2024 OSMA Annual Meeting
Resolution Committee Two
Resolutions 19-36

#19 - Support for Physician Orders for Life Sustaining Treatment (POLST)

#20 - Adult Immunization Registry

#21 - “Guarantee Issue” Protections for Traditional Medicare

#22 - Insurer Accountability When Prior Authorization Harms Patients

#23 - Eliminate Unnecessary Prior Authorization

#24 - Oversight of Health Insurance Companies

#25 - Opposing Take Back Payments

#26 - Advocating for 12-Month Continuous Medicaid Enrollment Periods to Improve Adult Health Outcomes in Ohio

#27 - Opposing Involuntary Surgeries on Intersex Youth and Infants

#28 - Opposition to Requirements for Gender-Based Treatment for Athletes

#29 - Firearm Safety for Civilians and Law Enforcement

#30 - Obesity as a Public Health Emergency

#31 - Supporting Programs and Policies to Address Disparities in Social Determinants of Health for Maternal and Infant Morbidity and Mortality in Ohio

#32 - Supporting Expanded Naloxone Availability and Training and Encouraging Mandated Access in Public Institutions

#33 - Expanding Access to Opioid Agonist Therapies with Associated Trained Medical Personnel in Rehabilitation Facilities

#34 - Encourage Marijuana Counseling and Harm Reduction

#35 - Increasing Awareness of Harmful Algal Bloom Toxicity

#36 - Support for Environmental Justice Initiatives

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 19 – 2024**
4
5 **Introduced by:** Robert Kose, MD
6
7 **Subject:** Support for Physician Orders for Life Sustaining Treatment
8 (POLST)
9
10 **Referred to:** Resolutions Committee No. 2
11
12 **- -**
13
14 **WHEREAS**, the OSMA strongly supports physicians and patients collaborating to
15 ensure patient's end of life decisions are respected and fulfilled; and
16
17 **WHEREAS**, a POLST provides clear guidance to healthcare providers regarding
18 patient and family's end of life decisions and is uniform across the state giving
19 consistent implementation and decreasing confusion; and
20
21 **WHEREAS**, a POLST gives a patient autonomy to express their preference
22 regarding end of life decisions in advance; and
23
24 **WHEREAS**, in an emergency situation or critical healthcare condition, a
25 documented POLST may be quickly assessed to give patient's treatment preferences
26 and avoid delays or unnecessary intervention; and
27
28 **WHEREAS**, a POLST provides legal protection for providers who are acting in
29 good faith, clarifying responsibilities and shielding from potential liability; and
30
31 **WHEREAS**, the Ohio DNR form is not a document which enables a person to
32 express their end of life decisions with clarity or nuance; and therefore
33
34 **BE IT RESOLVED**, the OSMA support existing efforts to enact Physician Orders
35 for Life Sustaining Treatments (POLST) to enable the Citizens of Ohio to document their
36 end of life healthcare decisions.
37
38 **Fiscal Note:** $ (Sponsor)
39 $ 1,000 (Staff)
40
41 **References:**
42
43 1. National POLST (www.polst.org)
44

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 20 – 2024

Introduced by: Robyn Chatman, MD

Subject: Adult Immunization Registry

Referred to: Resolutions Committee No. 2

- -

WHEREAS, the value of vaccines as a critical component of our public health infrastructure has been established; and

WHEREAS, that a significant number of adult vaccines are administered by pharmacies; and

WHEREAS, every state now has an immunization registry; and

WHEREAS, pediatric vaccines are routinely reported electronically to the appropriate state registry; and

WHEREAS, immunization registry data is commonly used in determining the effectiveness of a given vaccine; and

WHEREAS, a significant number of adult vaccines provided by pharmacies are never recorded in the patient's primary care chart; and therefore

BE IT RESOLVED, that the Ohio State Medical Association make every effort to encourage the Ohio Legislature to require that all vaccine providers participate in IMPACT SIIS; and be it further

RESOLVED, that vaccine providers in the United States be required to report all immunizations to their respective state immunization registry for both adults and children; and be it further

RESOLVED, that the OSMA delegation to the AMA take this resolution to the AMA House of Delegates for their consideration.

Fiscal Note: $ (Sponsor)
$ 5,000 (Staff)

References:

1. Stolpe, S., & Choudhry, N. K. (2019). Effect of automated immunization

47 registry-based telephonic interventions on adult vaccination rates in community
48 pharmacies: a randomized controlled trial. Journal of Managed Care &
49 Specialty Pharmacy, 25(9), 989-994.
50 2. Woods, L. O., Bridges, C. B., Graitcer, S. B., & Lamont, B. (2016). US
51 Immunization program adult immunization activities and resources. Human
52 Vaccines & Immunotherapeutics, 12(4), 1045-1050.
53 3. Placzek, H., & Madoff, L. C. (2011). The use of immunization registry-based data
54 in vaccine effectiveness studies. Vaccine, 29(3), 399-411.
55

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 21 – 2024

Introduced by: District 2

Subject: “Guarantee Issue” Protections for Traditional Medicare

Referred to: Resolutions Committee No. 2

- -

WHEREAS, the Federal Medicare program has 4 parts A,B,C D, offering Hospital, Physician and Pharmacy benefits; and

WHEREAS, Part C is known as Medicare Advantage, which has become popular through its market offerings of zero premiums for enrollees plus additional benefits which are not available through traditional Medicare; and

WHEREAS, Medicare Advantage plans have various other limitations such as narrow networks and narrow drug benefits as well as numerous preauthorization requirements; and

WHEREAS, a traditional Medicare plan needs to be supplemented by additional Medigap or Supplemental Insurance policies to cover what Medicare approves but does not cover (20%); and

WHEREAS, once an enrollee joins a Medicare Advantage plan and then wants to change back to traditional Medicare with supplemental insurance, there are severe restrictions to get a Medigap or Supplemental Insurance policy. In essence enrollees are stuck in an Advantage plan even if the plan does not serve a patient’s needs; and

WHEREAS, there are only 4 states in the country which have “guaranteed issue” protections for access to Medigap or supplemental policies post the initial sign-up of Medicare beneficiaries age 65 or older. (Connecticut, Massachusetts, New York and Maine). Ohio is not one of those states. (Reference Wall Street Journal). Some states have very limited protections for those with pre-existing medical conditions seeking Medigap policies; and therefore

BE IT RESOLVED that the Ohio State Medical Association (OSMA) will take all necessary steps to require guaranteed issue protections allowing access to Medigap Insurance coverage for beneficiaries switching from Medicare Advantage to traditional Medicare during the annual open enrollment period; and be it further

RESOLVED, that the OSMA delegation to AMA will take this resolution to AMA seeking all necessary actions (legislative or administrative) to allow Medicare

beneficiaries age 65 and older the freedom to change back to Traditional Medicare with federal guaranteed issue protection to obtain Medigap insurance once they have disenrolled from Medicare Advantage Plans.

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

References:

1. https://www.wsj.com/health/healthcare/medicare-advantage-enrollment-risks-923e7952

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2024

Introduced by: Medical Student Section

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: Resolutions Committee No. 2

- -

WHEREAS, prior authorization (PA) is an advanced approval process that insurers and other payers use as a healthcare utilization management tool to deny payment for covered benefits when the payer deems the benefit clinically unnecessary;[1] and

WHEREAS, prior authorization requirements are rapidly increasing each year, which leads to not only increased administrative duties for physicians and their practice staff but also delayed care for patients;[2] and

WHEREAS, a 2022 study by our AMA on PA demonstrated that 88% of physicians experience high or extremely high administrative burdens due to prior authorization requirements and that 94% of physicians believe prior authorizations delay patient access to necessary care;[3] and

WHEREAS, the process of PA reviews, which health plans are frequently known to delegate to third-party contractors, causes significant delays in appropriate patient care that can lead to prolonged suffering and unnecessary deaths;[4] and

WHEREAS, the 2022 physician survey by our AMA found that 89% of physicians believe PA requirements have a negative impact on clinical outcomes for patients, with 33% of physicians reporting that PAs have led to their patients experiencing serious adverse health outcomes, including hospitalization, life-threatening events, or disability;[3] and

WHEREAS, other surveys by the American Society of Clinical Oncologists (ASCO), the American Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation Oncology (ASRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO reporting a patient experienced harms due to PA, including 35% who specifically attributed a patient's loss of life to prior authorization requirements;[5-8] and

WHEREAS, the data strongly suggests that insurers are denying justified healthcare, with the 2022 AMA physician survey reporting that only 1% of physicians

believe that PA criteria are always based on evidence-based medicine or specialty society guidelines;[3] and

WHEREAS, capitated payment models like Medicaid Managed Care and Medicare Advantage Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based on expected costs regardless of whether the actual cost was higher or lower, create an incentive to minimize enrollee services and maximize PA denials;[9] and

WHEREAS, reporting by the Office of Inspector General (OIG) for the United States Department of Health and Human Services has frequently shown that many denials were inappropriate, with a 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of payment denials met Medicare coverage rules and internal reimbursement guidelines;[9] and

WHEREAS, a 2023 Kaiser Family Foundation (KFF) study as well as two separate OIG reports found that, although just 11% of PA denials by MAOs are appealed, the vast majority of appeals were either completely or partially overturned;[10-12] and

WHEREAS, the KFF study and OIG reports noted that their findings were particularly concerning because the appeals process was largely underutilized by beneficiaries and providers with only 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny coverage knowing only a small portion of PA decisions will be formally appealed;[10-12] and

WHEREAS, despite increasing evidence of inappropriate PA denials by insurers, there currently is no consensus on how to hold insurers liable for denials that result in preventable injury to patients, with largely unsuccessful litigation strategies ranging from bad faith breach of contract to negligent breach of duty, and at least one effort in Texas preempted by the Employment Income & Retirement Act of 1974 (ERISA);[4,13-14] and

WHEREAS, even when state statute or case law permits a bad faith claim against an insurance company for a wrongful coverage denial and the claim is not preempted by ERISA, it’s often impossible to recover punitive damages, which may require proving that the insurance company acted with a higher degree of intent than that required for compensatory damages;[15] and

WHEREAS, in a recent New York case in which a delayed PA approval resulted in the preventable, rapid progression of a woman’s cancer, the U.S. District Court for the Southern District of New York ruled against the woman when it held that existing New York law does not impose a duty of reasonable care on insurance companies that engage in PA review, highlighting the need for aggressive state legislative reform to increase liability for state-regulated insurers;[16] and

WHEREAS, efforts to hold insurers liable for PA denials that result in preventable injury have been slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which require beneficiaries to settle disputes out of court by an impartial third party rather than before a jury or judge and often include waivers that prevent beneficiaries from bringing class action suits;[17-18] and

WHEREAS, a 2019 review of arbitration clauses used by Fortune 100 companies found that many of the nation's largest health insurance companies, including UnitedHealth Group, Anthem, Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers;[18] and

WHEREAS, mandatory arbitration clauses are particularly insidious in health insurance contracts given the wide gap in bargaining power between the insurance company and beneficiary and limited selection of alternate insurers as a result of increasing consolidation in insurance markets;[19-20] and

WHEREAS, while arbitration may be preferred by some individuals, data suggests it is generally bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's arbitration program is nearly $400,000 less than median awards for medical malpractice jury trials in California;[21] and

WHEREAS, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173), nearly 90 prior authorization reform bills have been proposed in current state legislatures, many of which draw on our AMA's model legislation, but none of these proposed bills that have received AMA support address insurers' legal liability when patients are harmed by prior authorizations;[22-23] and

WHEREAS, though the OSMA has advocated extensively for the reformation of PA, its efforts have focused largely on streamlining the process rather than creating or enforcing legal liability for PA denials that injure patients;[27,28] and therefore

BE IT RESOLVED, that our OSMA advocate for increased legal accountability of insurers and other payers when prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts.

