that support
328 health; and (2) supports legislative and policy changes that streamline, simplify, and
329 reduce or eliminate the cost of obtaining identification cards for the homeless population.
330

331 **Improving Care to Lower the Rate of Recidivism H-430.978**

- 332 1. Our American Medical Association will advocate and encourage federal, state, and
333 local legislators and officials to increase access to community mental health
334 facilities, community drug rehabilitation facilities, appropriate clinical care, and
335 social support services (e.g., housing, transportation, employment, etc.) to meet the
336 needs of indigent, homeless, and released previously incarcerated persons.
337 2. Our AMA will advocate and encourage federal, state, and local legislators and
338 officials to advocate prompt reinstatement in governmental medical programs and
339 insurance for those being released from incarceration facilities.
340

341 **Maintaining Mental Health Services by States H-345.975**

- 342 1. Our American Medical Association supports maintaining essential mental health
343 services at the state level, to include maintaining state inpatient and outpatient
344 mental hospitals, community mental health centers, addiction treatment centers,
345 and other state-supported psychiatric services.
346 2. Our AMA supports state responsibility to develop programs that rapidly identify and
347 refer individuals with significant mental illness for treatment, to avoid repeated
348 psychiatric hospitalizations and repeated interactions with the law, primarily as a
349 result of untreated mental conditions.
350 3. Our AMA supports increased funding for state Mobile Crisis Teams to locate and
351 treat homeless individuals with mental illness.
352 4. Our AMA supports enforcement of the Mental Health Parity Act at the federal and
353 state level.
354 5. Our AMA will take these resolves into consideration when developing policy on
355 essential benefit services.
356

357 **Housing Insecure Individuals with Mental Illness H-160.978**

- 358 1. Our American Medical Association believes that public policy initiatives directed to
359 the homeless, including the homeless mentally ill population, should include the
360 following components:
361 a. Access to care (e.g., integrated, comprehensive services that permit flexible,
362 individualized treatment; more humane commitment laws that ensure active

- 363 inpatient treatment; and revisions in government funding laws to ensure
364 eligibility for homeless persons).
- 365 b. Clinical concerns (e.g., promoting diagnostic and treatment programs that
366 address common health problems of the homeless population and promoting
367 care that is sensitive to the overriding needs of this population for food, clothing,
368 and residential facilities).
- 369 c. Program development (e.g., advocating emergency shelters for the homeless;
370 supporting a full range of supervised residential placements; developing specific
371 programs for multiproblem patients, women, children, and adolescents;
372 supporting the development of a clearinghouse; and promoting coalition
373 development).
- 374 d. educational needs;
- 375 e. housing needs; and
- 376 f. research needs.
- 377 g. Our AMA encourages medical schools and residency training programs to
378 develop model curricula and to incorporate in teaching programs content on
379 health problems of the homeless population, including experiential community-
380 based learning experiences.
- 381 h. Our AMA urges specialty societies to design interdisciplinary continuing medical
382 education training programs that include the special treatment needs of the
383 homeless populations

47 **WHEREAS**, under Ohio Revised Code Section 6109.20, public water systems
48 serving 5,000 or more people must fluoridate water if natural fluoride levels fall below 0.8
49 mg/L to maintain fluoride content between 0.8 and 1.3 mg/L¹⁵; and
50

51 **WHEREAS**, House Bill 182 was introduced in 2025 in the Ohio General Assembly
52 to prohibit public water systems from adding fluoride to drinking water¹⁶; and
53

54 **WHEREAS**, cessation of community water fluoridation has been shown to
55 increase disparities in dental caries, particularly affecting children of lower socioeconomic
56 status¹⁷; and
57

58 **WHEREAS**, a cost-effectiveness analysis projected that removing public water
59 fluoridation would result in a 9.8 billion dollar increase in healthcare costs over a 5-year
60 period¹⁸; and therefore be it
61

62 **RESOLVED**, that our OSMA support efforts by state and county health authorities
63 to achieve and maintain fluoridation of public water supplies statewide
64

65 **Fiscal Note:** \$ X (Sponsor)
66 \$ 500 (Staff)
67

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135

131 **Relevant OSMA Policy:**

132 **Policy 24 - 2010 - Updating of the Safe Drinking Water Act**

- 133 1. The OSMA shall petition the appropriate state agencies to identify those local
134 water utilities at risk and to take appropriate steps to assure safe drinking water.
135

136 **Relevant AMA Materials:**

137 **H-440.972 – Water Fluoridation**

- 138 1. Our American Medical Association urges state health departments to consider
139 the value of requiring statewide fluoridation (preferably a comprehensive program
140 of fluoridation of all public water supplies, where these are fluoride deficient), and
141 to initiate such action as deemed appropriate.
142 2. Our AMA supports the 2011 proposed fluoridation standards as promulgated by
143 the US Department of Health and Human Services and the Environmental
144 Protection Agency.

145
146 **D-440.999 – Chemical Analysis Report of Public and Commercial Water**

- 147 1. Our American Medical Association requests the appropriate federal agency to
148 require analysis and appropriate labeling of the chemical content, including
149 fluoride, of commercially bottled water, as well as of the water supplies of cities
150 or towns.
151 2. Our AMA urges the FDA to require that annual water quality reports from bottled
152 water manufacturers be publicly accessible in a readily available format.
153 3. Our AMA urges the FDA to evaluate bottled water for changes in quality after
154 typical storage conditions.