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

References:

1. Prior authorization practice resources. American Medical Association [web]. Updated May 18, 2023. Accessed August 26, 2023. https://www.ama-assn.org/practice-management/sustainability/prior-authorization-practice-resources

136 2. Ernst C. Virtually all medical groups say payer prior authorization requirements
137 aren't improving. MGMA Stat [web]. Published March, 2, 2022. Accessed August
138 26, 2023. https://www.mgma.com/mgma-stats/virtually-all-medical-groups-say-
139 payer-prior-authorization-requirements-aren-t-improving
140 3. 2022 AMA prior authorization (PA) physician survey. American Medical
141 Association [web]. Accessed August 26, 2023. https://www.ama-
142 assn.org/system/files/prior-authorization-survey.pdf
143 4. Henry TA. Cancer killed Kathleen Valentini, but prior auth shares the blame.
144 American Medical Association [web]. Published June 16, 2022. Accessed August
145 26, 2023. https://www.ama-assn.org/practice-management/prior-
146 authorization/cancer-killed-kathleen-valentini-prior-auth-shares-blame
147 5. New survey: utilization management delays cancer care; leads to more stress
148 and contributes to worse outcomes. ACS CAN Press Release [web]. Published
149 March 28, 2019. Accessed August 26, 2023.
150 https://www.fightcancer.org/releases/new-survey-utilization-management-delays-
151 cancer-care-leads-more-stress-and-contributes
152 6. Press kit: prior authorization obstacles to cancer patient care. ASTRO News and
153 Media Center [web]. Updated October 25, 2021. Accessed August 26, 2023.
154 https://www.astro.org/News-and-Publications/News-and-Media-Center/Press-
155 Kits/2019/priorauthpress
156 7. Association for Clinical Oncology. ASCO prior authorization survey summary.
157 ASCO [web]. Published November 2022. Accessed August 26, 2023. https://old-
158 prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-
159 November-2022.pdf
160 8. Trapani D, Kraemer L, Rugo HS, and Lin NU. Impact of prior authorization on
161 patient access to cancer care. ASCO Educational Book. May 23, 2023; 43. doi:
162 10.1200/EDBK_100036
163 9. Grimm CA. Some Medicare Advantage Organization denials of prior
164 authorization requests raise concerns about beneficiary access to medically
165 necessary care. US DHHS Office of Inspector General. April 2022.
166 https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
167 10. Biniek JF and Sroczynski N. Over 35 million prior authorization requests were
168 submitted to Medicare Advantage plans in 2021. Kaiser Family Foundation [web].
169 Published February 2, 2023. Accessed August 26, 2023.
170 https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-
171 requests-were-submitted-to-medicare-advantage-plans-in-2021/
172 11. Levinson DR. Medicare Advantage appeal outcomes and audit findings raise
173 concerns about service and payment denials. DHHS Office of Inspector General.
174 September 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
175 12. Murrin S. Some Medicare Part D beneficiaries face avoidable extra steps that
176 can delay or prevent access to prescribed drugs. DHHS Office of Inspector
177 General. September 2019. https://oig.hhs.gov/oei/reports/oei-09-16-00411.pdf
178 13. Mariner WK. The Supreme Court's limitation of managed-care liability. New
179 England Journal of Medicine. 2004;351(13):1347-1352.
180 doi:10.1056/nejmlim042143

181 14. Stern JB. Will the tort of bad faith breach of contract be extended to health
182 maintenance organizations? Law, Medicine and Health Care. 1983;11(1):12-21.
183 doi:10.1111/j.1748-720x.1983.tb00804.x
184 15. Bad faith insurance claims: are punitive damages available? Lee Cossell &
185 Feagley, LLP. June 24, 2021. Accessed August 27, 2023.
186 https://www.nleelaw.com/bad-faith-insurance-and-punitive-damages/
187 16. Valentini v. Grp. Health, 20 Civ. 9526 (JPC) (S.D.N.Y. Dec. 27, 2021)
188 17. Sachs S. The jury is out: mandating pre-treatment arbitration clauses in patient
189 intake. Journal of Dispute Resolution. 2018;2018(2):116-131.
190 https://scholarship.law.missouri.edu/cgi/viewcontent.cgi?article=1813&context=jd
191 r
192 18. Szali IS. The prevalence of consumer arbitration agreements by America's top
193 companies. UC Davis Law Review. 2019;52:233-259.
194 https://lawreview.law.ucdavis.edu/online/vol52/52-online-Szalai.pdf
195 19. Dafny LS. Evaluating the impact of health insurance industry consolidation:
196 learning from experience. November 20, 2015. Accessed August 26, 2023.
197 https://www.commonwealthfund.org/publications/issue-
198 briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation
199 20. Cogan JA. Readability, contracts of recurring use, and the problem of ex post
200 judicial governance of health insurance policies. Roger Williams University Law
201 Review. 2010;15(1):93-127. https://ssrn.com/abstract=1991348
202 21. Arbitration clauses in insurance contracts: the urgent need for reform. Public
203 Citizen [web]. Accessed August 26, 2023.
204 https://www.citizen.org/article/arbitration-clauses-in-insurance-contractsthe-
205 urgent-need-for-reform/
206 22. H.R.3173 - 117th Congress (2021-2022): Improving Seniors' Timely Access to
207 Care Act of 2021. Updated September 15, 2022. Accessed August 27, 2023.
208 https://www.congress.gov/bill/117th-congress/house-bill/3173
209 23. O'Reilly KB. Bills in 30 states show momentum to fix prior authorization. AMA
210 [web]. Published May 10, 2023. Accessed August 27, 2023. https://www.ama-
211 assn.org/practice-management/prior-authorization/bills-30-states-show-
212 momentum-fix-prior-authorization
213 24. H.R.3947 - 117th Congress (2021-2022): Justice for Patients Act. Updated June
214 17, 2021. Accessed August 27, 2023. https://www.congress.gov/bill/117th-
215 congress/house-bill/3947
216 25. H.R.7780 - 117th Congress (2021-2022): Mental Health Matters Act. Updated
217 October 11, 2022. Accessed August 27, 2023.
218 https://www.congress.gov/bill/117th-congress/house-bill/7780/
219 26. S.1376 - 118th Congress (2023-2024): Forced Arbitration Injustice Repeal Act.
220 Updated April 27, 2023. Accessed August 27, 2023.
221 https://www.congress.gov/bill/118th-congress/senate-bill/1376
222 27. Policy Compendium. Ohio State Medical Association. (See relevant OSMA policy
223 below).
224 28. Insurance Reform. Ohio State Medical Association. Accessed November 30,
225 2023. https://www.osma.org/aws/OSMA/pt/sp/insurance-reform
226
227

228
229 OSMA Policy:
230
231 **Policy 09 – 2016 – Prior Authorization for Patients Injured at Work**
232 1. The OSMA shall survey physician members who are treating patients with work related
233 conditions to determine the problems associated with obtaining prior authorization for treatment
234 including procedures and medications.
235 2. The OSMA shall request that the Bureau of Workers Compensation and self-insured
236 employers address the problems associated with obtaining prior authorization for patients
237 injured at work to allow treatment of patients to occur in a timely and appropriate manner.
238
239 **Policy 19 – 2018 – Prior Authorization for Durable Medical Equipment (DME)**
240 1. Denials of prior authorization for durable medical equipment (DME) must be based on true
241 medical necessity not arbitrary time limits or other paperwork issues.
242 2. The OSMA continue to work to improve the prior authorization process including working with
243 our Ohio Congressional Delegation and our American Medical Association to improve the
244 process for Medicare Managed Care plans.
245 3. The OSMA Delegation take this policy to the American Medical Association Annual Meeting.
246
247 **Policy 14 – 2019 – Compensation for Prior Authorization Services**
248 1. The OSMA opposes pre-authorization as a requirement for patient care.
249 2. The OSMA shall seek legislation that provides for appropriate compensation to physician
250 offices for expenses incurred in obtaining prior authorizations for patient care.
251
252 **Policy 23 – 2022 – Prohibit Reversal of Prior Authorization**
253 1. The Ohio State Medical Association (OSMA) supports legislation to prohibit retroactive denial
254 of a previously approved medication, procedure, or test unless the patient is no longer insured
255 by that company at the time of service.
256 2. The OSMA delegation to the AMA will take this topic regarding reversal of prior authorization
257 to the AMA House of Delegates to advocate for this change as a part of their greater effort to
258 eliminate prior authorization all together.
259
260 **Policy 10 – 2023 – Supporting Increased Access to HIV Prevention Medication**
261 1. The OSMA opposes prior authorization requirements for HIV pre-exposure prophylaxis
262 (PrEP) and post-exposure prophylaxis (PEP) medications.
263 2. The OSMA supports requiring state-regulated payers to cover full costs of HIV prevention
264 medications and related services, including screenings, diagnostic procedures, administrative
265 fees, and clinical follow-ups in-person or via telemedicine, without any cost-sharing obligation
266 for the plan holder.
267 3. The OSMA supports legislation requiring all payers in Ohio to add long-acting injectable
268 variations of PrEP to their formularies to ensure that they are accessible to eligible patients.
269
270 **Policy 25 – 2023 – Codifying Efforts for Legislative Action on Prior Authorization**
271 1. The OSMA will seek legislative solutions to reduce the burden of prior authorization
272 requirements.

273 2. The OSMA advocacy team will report back annually to the House of Delegates on the status
274 of prior authorization advocacy efforts unless deemed unnecessary by Council.
275

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 23 – 2024**
4
5 **Introduced by:** District 3
6
7 **Subject:** Eliminate Unnecessary Prior Authorization
8
9 **Referred to:** Resolutions Committee No. 2
10
11 -
12
13 **WHEREAS**, the prior authorization process is insulting to physicians who are
14 trained to evaluate patients and determine what medically necessary tests and
15 medications are needed to improve a patient's health; and
16
17 **WHEREAS**, prior authorization is a means for the insurance companies to delay
18 or deny care for patients; and
19
20 **WHEREAS**, physicians (MD and DO) undergo extensive training including
21 medical school and residency training and ongoing CME to determine what tests and
22 medications are medically necessary for their patients; and therefore
23
24 **BE IT RESOLVED**, that it is the position of our OSMA that a signed physician's
25 order or prescription should be all that is necessary to validate medical necessity for a
26 procedure, test, or medication.
27
28 **Fiscal Note:** $ (Sponsor)
29 $ 500 (Staff)
30

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 24 – 2024

Introduced by: Brooke Wolf, MD, Mary LaPlante, MD

Subject: Oversight of Health Insurance Companies

Referred to: Resolutions Committee No. 2

- -

WHEREAS, the OSMA is concerned that our patients face significant roadblocks in gaining access to their medical insurance benefits and are not receiving the full benefits, to which they are entitled by their contracts, because of financial motivated, unreasonably narrow definitions of medical necessity practiced by health insurance carriers, which are, in some cases, inconsistent with their own written criteria; and

WHEREAS, health insurance carriers commonly use various unreasonable roadblocking tactics to delay payment to physicians or to avoid covering care the treating physician feels is medically necessary. These financially motivated tactics delay treatment of the patient, take physician and office time away from patient care, and contribute to a decrease in physician morale and to an increase in physician burnout; and

WHEREAS, the Ohio Department of Insurance (ODI) has responsibility of oversight of health insurance carriers, but currently investigates only individual complaints brought by patients or physicians rather than initiating proactive reviews of insurance company policies and procedures to assess whether they are consistent with quality medical practice and in good faith with the best interest of patients; and

WHEREAS, there is a precedent in Section 3902.36 of the Ohio Revised Code, commonly known as the Mental Health Parity Act, requiring the ODI "to implement and enforce all applicable provisions of that act...and to proactively ensure compliance by health plan issuers", including reasonable standards for medical necessity. Rather than just responding to complaints, therefore it would be reasonable to ask ODI to do similar proactive review of health insurance carrier policies for approving all medical care; and

WHEREAS, busy physicians, focused on patient care, generally do not submit complaints about insurance company policies and procedures to the ODI. Patients generally do not have the medical knowledge to know what care is necessary. Although they are frustrated by roadblocks, patients rely on their doctors to battle for their medically necessary care and are not motivated to complain to the ODI. Therefore unfair, unreasonable policies and practices by health insurance companies go largely unreported; and therefore

47 **BE IT RESOLVED**, that our OSMA support proactive oversight of health
48 insurance carrier policies and practices by the ODI by encouraging the ODI to develop a
49 panel, with physician participation, to provide oversight of health insurance carrier
50 policies and practices; and be it further
51
52 **RESOLVED**, that our OSMA actively encourages and supports physicians,
53 patients, and hospitals reporting inappropriate and unfair practices by health insurance
54 carriers directly to the Department of Insurance; and be it further
55
56 **RESOLVED**, that our OSMA create a structure to which physicians can report
57 concerns and submit gathered information, regarding inappropriate, unsafe, or unfair
58 health insurance carrier policies to be compiled, evaluated for merit, and, if validated,
59 reported to the ODI, with appropriate supporting information from the OSMA.
60
61 **Fiscal Note:** $ (Sponsor)
62 $ 1,000 (Staff)
63

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 25 – 2024**
4
5 **Introduced by:** Mary LaPlante, MD, FACOG
6
7 **Subject:** Opposing Take Back Payments
8
9 **Referred to:** Resolutions Committee No. 2
10
11 -
12
13 **WHEREAS**, insurance carriers will review and determine a payment is lower than
14 originally determined; and
15
16 **WHEREAS**, the insurance carriers will adjust subsequent payments with a
17 reduced payment; and
18
19 **WHEREAS**, current OSMA policy only addresses the time in which an insurance
20 company may review the payment, and any payment for a medical service should be
21 final or additive; and therefore
22
23 **BE IT RESOLVED**, that our OSMA oppose any take back by insurance
24 companies for payments made to physicians; and be it further
25
26 **RESOLVED**, that our OSMA explore options to address the problem of health
27 insurance take back policies with the Ohio Department of insurance; and be it further
28
29 **RESOLVED**, that our OSMA support an appeal process for any take back
30 payment by a health insurance payers.
31
32 **Fiscal Note:** $ (Sponsor)
33 $ 50,000 (Staff)
34
35 OSMA Policy:
36
37 **Policy 42 – 1979 – Retrospective Review**
38
39 1. The OSMA opposes retrospective review payment for health care claims.
40
41 2. Where retrospective review and denial is presently being carried out by third-party
42 payers, the OSMA supports an appeal mechanism available upon request of
43 physician or patient which is not under the control of the third-party payor and
44 consists of a committee of the physician's peers.
45
46

47 **Policy 17 – 2018 – OSMA to Seek Time Parity for Physician Claims Filing and**
48 **Insurance Take Back**
49
50 The OSMA again make every effort to limit the allowed time for insurance companies
51 "look back/take back" payments to be commensurate to the time frame allowed for
52 physicians to file claims.
53

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 26 – 2024**
4
5 **Introduced by:** Medical Student Section
6
7 **Subject:** Advocating for 12-Month Continuous Medicaid Enrollment Periods
8 to Improve Adult Health Outcomes in Ohio
9
10 **Referred to:** Resolutions Committee No. 2
11
12 -
13
14 **WHEREAS**, Medicaid churn is the cycle of losing and regaining Medicaid
15 coverage, which disrupts access to healthcare for eligible individuals, affecting their
16 continuity of care and health outcomes; and
17
18 **WHEREAS**, intermittent eligibility redeterminations, difficulties navigating renewal
19 procedures, changing family circumstances, address changes, and income fluctuations
20 can lead to the unexpected loss of coverage, even among individuals who are still
21 eligible[1]; and.
22
23 **WHEREAS**, due to gaps in coverage, Medicaid beneficiaries are covered for less
24 than 10 months of the year, on average[1,2]; and
25
26 **WHEREAS**, Medicaid churn is associated with increased emergency department
27 visits, untreated chronic conditions, and preventable hospitalizations, disproportionately
28 affecting vulnerable populations including Black and Latino individuals, people with
29 disabilities, and young adults[3-5]; and
30
31 **WHEREAS**, the administrative costs of disenrollment and re-enrollment in
32 Medicaid are estimated to be between $400 and $600 per person, leading to substantial
33 unnecessary state expenditures[6]; and
34
35 **WHEREAS**, Ohio has experienced a significant increase in Medicaid enrollment,
36 with over 800,000 additional individuals since 2020, leading to administrative challenges
37 and expected increases in churn after the COVID-19 Public Health Emergency[5,7]; and
38
39 **WHEREAS**, the end of the continuous enrollment period provided during the
40 Public Health Emergency is estimated to result in the loss of Medicaid coverage for
41 between 200,000 and 249,000 Ohioans through 2024 due to administrative churn,
42 beginning in April, 2023[5,7]; and
43
44 **WHEREAS**, states like New York, which have implemented 12-month continuous
45 Medicaid enrollment periods, have seen cost savings due to more predictable
46 healthcare utilization and lower administrative caseloads[8]; and

WHEREAS, the implementation of continuous enrollment in New York resulted in a modest increase in net Medicaid spending of 2-3%, a figure comparable to budgetary changes seen in states that are already extending continuous coverage periods to children, such as Ohio[1,9]; and

WHEREAS, 12-month continuous Medicaid enrollment periods are associated with significant individual monthly cost savings relative to adults who experience churn[1]; and

WHEREAS, Ohio currently implements 12-month continuous enrollment periods for children, and pregnant and postpartum individuals enrolled in Medicaid, demonstrating a precedent and framework for broader application of this policy within the state's Medicaid program; and

WHEREAS, children and postpartum individuals in Ohio who benefit from 12-month continuous Medicaid coverage experience improved health outcomes, underlining the efficacy of extended coverage periods in promoting consistent and preventive healthcare access[10,11]; and

WHEREAS, all states have the authority to submit a Section 1115 Demonstration Waiver to the federal government, which would allow Ohio to enact 12-month continuous eligibility periods for adult Medicaid beneficiaries[12,13]; and

WHEREAS, the American Medical Association advocates for the adoption of 12-month continuous Medicaid enrollment across Medicaid programs, yet the Ohio State Medical Association currently lacks explicit policy advocating for the extension of this approach to adult beneficiaries in Ohio[14]; and therefore

BE IT RESOLVED, that our OSMA supports the adoption of 12-month continuous eligibility across Ohio Medicaid programs.

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

References:

1. Sugar S, Peters C, DeLew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021
2. Ku L, Platt I. Duration and Continuity of Medicaid Enrollment Before the COVID-19 Pandemic. *JAMA Health Forum*. 2022;3(12):e224732. Published 2022 Dec 2. doi:10.1001/jamahealthforum.2022.4732

92 3. Bindman AB, Chattopadhyay A, Auerback GM. Interruptions in Medicaid
93 coverage and risk for hospitalization for ambulatory care-sensitive conditions.
94 *Ann Intern Med*. 2008;149(12):854-860. doi:10.7326/0003-4819-149-12-
95 200812160-00004
96 4. Roberts ET, Pollack CE. Does Churning in Medicaid Affect Health Care Use?
97 *Med Care*. 2016;54(5):483-489. doi:10.1097/MLR.0000000000000509
98 5. Issue Brief No. HP-2022-20. "Unwinding the Medicaid Continuous Enrollment
99 Provision: Projected Enrollment Effects and Policy Approaches" Washington, DC:
100 Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of
101 Health and Human Services. August 19, 2022
102 6. Swartz K, Short PF, Graefe DR, Uberoi N. Reducing Medicaid Churning:
103 Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most
104 Effective. *Health Aff (Millwood)*. 2015;34(7):1180-1187.
105 doi:10.1377/hlthaff.2014.1204
106 7. Anthes, L. (2023, April 7). *What patients, providers and advocates need to know*
107 *about the phe's impact on Medicaid*. The Center for Community
108 Solutions.https://www.communitysolutions.com/what-patients-providers-and-
109 advocates-need-to-know-about-the-phes-impac
110 8. Liu, H. H., Dick, A. W., Qureshi, N., Baxi, S. M., Roberts, K. J., Ashwood, J. S.,
111 Guerra, L. A., Ruder, T., & Shih, R. A. (2022). New York State 1115
112 Demonstration Independent Evaluation: Interim Report. Rand health quarterly,
113 9(3), 5.
114 9. Ku L, Steinmetz E, Bruen BK. Continuous-eligibility policies stabilize Medicaid
115 coverage for children and could be extended to adults with similar results. *Health*
116 *Aff (Millwood)*. 2013;32(9):1576-1582. doi:10.1377/hlthaff.2013.0362
117 10. Dunlop AL, Joski P, Strahan AE, Sierra E, Adams EK. Postpartum Medicaid
118 Coverage and Contraceptive Use Before and After Ohio's Medicaid Expansion
119 Under the Affordable Care Act. *Womens Health Issues*. 2020;30(6):426-435.
120 doi:10.1016/j.whi.2020.08.006
121 11. Brantley E, Ku L. Continuous Eligibility for Medicaid Associated With Improved
122 Child Health Outcomes. *Med Care Res Rev*. 2022;79(3):404-413.
123 doi:10.1177/10775587211021172
124 12. Kaiser Family Foundation. Section 1115 Waiver Watch: Continuous Eligibility
125 Waivers and Implications for Unwinding. 2023. https://www.kff.org/policy-
126 watch/section-1115-waiver-watch-continuous-eligibility-waivers-and-implications-
127 for-unwinding/
128 13. State Report on Plans for Prioritizing and Distributing Renewals Following the
129 End of the Medicaid Continuous Enrollment Provisions. Ohio Plan submitted to
130 CMS (2022)
131 https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/Unwinding/Ohio+Pla
132 n+Submitted+to+CMS+December+20%2C+2022.pdf
133 14. American Medical Association. Basic Health Program Policy H-165.832. 2022.
134 15. AMA Policy: Basic Health Program H-165.832
135 16. AMA Policy: Health Insurance Exchange Authority and Operation H-165.839

136
137

OSMA Policy:

Policy 25 – 2016 – Access to Care for Medicaid and Medicaid Product Insured Patients in Ohio

1. The OSMA advocates that Ohio Medicaid and Medicaid product insurers extend coverage to their patients for thirty days beyond the date of non-coverage and reimburse physicians who provide services during this time period.

Policy 01 – 2017 – Supporting Changes in Health Care Policy that Increase Coverage and Expand Benefits

1. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts and supports providing all Ohio citizens with high quality health care.

2. The OSMA opposes changes to healthcare policy that would decrease access to health care coverage for the citizens of Ohio.

3. The OSMA supports the inclusion of young adults up to age 26 on their parents'/guardians' health care plans.

4. The OSMA supports health care policies that allow states and institutions the right to explore and develop individualized models for covering the uninsured.

   Policy 01 – 2017 was reaffirmed at the 2019 OSMA House of Delegates.

Policy 23 – 2018 – Maintaining Medicaid Coverage for Group VIII Enrollees

1. The OSMA supports the ongoing coverage of those individuals defined as Medicaid group VIII eligible individuals by any program deemed to continue their coverage in a manner comparable to coverage as allowed by the Affordable Care Act, and oppose programs which would not continue commensurate coverage.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 27 – 2024

Introduced by: Medical Student Section

Subject: Opposing Involuntary Surgeries on Intersex Youth and Infants

Referred to: Resolutions Committee No. 2

- -

WHEREAS, the National Institutes of Health define intersex as "a general term used to refer to individuals born with, or who develop naturally in puberty, biological sex characteristics that are not typically male or female"[1]; and

WHEREAS, the reproductive organs of intersex children do not necessarily correlate with their gender identity in adulthood[2-7]; and

WHEREAS, variability in gender identity among intersex children and adults following socialization as one of the binary genders necessitates an individualized approach to treatment of intersex children, not necessarily involving surgery[8]; and

WHEREAS, most medically unnecessary surgeries performed on intersex individuals are completed prior to the individual's second birthday, before they have the communication skills to comprehend a surgical intervention or provide informed assent, which differs from consent in that it is an educated understanding of and agreement with the treatment plan but is not a formal written agreement[9-10]; and

WHEREAS, informed assent in pediatrics requires that a child be old enough to understand what is being done to their body, old enough to give their permission for it to be done to them, and respect for their wishes and autonomy should they object to it, with autonomy meaning their ability to provide educated input regarding their own healthcare[11-13]; and

WHEREAS, informed consent in pediatrics requires the voluntary agreement of a child's parents or guardians, in cases where the child is under 18, to a medical intervention or participation in research trial[11-13]; and

WHEREAS, current pediatric approaches to a diagnosis of difference in sexual development (DSD) at birth or in childhood involve a multidisciplinary strategy with delayed surgical intervention when possible and choice on the part of the individual diagnosed with DSD[12,14,15]; and

WHEREAS, the American Academy of Family Physicians opposes medically unnecessary surgeries performed on intersex infants and children without their assent,

due to increased risk of substance use disorders, worsened sexual function, and suicide attempts later in life, with approximately 31.8% of intersex adults attempting suicide at some point in their life[9,16-20]; and

WHEREAS, GLMA: Health Professionals Advancing LGBTQ Equality recommends delay of gender-related medical interventions, including surgery and hormone therapy, for patients with DSD until these patients are old enough to provide informed consent[21]; and

WHEREAS, the North American Society for Pediatric and Adolescent Gynecology supports respecting the autonomy of intersex patients and delaying medically unnecessary surgeries for intersex patients until they are able to give complete informed consent[19,22]; and

WHEREAS, as of January 14, 2024, the Ohio House has voted to override Gov. Mike DeWine's veto of House Bill 68, which would protect physicians who perform medically unnecessary surgeries on intersex infants and youth, and the Ohio Senate will hold their vote on January 24, 2024[23]; and therefore

BE IT RESOLVED, that our OSMA supports the creation and distribution of educational resources and strengthened family support for parents of intersex infants and youth regarding surgical and medical options for treatment, including the option for delayed care; and be it further

RESOLVED, that our OSMA supports informed decision-making and delayed intervention in the surgical treatment of intersex infants and youth.

Fiscal Note: $ (Sponsor)
$ 100,000 (Staff)

References:

1. National Institutes of Health. Sex, gender, and sexuality. nih.gov. Updated December 8, 2022. Accessed January 19, 2022. https://www.nih.gov/nih-style-guide/sex-gender-sexuality
2. MacGillivray MH, Mazur T. Intersex. *Advances in Pediatrics*. 2005;52:295-319. doi: https://doi.org/10.1016/j.yapd.2005.04.004
3. Vilain E. Genetics of sexual development. *Annual Review of Sex Research*. 2000;11(1):1-25. https://www.tandfonline.com/doi/abs/10.1080/10532528.2000.10559783?casa_token=oiPtuxNtgwcAAAAA:TSBwK8Zq3TDb5JqCnr1mkiu_eL4Uf_4MUmE47o0tQaefkPw0kaGJ00u1tgtTG-UZYkKq0MuwugBV
4. Quigley CA. Genetic basis of sex determination and sex differentiation. *Endocrinology*. 2001;3:1926-1946.
5. Lee PA. A perspective on the approach to the intersex child born with genital ambiguity. *Journal of Pediatric Endocrinology and Metabolism*. 2004;17:133-140. doi: https://doi.org/10.1515/JPEM.2004.17.2.133

95 6. Ahmed SF, Morrison S, Hughes IA. Intersex and gender assignment; the third way?
96 *Archives of Disease in Childhood*. 2004;89(9):847-850. doi: 10.1136/adc.2003.035899
97 7. Ogilvy-Stuart AL, Brain CE. Early assessment of ambiguous genitalia. *Archives of*
98 *Disease in Childhood*. 2004;89(5):401-407. doi: 10.1136/adc.2002.011312
99 8. Babu R, Shah U. Gender identity disorder (GID) in adolescents and adults with
100 differences of sex development (DSD): A systematic review and meta-analysis. *Journal*
101 *of Pediatric Urology*. 2021;17(1):39-47. doi: https://doi.org/10.1016/j.jpurol.2020.11.017
102 9. Human Rights Campaign, InterACT. Understanding the intersex community. hrc.org.
103 Accessed January 25, 2022. https://www.hrc.org/resources/understanding-the-intersex-
104 community
105 10. Grootens-Wiegers P, Hein IM, van den Broek JM, de Vries MC. Medical decision-making
106 in children and adolescents: developmental and neuroscientific aspects. *BMC Pediatrics*.
107 2017;17(1):120. doi: 10.1186/s12887-017-0869-x.
108 11. Jones R, Talebian B, Jones V. Redefining informed consent as part of consent training
109 in pediatrics. *JAMA Pediatrics*. 2018;172(7):702. doi:10.1001/jamapediatrics.2018.0922
110 12. Loeff DS, Shakhsheer BA. The ethics of informed consent and shared decision-making
111 in pediatric surgery. *Seminars in Pediatric Surgery*. 2021;30(5).
112 https://doi.org/10.1016/j.sempedsurg.2021.151101
113 13. Wasserman JA, Navin MC, Vercler CJ. Pediatric assent and treating children over
114 objection. *Pediatrics*. 2019;144(5):e20190382. https://doi.org/10.1542/peds.2019-0382
115 14. Profeta G, Micangeli G, Tarani F, Paparella R, Ferraguti G, Spaziani M, Isidori AM,
116 Menghi M, Ceccanti M, Fiore M, Tarani L. Sexual Developmental Disorders in Pediatrics.
117 *La Clinica Terapeutica*. 2022;173(5):475-488. doi: 10.7417/CT.2022.2466
118 15. American Urological Association and Societies for Pediatric Urology. Pediatric Decision
119 Making and Differences of Sex Development: A Societies for Pediatric Urology and
120 American Urological Association Joint Position Statement. auanet.org. Published July
121 2019. Accessed January 14, 2024. https://www.auanet.org/about-us/policy-and-position-
122 statements/joint-statement-on-dsd
123 16. American Academy of Family Physicians. Genital surgeries in intersex children.
124 aafp.org. Published 2018. Accessed January 19, 2022.
125 https://www.aafp.org/about/policies/all/genital-surgeries.html
126 17. Knight K. First US hospital pledges to end intersex surgeries. hrw.org. Published July 30,
127 2020. Accessed January 19, 2023. hrw.org/news/2020/07/30/first-us-hospital-pledges-
128 end-intersex-surgeries
129 18. Sundin L. Imposing identity: why states should restrict infant intersex surgery. *SMU Law*
130 *Review*. 2020;73(3):637-666.
131 19. InterACT. What is intersex? interactadvocates.org. Updated January 26, 2021.
132 Accessed March 1, 2023. https://interactadvocates.org/faq/#intersexhealthy
133 20. Rosenwohl-Mack A, Tamar-Mattis S, Baratz AB, Dalke KB, Ittelson A, Zieselman K, Flatt
134 JD. A national study on the physical and mental health of intersex adults in the U.S.
135 *PLoS One.* 2020;15(10): e0240088. doi: 10.1371/journal.pone.0240088.
136 21. Toler J. Medical and surgical intervention of patients with differences in sex
137 development. *GLMA Policy and Government Affairs Committee*. 2016. Accessed
138 January 14, 2024. https://interactadvocates.org/wp-content/uploads/2016/11/11-2-16-
139 GLMA-Position-Medical-Surgical-Intervention-of-Patients-with-DSD.pdf
140 22. Advocacy Committee, The North American Society for Pediatric and Adolescent
141 Gynecology. NASPAG position statement on surgical management of DSD. *Journal of*
142 *Pediatric and Adolescent Gynecology*. 2018;31(1):1. doi:
143 https://doi.org/10.1016/j.jpag.2017.12.006
144 23. Click G, et al. Enact Ohio Saving Adolescents from Experimentation (SAFE) Act. *The*
145 *Ohio Legislature 135th General Assembly*. Accessed December 1, 2023. https://search-

prod.lis.state.oh.us/solarapi/v1/general_assembly_135/bills/hb68/PH/02/hb68_02_PH?format=pdf
24. AMA Policy: Opposition to Requirements for Gender-Based Treatments for Athletes H-470.951
25. AMA Policy: Neonatal Male Circumcision H-60.945
26. AMA-MSS Policy: Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development 245.020

OSMA Policy:

Policy 22-2017 – Opposition to the Practice of LGBTQ “Conversion Therapy” or “Reparative Therapy”

1. The OSMA affirms that individuals who identify as homosexual, bisexual, transgender, or are otherwise not heteronormative are not inherently suffering from a mental disorder.
2. The OSMA strongly opposes the practice of “Conversion Therapy,” “Reparative Therapy” or other techniques aimed at changing a person’s sexual orientation or gender identity.

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 28 – 2024**
4
5 **Introduced by:** Young Physician Section and Medical Student Section
6
7 **Subject:** Opposition to Requirements for Gender-Based Treatment for
8 Athletes
9
10 **Referred to:** Resolutions Committee No. 2
11
12 -
13
14 **WHEREAS**, the Ohio legislature overrode Governor DeWine's veto of House Bill
15 68[1]; and
16
17 **WHEREAS**, in addition to banning transgender minors from receiving gender-
18 affirming medical care, House Bill 68 will prevent transgender girls from participating in
19 girls' and women's sports[1]; and
20
21 **WHEREAS,** updated (2021) International Olympic Committee guidelines state:
22 • eligibility criteria should be established and implemented fairly and in a
23 manner that does not systematically exclude athletes from competition based
24 upon their gender identity, physical appearance and/or sex variations;
25 • no athlete should be subject to targeted testing because of, or aimed at
26 determining, their sex, gender identity and/or sex variations;
27 • athletes should not be pressured to undergo medically unnecessary
28 procedures or treatment to meet eligibility criteria; and
29 • criteria to determine eligibility should not include gynecological examinations
30 or other invasive physical examinations aimed at determining an athlete's
31 gender or sex[2]; and
32
33 **WHEREAS,** thresholds for hormonal assay cutoffs are arbitrary, and cannot be
34 used in an attempt to achieve "fairness" in athletic competition, nor can they adequately
35 measure competitive advantage/disadvantage; and
36
37 **WHEREAS**, AMA has policy opposing "(1) mandatory testing, medical treatment
38 or surgery for transgender athletes and athletes with Differences of Sex Development
39 (DSD), and affirm that these athletes be permitted to compete in alignment with their
40 identity; (2) the use of specific hormonal guidelines to determine gender classification
41 for athletic competitions; and (3) satisfying third-party requirements to certify or confirm
42 an athlete's gender through physician participation"; and therefore
43
44 **BE IT RESOLVED**, that Ohio State Medical Association opposes (1) mandatory
45 testing, medical treatment or surgery for transgender athletes and athletes with
46 Differences of Sex Development (DSD), and affirm that these athletes be permitted to

47 compete in alignment with their identity; (2) the use of specific hormonal guidelines to
48 determine gender classification for athletic competitions; and (3) satisfying third-party
49 requirements to certify or confirm an athlete's gender through physician participation.
50
51 **Fiscal Note:** $ (Sponsor)
52 $ 500 (Staff)
53
54 **References:**
55
56

57 1https://abcnews.go.com/US/ohio-senate-overrides-governor-veto-trans-care-
58 sports/story?id=106634032
59
60 2https://stillmed.olympics.com/media/Documents/Beyond-the-Games/Human-
61 Rights/IOC-Framework-Fairness-Inclusion-Non-discrimination-2021.pdf

62

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 29 – 2024

Introduced by: Young Physician Section and Medical Student Section

Subject: Firearm Safety for Civilians and Law Enforcement

Referred to: Resolutions Committee No. 2

- -

WHEREAS, firearm injuries are the leading cause of death among children and teens, and is thus a public health problem[1]; and

WHEREAS, using firearms is the most common method of suicide in the United States, contributing to the suicide public health crisis[2]; and

WHEREAS, in an April 2023 Fox News poll, Americans overwhelmingly favor background checks (87%), requiring mental health checks (80%), flagging individuals who are at risk of harm to self (80%), and requiring a 30-day waiting period (77%)[3]; and

WHEREAS, OSMA Policy 54-1989, "Waiting Period before Gun Purchase" states "The OSMA supports a waiting period of at least one week before purchasing any form of firearm in the state of Ohio"; and

WHEREAS, state legislators are introducing legislation to require universal background checks, reintroduce concealed carry permits, and prohibiting people convicted of domestic violence from owning a firearm[4]; and

WHEREAS, Ohio House Bill 99 now allows for teachers to be armed in the classroom after only 24 hours of training, though it was opposed by both teachers' and law enforcement groups[5]; and

WHEREAS, the Ohio Fraternal Order of Police (FOP) opposed the elimination of concealed carry permits in Senate Bill 215, which also eliminated the affirmative duty to inform law enforcement of a concealed weapon, jeopardizing the safety of law enforcement officers[6]; and therefore

BE IT RESOLVED, that the Ohio State Medical Association supports a required background check for the purchase of all firearms; and be it further

RESOLVED, that the Ohio State Medical Association supports extreme risk protection orders, also known as "red flag laws", for individuals who have demonstrated significant signs of potential harm to self or others; and be it further

47 **RESOLVED,** that the Ohio State Medical Association reaffirms OSMA policy 54-
48 1989 “Waiting Period before Gun Purchase”; and be it further
49
50 **RESOLVED,** that the Ohio State Medical Association supports safety training
51 requirements and a permit to carry a concealed firearm; and be it further
52
53 **RESOLVED,** that the Ohio State Medical Association opposes possessing a
54 firearm in schools with the exception of trained security or law enforcement officers.
55
56
57 **Fiscal Note:** $ (Sponsor)
58 $ 50,000 (Staff)
59
60 **References:**
61
62 [1]https://www.cdc.gov/violenceprevention/firearms/firearm-research-
63 findings.html#:~:text=Taking%20into%20account%20all%20types,19%20in%202020%2
64 0and%202021.
65 [2]https://www.cdc.gov/suicide/suicide-data-statistics.html
66 [3]https://www.foxnews.com/official-polls/fox-news-poll-voters-favor-gun-limits-arming-
67 citizens-reduce-gun-violence
68 [4]https://ohiocapitaljournal.com/2024/02/16/ohio-democrats-unveil-numerous-gun-safety-
69 bills-likely-to-be-shot-down-by-gop-led-legislature/
70 [5]https://www.npr.org/2022/06/13/1104570419/ohio-dewine-guns-teachers
71 [6]https://www.news5cleveland.com/news/politics/ohio-politics/our-voices-are-not-heard-
72 ohios-largest-police-union-slams-new-gop-gun-bills
73

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 30 – 2024**
4
5 **Introduced by:** Medical Student Section
6
7 **Subject:** Obesity as a Public Health Emergency
8
9 **Referred to:** Resolutions Committee No. 2
10
11 -
12
13 **WHEREAS**, from 1999 to 2020, obesity prevalence in adults in the United States
14 increased from 30.5% to 41.9%, and the prevalence of severe obesity increased from
15 4.7% to 9.2[1]; and
16
17 **WHEREAS**, obesity disproportionately impacts Black and Hispanic Americans
18 (49.9% and 45.6%, respectively, compared to 41.4% in the White American population),
19 those in rural areas (34.2% compared to 28.7% in metro areas), and people with less
20 formal education (46.4% of high school graduates without higher education compared to
21 34.1% of college graduates)[1]; and
22
23 **WHEREAS**, from 1999 to 2020, obesity prevalence in the pediatric population in
24 the United States increased from 13.9% to 19.7%[1]; and
25
26 **WHEREAS**, as of 2021, Ohio's obesity rate of 46.7% for all ages is significantly
27 higher than the national average of 42.7%[2]; and
28
29 **WHEREAS**, overweight and obese status are independently correlated with
30 poorer health outcomes including, but not limited to, higher mortalities from
31 cardiovascular disease and hepatocellular cancer[3]; and
32
33 **WHEREAS**, physicians do not talk to their overweight patients enough about
34 their weight, despite this conversation's ability to improve the odds (2:1) that patients
35 will lose greater than 10% of their weight in the following year[4]; and
36
37 **WHEREAS**, healthcare practitioners are often apprehensive when initiating a
38 conversation about obesity with their patients[5]; and
39
40 **WHEREAS**, when physicians and patients talk about weight and weight-related
41 issues, there is a disagreement about the effectiveness of these discussions,
42 exacerbating a lack in confidence in providers to address weight concerns[6]; and
43
44 **WHEREAS**, patients and physicians perpetuate misconceptions and notions
45 about obesity which lack scientific support, leading to confusion and suboptimal patient
46 care[7]; and

WHEREAS, physicians provide personal opinions and generic advice to patients about weight, suggesting a need for more effective guidance for making personalized recommendations[8,9]; and

WHEREAS, in a 2020 survey of Primary Care Providers (PCPs) in the Midwestern United States, 73% of physicians requested information on health system resources for obesity treatment and 62.6% requested more training on effective dietary counseling[10]; and

WHEREAS, medical schools provide an average of fewer than 20 hours of nutrition instruction to students, despite a minimum 25 hours being recommended by the 1985 Report of the National Research Council's Committee on Nutrition in Medical Education[11]; and

WHEREAS, medical students are uncomfortable having weight-related discussions with patients[12]; and

WHEREAS, having structured patient encounters with overweight standardized patients as medical students is correlated with reduced negative stereotyping and greater empathy and ability to work well with overweight patients[13]; and

WHEREAS, Body Mass Index (BMI) is the current metric for determining anthropometric characteristics and is used as a predictor for cardiometabolic health risks; however, it is a poor indicator of percent body fat and overall health[14]; and

WHEREAS, waist-to-height ratio has been shown to be a better predictor for cardiometabolic health risks than BMI[15]; and

WHEREAS, the OSMA public health policy 11-2022 is limited to addressing weight stigma among healthcare workers; and

WHEREAS, the OSMA includes in its values that promoting innovation improves the health of patients[16]; and therefore

BE IT RESOLVED, that our OSMA support the utilization of other evidenced-based anthropometric measures, including but not limited to weight-to-height ratio, in health screenings that better reflect comorbid health risks than BMI; and be it further

RESOLVED, the OSMA supports training to further educate healthcare practitioners and trainees about healthy diet, the multifactorial nature of body weight, the impact of obesity, and strategies to reduce the detrimental health effects of obesity on Ohioans, including avoidance of obesity in the pediatric population and the integration of developing weight-loss medical interventions.

Fiscal Note: $ (Sponsor)

$ 500 (Staff)

References:

1. Trust for America's Health, (2022), The State of Obesity: Better Policies for a Healthier America- Special Feature: Food and Nutrition Insecurity Among Youth and Families. Issue Report. 2022ObesityReport_FINAL3923.pdf (tfah.org)
2. *Obesity Prevalence & Comorbidity MAP*. (2021). https://obesitymap.norc.org/
3. Gupta, A., Das, A., Majumder, K., Arora, N., Mayo, H. G., Singh, P. P., Beg, M. S., & Singh, S. (2018). Obesity is Independently Associated With Increased Risk of Hepatocellular Cancer-related Mortality: A Systematic Review and Meta-Analysis. American journal of clinical oncology, 41(9), 874–881. https://doi.org/10.1097/COC.0000000000000388
4. Andrew C. Pool, Jennifer L. Kraschnewski, Lindsay A. Cover, Erik B. Lehman, Heather L. Stuckey, Kevin O. Hwang, Kathryn I. Pollak, Christopher N. Sciamanna, The impact of physician weight discussion on weight loss in US adults, Obesity Research & Clinical Practice, Volume 8, Issue 2, 2014, Pages e131-e139, ISSN 1871-403X, https://doi.org/10.1016/j.orcp.2013.03.003.
5. Albury C, Strain WD, Brocq SL, et al. The importance of language in engagement between health-care professionals and people living with obesity: a joint consensus statement. Lancet Diabetes Endocrinol. 2020;8(5):447-455. doi:10.1016/S2213-8587(20)30102-9
6. Greiner, K. A., Born, W., Hall, S., Hou, Q., Kimminau, K. S., & Ahluwalia, J. S. (2008). Discussing weight with obese primary care patients: physician and patient perceptions. Journal of general internal medicine, 23(5), 581–587. https://doi.org/10.1007/s11606-008-0553-9
7. Casazza, K., Fontaine, K. R., Astrup, A., Birch, L. L., Brown, A. W., Bohan Brown, M. M., Durant, N., Dutton, G., Foster, E. M., Heymsfield, S. B., McIver, K., Mehta, T., Menachemi, N., Newby, P. K., Pate, R., Rolls, B. J., Sen, B., Smith, D. L., Jr, Thomas, D. M., & Allison, D. B. (2013). Myths, presumptions, and facts about obesity. The New England journal of medicine, 368(5), 446–454. https://doi.org/10.1056/NEJMsa1208051
8. Madeleine Tremblett, Annabel Y X Poon, Paul Aveyard, Charlotte Albury, What advice do general practitioners give to people living with obesity to lose weight? A qualitative content analysis of recorded interactions, Family Practice, 2022;, cmac137, https://doi.org/10.1093/fampra/cmac137
9. Treatment- Obesity (2023, December 15). *Treatment*. Nhs.uk. https://www.nhs.uk/conditions/obesity/treatment/
10. Oshman, L., Othman, A., Furst, W., Heisler, M., Kraftson, A., Zouani, Y., Hershey, C., Cho, T., Guetterman, T. C., Piatt, G., & Griauzde, D. H. (2023). Primary care providers' perceived barriers to obesity treatment and opportunities for improvement: A mixed methods study. *PLOS ONE*, *18*(4), e0284474. https://doi.org/10.1371/journal.pone.0284474
11. Adams, K. M., Butsch, W. S., & Kohlmeier, M. (2015). The state of nutrition education at US medical schools. *Journal of Biomedical Education*, *2015*, 1–7. https://doi.org/10.1155/2015/357627
12. Ockene, J.K., Pbert, L., Crawford, S. et al. Teaching Medical Students to Help Patients Manage Their Weight: Outcomes of an Eight-School Randomized Controlled Trial. J GEN INTERN MED 36, 3000–3007 (2021). https://doi.org/10.1007/s11606-020-06571-x
13. Kushner, R. F., Zeiss, D. M., Feinglass, J. M., & Yelen, M. (2014). An obesity educational intervention for medical students addressing weight bias and communication

skills using standardized patients. BMC medical education, 14, 53. https://doi.org/10.1186/1472-6920-14-53
14. Nuttall FQ. Body Mass Index: Obesity, BMI, and Health: A Critical Review. Nutr Today. 2015;50(3):117-128. doi:10.1097/NT.0000000000000092
15. Kenneth Lo, Yu-Qing Huang, Geng Shen, Jia-Yi Huang, Lin Liu, Yu-Ling Yu, Chao-Lei Chen, Ying Qing Feng, Effects of waist to height ratio, waist circumference, body mass index on the risk of chronic diseases, all-cause, cardiovascular and cancer mortality, Postgraduate Medical Journal, Volume 97, Issue 1147, May 2021, Pages 306–311, https://doi.org/10.1136/postgradmedj-2020-137542
16. OSMA | Our work. (n.d.). https://www.osma.org/aws/OSMA/pt/sp/ourwork
17. AMA Policy: Addressing Adult and Pediatric Obesity D-440.954
18. AMA Policy: Obesity as a Major Health Concern H-440.902
19. AMA Policy: Recognizing and Taking Action in Response to the Obesity Crisis D-440.980
20. AMA Policy: Recognition of Obesity as a Disease H-440.842
21. AMA Policy: Obesity as a Major Public Health Problem H-150.953
22. AMA Policy: Prevention of Obesity Through Instruction in Public Schools H-170.961
23. AMA Policy: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders H-440.800
24. AMA Policy: The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity H-440.866
25. AMA Policy: Combating Obesity and Health Disparities H-150.944

OSMA Policy:

Policy 11-2022 Addressing Weight Stigma Among Healthcare Workers

1. The Ohio State Medical Association (OSMA) supports health promotion techniques that center around healthy behavior and lifestyle modifications rather than weight reduction alone.
2. The OSMA supports educational training to further educate healthcare practitioners and trainees about the multifactorial nature of body weight, the impact of weight stigma, and strategies to reduce the detrimental health effects of weight stigma on Ohioans.

Policy 41-2008 Childhood Obesity and Nutrition in the Schools

1. The OSMA recommends that our members advocate that their local schools remove soft drinks and candy from vending machines.
2. The OSMA recommends that our members be involved in advocating for healthy nutrition in their local schools.

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 31 – 2024**
4
5 **Introduced by:** Medical Student Section
6
7 **Subject:** Supporting Programs and Policies to Address Disparities in
8 Maternal and Infant Morbidity and Mortality in Ohio
9
10 **Referred to:** Resolutions Committee No. 2
11
12 **- -**
13
14 **WHEREAS**, infant mortality in the United States was 5.44 infant deaths per 1,000
15 infant births in 2021, a 2% increase from 2020[1,2]; and
16
17 **WHEREAS**, maternal mortality in the United States reached 32.9 deaths per
18 100,000 live births in 2021[3], a 38% increase from 2020; and
19
20 **WHEREAS**, the United States lags behind many other developed countries on
21 infant mortality and maternal mortality indicators, ahead of only 6 and 7 Organization for
22 Economic Cooperation and Development (OECD) countries of 38, respectively; and
23
24 **WHEREAS**, the infant mortality rate in Ohio is 6.7 deaths per 1,000 births and
25 surpasses the state and national goal of 6.0 deaths per 1,000 births[4]; and
26
27 **WHEREAS**, the pregnancy related mortality ratio (PRMR), defined by the
28 number of maternal deaths related to pregnancy within a year of birth, has increased in
29 Ohio from 10.8 in 2008 to 23.7 in 2018[5]; and
30
31 **WHEREAS**, infant mortality and maternal mortality disproportionately impact
32 persons of color, with the infant mortality ratio up to 2.7 times higher for infants of color
33 and maternal mortality 2.5 times higher for women of color[4,6]; and
34
35 **WHEREAS**, the death of a pregnant person during pregnancy and childbirth
36 extends beyond the individual tragedy of losing a life but also affects the immediate
37 family, interrupts education, and leads to spiraling cycles of poverty within families, and
38 having disastrous consequences on communities including the increase of long-term
39 infant and maternal morbidity and mortality rates and distrust in the healthcare field[7];
40 and
41
42 **WHEREAS**, low parental education level, Black race, low prenatal care access
43 and lack of supplemental income are social drivers that have been associated with
44 increased infant morbidity and mortality in the US[8–12]; and
45

46 **WHEREAS**, poor healthcare access, including but not limited to prenatal care,
47 health insurance coverage, and culturally appropriate care, low educational attainment,
48 poor built environment for physical activity, and lack of food access have been identified
49 as social drivers of maternal morbidity and mortality disparities in the US[13]; and
50
51 **WHEREAS**, community-based programs such as the Maternal Infant Wellness
52 Program and Moms2B have been proven to reduce infant mortality rates and address
53 health disparities by using a comprehensive, collaborative strategy between academic
54 medicine and community-based organizations to address social determinants of health
55 throughout Ohio[14–16]; and
56
57 **WHEREAS**, state policies such as child and maternal home well visits, expanded
58 Medicaid coverage, and Women, Infant and Children (WIC) and Supplemental Nutrition
59 (SNAP) programs have lowered the burden of seeking accessible prenatal care for
60 mothers, helped to ameliorate negative birth outcomes and mitigate outcome disparities
61 for at-risk populations through targeting social determinants[9,11,17,18]; and
62
63 **WHEREAS**, providing sustained, individualized, quality patient care before and
64 after a pregnancy is recommended by the American College of Obstetricians (ACOG)
65 and the American Academy of Pediatrics (AAP) as key provider actions to preventing
66 infant mortality and maternal mortality[19,20]; and
67
68 **WHEREAS**, our OSMA has passed policy to support legislative action that
69 fosters research and direct healthcare advancements in addressing pregnancy-related
70 morbidity and mortality in Ohio, including education of healthcare providers in identifying
71 and referring patients to community health pregnancy-related morbidity and mortality
72 programs and educating healthcare providers about health disparities in general[21]; and
73
74 **WHEREAS**, the AMA has passed policy to evaluate the issue of health
75 disparities in maternal and infant mortality (D-420.993, D-245.994) and to reduce
76 inequities and improve access to insurance for maternal health care **(**H-60.909, H-
77 185.917**,** D-245.994); and therefore
78
79 **BE IT RESOLVED**, that our OSMA supports legislation and government action
80 that promotes academic and community-based research to monitor infant mortality
81 rates, associated disparities, and the social factors which cause them; and be it further
82
83 **RESOLVED**, that our OSMA collaborates with the Maternal Infant and Wellness
84 Program to improve birth outcomes with a focus on health disparities; and be it further
85
86 **RESOLVED**, that our OSMA support legislation and government action that
87 reduces barriers to healthcare access and educational attainment in communities of
88 underrepresented persons; and be it further
89

RESOLVED, that our OSMA promote the utilization of and individualized care by member physicians before and after pregnancy, leading to more equitable health outcomes for infants and parents.

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

References:

1. Ely D, Driscoll A. *Infant Mortality in the United States, 2021: Data From the Period Linked Birth/Infant Death File*. 2023. https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-11.pdf
2. Centers for Disease Control and Prevention. *Infant Mortality*, September 13, 2023. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm
3. Hoyert D. *Maternal Mortality Rates in the United States,* 2021*.* Published 2023. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm
4. Mayer D. *Infant Vitality,* 2023. https://odh.ohio.gov/know-our-programs/infant-vitality
5. Ohio Department of Health. *Ohio Maternal Health Data and Reports,* 2018. https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/reports
6. Ohio Department of Health. *Severe Maternal Morbidity and Racial Disparities in Ohio, 2016-2019*, 2020. https://odh.ohio.gov/wps/wcm/connect/gov/0657b23a-baba-4a74-b31c-25e216728849/PAMR+SMM+Final.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-0657b23a-baba-4a74-b31c-25e216728849-nIngvoH
7. Miller S, Belizán JM. The true cost of maternal death: individual tragedy impacts family, community and nations. *Reprod Health*. 2015;12(1):56. doi:10.1186/s12978-015-0046-3
8. Green T, Hamilton TG. Maternal educational attainment and infant mortality in the United States: Does the gradient vary by race/ethnicity and nativity? *Demogr Res*. 2019;41:713-752.
9. Keene Woods N, Reyes J, Chesser A. Infant Mortality and Race in Kansas: Associations With Women, Infants, and Children Services. *J Prim Care Community Health*. 2016;7(3):194-198. doi:10.1177/2150131916635572
10. Newman K. *Relationship between Income, Maternal and Infant Factors, and Infant Mortality Rates in African American Communities*. 2022. Accessed November 14, 2023. https://www.proquest.com/openview/a26b150cf48b8307e8afb48131a98fbf/1?pq-origsite=gscholar&cbl=18750&diss=y
11. Soneji S, Beltrán-Sánchez H. Association of Special Supplemental Nutrition Program for Women, Infants, and Children With Preterm Birth and Infant Mortality. *JAMA Netw Open*. 2019;2(12):e1916722. doi:10.1001/jamanetworkopen.2019.16722
12. Orischak M, Fru DN, Kelly E, DeFranco EA. Social determinants of infant mortality amongst births to non-Hispanic Black women. *Am J Obstet Gynecol*. 2022;226(1):S706. doi:10.1016/j.ajog.2021.11.1164
13. Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and Structural Determinants of Health Inequities in Maternal Health. *J Womens Health*. 2021;30(2):230-235. doi:10.1089/jwh.2020.8882
14. Hade EM, Lynch CD, Benedict JA, et al. The Association of Moms2B, a Community-Based Interdisciplinary Intervention Program, and Pregnancy and Infant Outcomes among Women Residing in Neighborhoods with a High Rate of Infant Mortality. *Matern*

140 *Child Health J*. 2022;26(4):923-932. doi:10.1007/s10995-020-03109-9
141 15. Gabbe PT, Reno R, Clutter C, et al. Improving Maternal and Infant Child Health
142 Outcomes with Community-Based Pregnancy Support Groups: Outcomes from Moms2B
143 Ohio. *Matern Child Health J*. 2017;21(5):1130-1138. doi:10.1007/s10995-016-2211-x
144 16. Ohio Department of Health. *Maternal Infant Wellness,* 2023. https://odh.ohio.gov/know-
145 our-programs/maternal-infant-wellness/welcome-to
146 17. Bellazaire A, Skinner E. *Preventing Infant and Maternal Mortality: State Policy Options,*
147 July 2019. https://www.ncsl.org/health/preventing-infant-and-maternal-mortality-state-
148 policy-
149 options#:~:text=Prevention%20measures%20include%20high%2Dquality,managing%20
150 diabetes%20and%20other%20interventions.
151 18. Meghea CI, You Z, Raffo J, Leach RE, Roman LA. Statewide Medicaid Enhanced
152 Prenatal Care Programs and Infant Mortality. *Pediatrics*. 2015;136(2):334-342.
153 doi:10.1542/peds.2015-0479
154 19. American College of Obstetricians and Gynecologists. *Optimizing Postpartum Care,*
155 May 2018. https://www.acog.org/clinical/clinical-guidance/committee-
156 opinion/articles/2018/05/optimizing-postpartum-care
157 20. Warren MD, Hirai AH, Lee V. Accelerating Upstream Together: Achieving Infant Health
158 Equity in the United States by 2030. *Pediatrics*. 2022;149(2):e2021052800.
159 doi:10.1542/peds.2021-052800
160 21. Ohio State Medical Association. *OSMA Policy Compendium*, 2023.
161 https://www.osma.org/aws/OSMA/pt/sp/policy-compendium
162 22. AMA Policy: Disparities in Maternal Mortality D-420.993
163 23. AMA Policy: State Maternal Mortality Review Committees H-60.909
164 24. AMA Policy: Reducing Inequities and Improving Access to Insurance for Maternal Health
165 Care H-185.917
166 25. AMA Policy: Infant Mortality D-245.994
167
168
169 OSMA Policy:
170
171 **Policy 20 – 2023 – Utilizing Principles of Collective Impact to Address Pregnancy-Related**
172 **Mortality in Ohio**
173 1. Our OSMA supports legislation and government action that works to foster research
174 and/or directly affect maternal mortality rates in the state of Ohio
175 2. Our OSMA collaborate with Ohio Pregnancy Associated Mortality Review and Ohio
176 Council to Advance Maternal Health to address pregnancy related morbidity and
177 mortality in Ohio
178 3. Our OSMA collaborate with healthcare facilities and other relevant stakeholders to
179 support the development of resources to train healthcare providers in identification and
180 referral of patients for participation in community health pregnancy-related morbidity and
181 mortality programs.
182
183 **Policy 06 – 2019 – Increase Awareness of Disparities in Medical Access and Treatment in**
184 **Ohio**
185 1. The OSMA shall work with appropriate stakeholders to increase awareness of Ohio
186 physicians, residents, and medical students of disparities in medical access and
187 treatment in Ohio based on disability, race, ethnicity, geography, and other social and
188 demographic factors through the utilization of existing resources
189

190 **Policy 25 – 2017 – Longitudinal Approach to Cultural Competency Dialogue on**
191 **Eliminating Health Care Disparities**
192 1. The OSMA encourages all medical education institutions in Ohio to engage in expert
193 facilitated, evidence-based dialogue in cultural competency and the physician's role in
194 eliminating cultural health care disparities in medical treatment.
195

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 32 – 2024

Introduced by: Medical Student Section

Subject: Supporting Expanded Naloxone Availability and Training and Encouraging Mandated Access in Public Institutions

Referred to: Resolutions Committee No. 2

- -

WHEREAS, the Ohio overdose crisis remains at catastrophic levels, with 5,174 lives lost to overdose in 2021 – the highest number of unintentional overdose deaths per year on record, a 3% increase from 2020 and 28% increase from 2019[1]; and

WHEREAS, naloxone is clinically proven to reduce mortality in people with opioid dependence compared to placebo[2]; and

WHEREAS, in March 2023, the U.S. Food and Drug Administration approved naloxone for over-the-counter (OTC), nonprescription use[3]; and

WHEREAS, according to the World Health Organization, those most likely to witness an overdose include people at risk of an opioid overdose, their friends or a family member, and those individuals whose work may bring them in contact with people who have overdosed[4]; and

WHEREAS, the Substance Abuse and Mental Health Services Administration identifies schools and workplaces as appropriate settings for readily accessible naloxone[5]; and

WHEREAS, naloxone is available in Ohio from many community-based organizations and health departments including but not limited to behavioral health providers, hospitals, Project DAWN programs, harm reduction programs, and ADAMHS Boards for low or no cost[5]; and

WHEREAS, anyone in Ohio can obtain free naloxone and overdose response education through Project DAWN locations[6]; and

WHEREAS, Ohio Revised Code 2925.61 states that a family member, friend, or other person in a position to assist an individual who appears to be experiencing an opioid-related overdose cannot be prosecuted for practicing medicine without a license or for most other drug offenses if that person obtains naloxone in a manner permitted by law, administers the naloxone to a person who appears to be experiencing a drug overdose, and attempts to summon emergency services as soon as practicable[7]; and

WHEREAS, there exists local precedents across the country for requiring naloxone in public spaces as life-saving interventions for overdose death prevention; and

WHEREAS, in July 2017, the Akron Public Schools Board of Education passed a motion to equip every middle school and high school in the district with naloxone[8]; and

WHEREAS, in July 2023, Mayor Rick Blangiardi of Honolulu, Hawaii signed Bill 28 which required naloxone to be available in Oahu bars and restaurants that serve alcohol as of January 1, 2024[9]; and

WHEREAS, there is national and state-wide precedent for requiring public spaces to have life-saving medical equipment with brief, understandable training information readily available and accessible on-site (i.e., automated external defibrillators (AEDs)); and

WHEREAS, House Bill 47, which mandates AEDs in schools, has passed the Ohio House of Representatives and, as of January 2024, is in Senate Committee[10]; and therefore

BE IT RESOLVED, that our OSMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the state following distribution and legislative edicts similar to those for Automated External Defibrillators.

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

References:

1. Ohio Department of Health. Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths. Accessed July 12, 2023. https://odh.ohio.gov/wps/wcm/connect/gov/86452388-2e4b-48d6-a5e8-90ce24b30d0f/Ohio+Quarterly+Overdose+Report_Preliminary+Data_Q1_2023.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-86452388-2e4b-48d6-a5e8-90ce24b30d0f-otRHmeH
2. National Academies Press (US). (2019, March 30). The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Medications for Opioid Use Disorder Save Lives - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK541393/
3. Food & Drug Administration. (2023, August 1). FDA Approves Second Over-the-Counter Naloxone Nasal Spray Product [News Release]. https://www.fda.gov/news-events/press-announcements/fda-approves-second-over-counter-naloxone-nasal-spray-product

93 4. HHS Office of the Surgeon General. (2018, April 5). U.S. Surgeon General's
94 Advisory on Naloxone and Opioid Overdose. Retrieved from
95 https://www.hhs.gov/surgeongeneral/priorities/opioids-and-
96 addiction/naloxoneadvisory/index.html.
97 5. Substance Abuse and Mental Health Services Administration. (n.d.). Non-
98 prescription ("Over-the-Counter") Naloxone Frequently Asked Questions.
99 https://www.samhsa.gov/medications-substance-use-disorders/medications-
100 counseling-related-conditions/naloxone/faqs
101 6. Ohio Department of Health. (n.d.). Project Dawn. https://odh.ohio.gov/know-our-
102 programs/project-dawn/project-
103 dawn#:~:text=Anyone%20in%20Ohio%20can%20obtain,List%20of%20Project%
104 20DAWN%20Locations.
105 7. Robert Wood Johnson Foundation. The Network for Public Health Law Drug
106 Overdose Prevention: Naloxone Access and Overdose Good Samaritan Law in
107 Ohio. (2018). https://www.networkforphl.org/wp-content/uploads/2020/01/Ohio-
108 Naloxone-Good-Sam-Laws-Fact-Sheet.pdf
109 8. Ohio Department of Health. TakeChargeOhio Naloxone in Schools Policy Brief.
110 (2020). https://takecharge.ohio.gov/static/healthcare-professionals-
111 toolkit/naloxone-resource-information/naloxone-in-schools_policy-brief.pdf
112 9. City & County of Honolulu. (n.d.). City Council records, BILL028(23), CD1.
113 https://hnldoc.ehawaii.gov/hnldoc/measure/2486
114 10. Ohio Legislature. (n.d.). House Bill 47 | 135th General Assembly.
115 www.legislature.ohio.gov. Retrieved November 30, 2023, from
116 https://www.legislature.ohio.gov/legislation/135/hb47#:~:text=To%20amend%20s
117 ections%20755.13%2C%203313.5310
118 11. AMA Policy: Increasing Availability of Naloxone and Other Safe and Effective
119 Overdose Reversal Medications H-95.932
120
121
122 OSMA Policy:
123
124 **Policy 8 – 2023 -- Reducing Barriers and Eliminating Disparities Surrounding Use**
125 **of Medications for Opioid Use Disorder in Ohio**
126 1. OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through
127 medication-assisted treatment and harm reduction services be amended to read
128 as follows:
129 2. The Ohio State Medical Association (OSMA) advocates for the use of
130 medication-assisted treatment, including but not limited to methadone or
131 buprenorphine, and harm reduction methods without penalty when clinically
132 appropriate.
133 3. The OSMA supports public awareness campaigns to increase education of
134 evidence-based services for opioid addiction, including but not limited to
135 medication-assisted treatment, harm reduction, and recovery services.
136 4. The OSMA supports existing and pilot programs for the distribution of fentanyl
137 test strips in at-risk communities in Ohio.

138 5. The OSMA supports legislation prohibiting prior authorization requirements and
139 other restrictions on use of evidence-based medications for opioid use disorder.
140 6. The OSMA supports research, policy, and education concerning the impacts of
141 racism and classism on patient awareness of and access to substance use
142 disorder treatment.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 33 – 2024

Introduced by: Medical Student Section

Subject: Expanding Access to Opioid Agonist Therapies with Associated Trained Medical Personnel in Rehabilitation Facilities

Referred to: Resolutions Committee No. 2

- -

WHEREAS, 2021 saw the highest number of unintentional drug overdose deaths in Ohio on record, with 5,174 individuals dying due to overdose, a 3% increase over 2020[1]; and

WHEREAS, 84% of unintentional drug overdose deaths involved opioids, and 80% were specifically related to fentanyl[1]; and

WHEREAS, buprenorphine is clinically proven to reduce illicit opioid use and mortality in people with opioid dependence compared to placebo[2,3] and reduce risk of relapse by approximately 50% compared to behavioral treatment alone[4]; and

WHEREAS, methadone maintenance therapy significantly improves retention in treatment and reduces heroin use compared to non-pharmacologic approaches[5];

WHEREAS, compared to (a) no treatment, (b) inpatient detoxification or residential services alone, (c) naltrexone, (d) nonintensive behavioral health therapy alone, and (e) intensive behavioral health treatment alone, treatment with buprenorphine or methadone is associated with fewer overdoses and reduced opioid-related acute care utilization for patients with opioid use disorder[6]; and

WHEREAS, the Society for Adolescent Health and Medicine recommends that adolescents and young adults also be offered medication for opioid use disorder (MOUD) as part of an integrated treatment approach that includes pharmacologic and nonpharmacologic strategies[7]; and

WHEREAS, buprenorphine is the only form of MOUD approved by the United States Food and Drug Administration for use in adolescents ages 16-18[8]; and

WHEREAS, a single-day count in March 2019 showed 66,296 individuals in Ohio enrolled in substance use treatment, an increase of over 10,000 individuals from 2017 (no data available in 2018)[9]; and

WHEREAS, over 85.1% (over 56,400) of these individuals received treatment specifically for a drug-related problem[9]; but only 13,672 were receiving buprenorphine and 5,824 were receiving methadone as part of their substance use treatment[9]; and

WHEREAS, nationally, only 29% of adult residential addiction treatment programs offer the standard of care: opioid agonist therapy like buprenorphine as maintenance, and 21% actively discourage its use[10 11]; and

WHEREAS, only 24% of nation-wide and 34% of Midwestern adolescent residential addiction treatment facilities offer buprenorphine[8], and

WHEREAS, Ohio's Section 1115 waiver establishes a requirement that residential treatment providers offer MOUD on-site or facilitate access to MOUD off-site[12]; and

WHEREAS, this waiver does not specify that opioid agonist or partial agonist therapies like methadone, buprenorphine, or buprenorphine-naloxone are offered, and it is set to expire in September 2024; and therefore

BE IT RESOLVED, that our OSMA amend Policy 13 - 2022 as follows:

Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio through Medication-Assisted Treatment and Harm Reduction Services

1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
4. The OSMA supports legislation prohibiting prior authorization requirements and other restrictions on use of evidence-based medications for opioid use disorder.
5. The OSMA supports research, policy, and education concerning the impacts of racism and classism on patient awareness of and access to substance use disorder treatment.
6. THE OSMA SUPPORTS LEGISLATION DIRECTING RESIDENTIAL TREATMENT PROVIDERS TO OFFER OPIOID AGONIST OR PARTIAL AGONIST THERAPIES, WITH ASSOCIATED TRAINED MEDICAL PERSONNEL, ON-SITE, OR TO FACILITATE ACCESS OFF-SITE.

92 **Fiscal Note:** $ (Sponsor)
93 $ 500 (Staff)
94
95 **References:**
96
97 1. ODH Violence and Injury Epidemiology and Surveillance Section, ODH Bureau of Vital
98 Statistics. *Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths*. Ohio
99 Department of Health; 2023.
100 2. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine Maintenance Versus Placebo or
101 Methadone Maintenance for Opioid Dependence. *Cochrane Database Syst Rev*.
102 2014;2014(2):CD002207. doi:10.1002/14651858.CD002207.pub4
103 3. *Health Aff Proj Hope*. 2011;30(8):1425-1433. doi:10.1377/hlthaff.2010.0532
104 4. Clark RE, Baxter JD, Aweh G, O'Connell E, Fisher WH, Barton BA. Risk Factors for Relapse
105 and Higher Costs Among Medicaid Members with Opioid Dependence or Abuse: Opioid
106 Agonists, Comorbidities, and Treatment History. *J Subst Abuse Treat*. 2015;57:75-80.
107 doi:10.1016/j.jsat.2015.05.001
108 5. Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid
109 replacement therapy for opioid dependence. *Cochrane Database Syst Rev*.
110 2003;(2):CD002209. doi:10.1002/14651858.CD002209
111 6. Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different
112 Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open*. 2020;3(2):e1920622.
113 doi:10.1001/jamanetworkopen.2019.20622
114 7. Medication for Adolescents and Young Adults With Opioid Use Disorder. *J Adolesc Health*.
115 2021;68(3):632-636. doi:10.1016/j.jadohealth.2020.12.129
116 8. King C, Beetham T, Smith N, et al. Treatments Used Among Adolescent Residential
117 Addiction Treatment Facilities in the US, 2022. *JAMA*. 2023;329(22):1983-1985.
118 doi:10.1001/jama.2023.6266
119 9. Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer:
120 Ohio, Volume 6: Indicators as Measured through the 2019 National Survey on Drug Use and
121 Health and the National Survey of Substance Abuse Treatment Services*. Substance Abuse
122 and Mental Health Services Administration; 2020:27-28, 30.
123 10. Beetham T, Saloner B, Gaye M, Wakeman SE, Frank RG, Barnett ML. Therapies Offered at
124 Residential Addiction Treatment Programs in the United States. *JAMA*. 2020;324(8):804-806.
125 doi:10.1001/jama.2020.8969
126 11. Madden EF. Intervention stigma: How medication-assisted treatment marginalizes patients
127 and providers. *Soc Sci Med 1982*. 2019;232:324-331. doi:10.1016/j.socscimed.2019.05.027
128 12. O'Brien P, Stewart M, White M, Shields M, Mulvaney-Day N. *State Residential Treatment for
129 Behavioral Health Conditions: Regulation and Policy - Ohio Summary*. Office for the Assistant
130 Secretary of Planning and Evaluation; 2021:11. https://aspe.hhs.gov/sites/default/files/2021-
131 08/StateBHCond-Ohio.pdf
132 13. AMA Policy: Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder
133 D-95.972
134 14. AMA Policy: Support the Elimination of Barriers to Evidence-Based Treatment for Substance
135 Use Disorders D-95.968
136
137
138 OSMA Policy:
139
140 **Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-
141 Assisted Treatment and Harm Reduction Services**

142
143 1. The Ohio State Medical Association (OSMA) advocates for the use of
144 medication-assisted treatment, including but not limited to methadone or
145 buprenorphine, and harm reduction methods without penalty when clinically
146 appropriate.
147 2. The OSMA supports public awareness campaigns to increase education of
148 evidence-based services for opioid addiction, including but not limited to
149 medication-assisted treatment, harm reduction, and recovery services.
150 3. The OSMA supports existing and pilot programs for the distribution of fentanyl
151 test strips in at-risk communities in Ohio.
152 4. The OSMA supports legislation prohibiting prior authorization requirements and
153 other restrictions on use of evidence-based medications for opioid use disorder.
154 5. The OSMA supports research, policy, and education concerning the impacts of
155 racism and classism on patient awareness of and access to substance use
156 disorder treatment.
157
158 **Policy 8 – 2023 - Reducing Barriers and Eliminating Disparities Surrounding Use of**
159 **Medications for Opioid Use Disorder in Ohio**
160
161 OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through medication-assisted
162 treatment and harm reduction services be amended to read as follows:
163
164 1. The Ohio State Medical Association (OSMA) advocates for the use of medication-
165 assisted treatment, including but not limited to methadone or buprenorphine, and
166 harm reduction methods without penalty when clinically appropriate.
167 2. The OSMA supports public awareness campaigns to increase education of
168 evidence-based services for opioid addiction, including but not limited to medication-
169 assisted treatment, harm reduction, and recovery services.
170 3. The OSMA supports existing and pilot programs for the distribution of fentanyl test
171 strips in at-risk communities in Ohio.
172 4. THE OSMA SUPPORTS LEGISLATION PROHIBITING PRIOR AUTHORIZATION
173 REQUIREMENTS AND OTHER RESTRICTIONS ON USE OF EVIDENCE-BASED
174 MEDICATIONS FOR OPIOID USE DISORDER.
175 5. THE OSMA SUPPORTS RESEARCH, POLICY, AND EDUCATION CONCERNING
176 THE IMPACTS OF RACISM AND CLASSISM ON PATIENT AWARENESS OF AND
177 ACCESS TO SUBSTANCE USE DISORDER TREATMENT.
178

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**
2
3 **Resolution No. 34 – 2024**
4
5 **Introduced by:** Jessica Geddes, MD, Kali Chiriboga, DO
6
7 **Subject:** Encourage Marijuana Counseling and Harm Reduction
8
9 **Referred to:** Resolutions Committee No. 2
10
11 -
12
13 **WHEREAS,** on November 7, 2023, Ohio became the 24th state to legalize
14 recreational marijuana;[1] and
15
16 **WHEREAS,** approximately half of Ohio adults have used marijuana and rates of
17 marijuana use are increasing both nationwide and in Ohio;[2] and
18
19 **WHEREAS,** patient disclosures regarding marijuana use are an opportunity for
20 physicians to counsel patients regarding risks and benefits of marijuana use but are
21 often met with variable responses from physicians;[34] and
22
23 **WHEREAS,** many physicians report a knowledge gap when it comes to
24 counseling patients on marijuana use;[5] and
25
26 **WHEREAS,** there is evidence for potential clinical uses (examples include for
27 chronic pain, chemotherapy-induced nausea and vomiting, and multiple sclerosis
28 spasticity symptoms), and medical risks (examples include lung injury from smoking,
29 increased risk of acute coronary syndromes in patients with known cardiovascular
30 disease or those at high risk for cardiovascular disease) of marijuana;[6] and
31
32 **WHEREAS,** there is evidence for marijuana harm reduction techniques, including
33 but not limited to: encouraging patients to get products from a medical dispensary or
34 authorized store, counseling regarding inconsistencies in labeling and advertising,
35 discussing risks of lung injury with smoking marijuana compared to other forms of
36 ingestion;[78] and
37
38 **WHEREAS,** physicians in Ohio should be prepared to discuss marijuana use
39 with patients including risks, benefits, and harm reduction strategies; and therefore
40
41 **BE IT RESOLVED,** that the OSMA encourages physicians to be informed
42 regarding risks, benefits, and harm reduction techniques related to marijuana use, both
43 medical and recreational.
44
45 **Fiscal Note:** $ (Sponsor)
46 $ 500 (Staff)

47
48 **References:**
49
50 [1] Cannabis Crossroads | Moritz College of Law. moritzlaw.osu.edu.
51 https://moritzlaw.osu.edu/faculty-and-research/drug-enforcement-and-policy-
52 center/research-and-grants/p olicy-and-data-analyses/cannabis-crossroads
53 [2] Half of Ohio Adults Have Tried Marijuana: Data Concern Public Health Advocates.
54 Prevention Action Alliance. Accessed February 21, 2024.
55 https://preventionactionalliance.org/news/half-of-ohio-adults-have-tried-marijuana-data-
56 concern-public-he alth-advocates/
57 [3] Rønne ST, Rosenbæk F, Pedersen LB, et al. Physicians' experiences, attitudes,
58 and beliefs towards medical cannabis: a systematic literature review. *BMC Family*
59 *Practice*. 2021;22(1). doi:https://doi.org/10.1186/s12875-021-01559-w
60 [4]Azcarate PM, Zhang AJ, Keyhani S, Steigerwald S, Ishida JH, Cohen BE. Medical
61 Reasons for Marijuana Use, Forms of Use, and Patient Perception of Physician
62 Attitudes Among the US Population. *Journal of General Internal Medicine*.
63 2020;35(7):1979-1986.
64 doi:https://doi.org/10.1007/s11606-020-05800-7
65 [5] Ibid.
66 [6]Frost M. Weighing benefits, harms of cannabis. immattersacp.org. Published April
67 2019. Accessed February 21, 2024.
68 https://immattersacp.org/archives/2019/04/weighing-benefits-harms-of-
69 cannabis.htm?_gl=1
70 [7] Fischer B, Russell C, Sabioni P, et al. Lower-risk cannabis use guidelines: a
71 comprehensive update of evidence and recommendations. *Am J Public Health*.
72 2017;107(8):1277, e1–e12. doi:10.2105/AJPH.2017.303818
73 [8] Meffert BN, Morabito DM, Mosich MK, Loflin MJ, Sottile J, Heinz AJ. Navigating
74 Blind in the Green Rush: Clinical Considerations and Harm Reduction Practices
75 for Cannabis. *Current Drug Research Reviews Formerly: Current Drug Abuse*
76 *Reviews*. 2019;11(1):3-11.
77 doi:https://doi.org/10.2174/2589977511666181109153958
78

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 35 – 2024

Introduced by: Medical Student Section

Subject: Increasing Awareness of Harmful Algal Bloom Toxicity

Referred to: Resolutions Committee No. 2

- -

WHEREAS, harmful algal blooms (HABs) have been plaguing both marine and freshwaters globally, and are especially concentrated in Lake Erie[1]; and

WHEREAS, the alarming emergence of HABs have thus far harmed humans, animals, and environments through the release and accumulation of toxins in water[1]; and

WHEREAS, toxins produced by cyanobacterial HABs can enter the human body through ingestion of contaminated water, direct skin contact during swimming, and aerosol inhalation[2]; and

WHEREAS, exposure to cyanotoxins can cause acute health effects, such as nausea, vomiting, headache, fever, and rashes, which may be exacerbated in patients with pre-existing or chronically diseased states[3]; and

WHEREAS, microcystin and cylindrospermopsin are primary cyanotoxins responsible for gastrointestinal illness and severe liver and kidney damage[4]; and

WHEREAS, the Ohio Environmental Protection Agency (EPA) issues frequent public drinking water advisories to alert individuals when the consumption of tap water may pose health risks from elevated levels of microcystin, cylindrospermopsin, anatoxin-a, or saxitoxin[5]; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) initiated the One Health Harmful Algal Bloom System (OHHABS), which found that 18 states, including Ohio, reported a total of 421 HAB events, 389 instances of human illness, and 413 cases of animal illness; between 2016 and 2018[6]; and

WHEREAS, according to a 2020 report from the CDC, 13 states, including Ohio, reported 227 HABs that resulted in 95 human illnesses, including gastrointestinal, respiratory, and dermal, and 1,170 animal illnesses[7]; and

WHEREAS, three pediatric patient cases of HAB poisoning were identified in the Western Lake Erie Basin between 2014-2016[8]; and

47
48 **WHEREAS,** HAB has its own International Classification of Diseases (ICD)
49 Code, “ICD-10-CM Code for Contact with and (suspected) exposure to harmful algae
50 and algae toxins Z77.121”[9]; and
51
52 **WHEREAS,** the Ohio Department of Health “Screen for Green” program supplies
53 providers with an algorithm and factsheet on how to recognize HAB exposure in
54 potential patients[10]; and
55
56 **WHEREAS,** the anticipated costs of digestive and respiratory illnesses
57 attributable to HABs are estimated to range from $86 to $14,600 per illness, which
58 includes treatment expenses, income reduction, loss of productivity, and the costs
59 associated with quality of life[11]; and
60
61 **WHEREAS,** cyanobacteria have also been found to disrupt ecosystems by
62 polluting drinking water sources, depleting oxygen for aquatic organisms, and
63 contaminating seafood with algal toxins[11]; and
64
65 **WHEREAS,** in August 2014, Ohio declared a state of emergency in response to
66 algal toxin contamination affecting the City of Toledo's water supply[12]; and
67
68 **WHEREAS,** during the emergency state, a “do not drink” advisory was issued in
69 Toledo, Ohio, due to elevated levels of cyanobacteria in treated drinking water
70 sources[13]; and
71
72 **WHEREAS,** HAB events in Lake Erie can pose serious economic ramifications,
73 such as in August 2014, where a single bloom led to a $65 million loss in the United
74 States[13]; and
75
76 **WHEREAS,** over the course of September, 2015, one HAB outbreak spanning
77 600 miles along the Ohio River incurred a daily cost of $7,700 for water treatment
78 plants in Cincinnati to ensure the safety of drinking water[14]; and
79
80 **WHEREAS,** Lake Erie HAB breakouts are becoming more frequent and potent,
81 as evidenced by the severity index, which measures the biomass of a bloom over its
82 spatial extent and assesses values above 7 as “particularly severe”[15,16]; and
83
84 **WHEREAS,** the severity index values recorded for the cyanobacterial blooms in
85 Western Lake Erie suggest relatively severe figures, registering at 8 in 2017, 7.3 in
86 2019, and 6.8 in 2022[15,16]; and
87
88 **WHEREAS,** HAB events continue to pose threats to Ohio’s water supply, as
89 seen in recent breakouts, which polluted water sources, gave rise to extensive dead
90 zones, adversely affected fish, deterred swimmers and boaters, and led to a decline in
91 the values of lakefront properties[17]; and
92

WHEREAS, for each incremental rise of 1 μg/L in Lake Erie HAB levels, lakeside property values are found to drop by 1.7%, which is equivalent to a reduction of $2,205[18]; and

WHEREAS, changes in the climate may lead to more optimal conditions for HAB events due to higher water temperatures and increased stormwater runoff of nutrients[19]; and

WHEREAS, nutrients such as phosphorus and nitrogen, sourced from agricultural fertilizers, sewage, and runoff from industrial facilities, contribute to the rapid growth of HABs[20]; and

WHEREAS, the 2023 Western Lake Erie HAB Seasonal Assessment reports that the total bioavailable phosphorus load accumulated in the Maumee River was 230 metric tons as of July 31st[21]; and

WHEREAS, in 2015, Ohio, Michigan, and the Canadian province of Ontario entered into the Western Basin of Lake Erie Collaborative Agreement, pledging to decrease nutrient levels entering the lake by 40% by 2025[22]; and

WHEREAS, according to the Ohio State Medical Association, in 2021, Governor DeWine enacted a two-year budget bill, which directed $170 million for the H2Ohio initiative, a water quality plan aimed at addressing water contaminants, mitigating algal blooms, and enhancing Ohio's wastewater infrastructure[23]; and

WHEREAS, the United States EPA approved a plan in September 2023 to limit phosphorus runoff into the Maumee River, which drains into the Western Basin of Lake Erie, in order to reduce harmful algal blooms[24]; and

WHEREAS, the National Integrated Drought Information System Reauthorization Act of 2018 authorizes the renewal of the Harmful Algal Bloom and Hypoxia Research and Control Act (HABHRCA) to further understand, predict, and analyze HABs[25,26]; and

WHEREAS, the 2022 Report to Congress from the National Oceanic and Atmospheric Administration mandates biennial updates on HABHRCA progress in the Great Lakes region[27]; and

WHEREAS, HAB breakouts result in an estimated annual economic loss of approximately $82 million due to declines in fishing and tourism activities in the affected region[28]; and

WHEREAS, the estimated average yearly economic repercussions of HABs in the United States ranges between $10-100 million and costs from a single significant HAB event can incur costs amounting tens of millions of dollars[29]; and therefore

BE IT RESOLVED, that our OSMA supports ongoing research into the human health effects of harmful algal contaminated water; and be it further

RESOLVED, that our OSMA supports initiatives to promote awareness of the harmful effects of algal blooms and be it further

RESOLVED, that our OSMA supports legislation to reduce nutrient runoff from factory farms and other commercial practices negatively impacting Lake Erie and other waterways.

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

References:

1. Howard MDA, Kudela RM, Hayashi K, et al. Multiple co-occurring and persistently detected cyanotoxins and associated cyanobacteria in adjacent California lakes. *Toxicon*. 2021;192:1-14. doi:10.1016/j.toxicon.2020.12.019
2. Wu J, Hilborn ED, Schaeffer BA, et al. Acute health effects associated with satellite-determined cyanobacterial blooms in a drinking water source in Massachusetts. *Environ Health*. 2021;20(1):83. Published 2021 Jul 16. doi:10.1186/s12940-021-00755-6
3. Lad A, Breidenbach JD, Su RC, et al. As we drink and breathe: adverse health effects of microcystins and other harmful algal bloom toxins in the liver, gut, lungs and beyond. *Life (Basel)*. 2022;12(3):418. Published 2022 Mar 14. doi:10.3390/life12030418
4. Algal blooms. *National Institute of Environmental Health Sciences.* 2023. https://www.niehs.nih.gov/health/topics/agents/algal-blooms/index.cfm#:~:text=HABs%2 0that%20occur%20in%20freshwater,as%20well%20as%20liver%20damage. 5. Harmful algal blooms. *Ohio Environmental Protection Agency.* https://epa.ohio.gov/monitor-pollution/pollution-issues/harmful-algae-blooms 6. Roberts, VA, Vigar, M, Backer, L, et al. Surveillance for harmful algal bloom events and associated human and animal illnesses - One Health Harmful Algal Bloom System,
United States, 2016-2018. *MMWR. Morbidity and mortality weekly report*, *69*(50), 1889–1894. 2020. https://doi.org/10.15585/mmwr.mm6950a2
7. Centers for Disease Control and Prevention (CDC). Summary Report – One Health Harmful Algal Bloom System (OHHABS), United States, 2020. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2022. https://www.cdc.gov/habs/data/2020-ohhabs-data-summary.html
8. French BW, Kaul R, George J, et al. A case series of potential pediatric cyanotoxin exposures associated with harmful algal blooms in Northwest

185 Ohio. *Infect Dis Rep*. 2023;15(6):726-734. Published 2023 Nov 20.
186 doi:10.3390/idr15060065
187 9. ICD-10-CM code for contact with and (suspected) exposure to harmful algae
188 and algae toxins Z77.121. *Codify by AAPC*.
189 https://www.aapc.com/codes/icd-10-
190 codes/Z77.121#:~:text=ICD%2D10%20code%20Z7
191 7.,and%20contact%20with%20health%20services%20
192 10. Screen for green. *Information for Healthcare Providers.* Ohio Department of
193 Health. https://odh.ohio.gov/know-our-programs/harmful-algal-
194 blooms/Information-for-Physicians /
195 11. Centers for Disease Control and Prevention.
196 https://www.cdc.gov/habs/pdf/Algal-Bloom-Brief-508.pdf
197 12. Jochem, G. Algae toxins in drinking water sickened people in 2 outbreaks.
198 *NPR*. 2017 Nov 9.
199 https://www.npr.org/sections/health-shots/2017/11/09/563073022/algae-
200 contaminates-dri nking-water
201 13. Colleen YE, Anders KE, Chaganti RS, et al. The Western Lake Erie culture
202 collection: A promising resource for evaluating the physiological and genetic
203 diversity of Microcystis and its associated microbiome. *Harmful Algae*.
204 2023;126(102440):1568-9883. https://doi.org/10.1016/j.hal.2023.102440
205 14. Seewer, John. Ohio River's huge algae bloom a warning for water suppliers.
206 *Phys.org*. 2015. https://phys.org/news/2015-10-ohio-river-huge-algae-
207 bloom.html
208 15. Algal blooms. *GLISA*.
209 https://glisa.umich.edu/resources-tools/climate-impacts/algal-
210 blooms/#:~:text=The%2020
211 11%20bloom%20was%20the,also%20rated%20as%20 relatively%20 severe.
212 16. Smaller-than-average harmful algal bloom predicted for Western Lake erie.
213 *National Oceanic and Atmospheric Administration.* 2023.
214 https://www.noaa.gov/news-release/smaller-than-average-harmful-algal-bloom-
215 predicted -for-western-lake-erie
216 17. The impacts of Lake Erie's harmful algal blooms on Great Lakes
217 businesses. *Great Lakes Business Network.*
218 https://www.nwf.org/-/media/PDFs/Regional/Great-Lakes/The-Impacts-of-Lake-
219 Eries-Har mful-Algal-Blooms-on-Great-Lakes-Businesses-v3-
220 062821.ashx?la=en&hash=FC1D272
221 634990F464429B7841E6FE5E6EDDF7B5B&hash=FC1D272634990F464429B
222 7841E6 FE5E6EDDF7B5B
223 18. Harmful algal blooms in Lake Erie affect property values. *wtol.com.* 2022.
224 https://www.wtol.com/article/tech/science/environment/lake-erie-algal-blooms-
225 reduce-pro perty-values/512-fd15f6c1-7414-4171-9cd8-3ac82cb9d7d4
226 19. Climate adaptation and harmful algal blooms. *United States Environmental*
227 *Protection Agency.* 2023 June 21.
228 https://www.epa.gov/arc-x/climate-adaptation-and-harmful-algal-blooms
229 20. Causes and ecosystem impacts. *Centers for Disease Control and*
230 *Prevention.* 2022. https://www.cdc.gov/habs/environment.html

231 21. Western Lake Erie HAB seasonal assessment. *National Centers for Coastal Ocean Science.* 2023.
233 https://nccospublicstor.blob.core.windows.net/hab-data/bulletins/lake-erie/2023/FinalAss essment_2023_10.pdf
235 22. Bunch, K. *What have Michigan, Ohio and Ontario undertaken so far on nutrients in Lake Erie?*. International Joint Commission. 2019.
237 https://www.ijc.org/en/what-have-michigan-ohio-and-ontario-undertaken-so-far-nutrients-lake-erie#:~:text=In%202015%2C%20the%20Canadian%20province,2025%2C%20c om pared%20to%202008%20levels.
241 23. State budget update: Governor Dewine Signs 2-year budget bill into law, issues line-item vetoes. *Ohio State Medical Association.* 2021.
243 https://www.osma.org/aws/OSMA/pt/sd/news_article/379450/_self/layout_details/false
245 24. *EPA approves Ohio's plan to reduce phosphorus pollution in western Basin of Lake Erie.* United States Environmental Protection Agency. 2023.
247 https://www.epa.gov/newsreleases/epa-approves-ohios-plan-reduce-phosphorus-pollutio n-western-basin-lake-erie
249 25. National Integrated Drought Information System Reauthorization Act of 2018, Pub. L. No. 115-423 (2019).
251 https://www.congress.gov/bill/115th-congress/senate-bill/2200#:~:text=The%20bill%20re authorizes%20through%20FY2023,%2C%20Data%2C%20and%20Information%20Servi ce.&text=ensuring%20that%20program%20volunteers%20may,observations%2C%20an d%20hazardous%20weather%20events.
257 26. 33 USC Ch. 53: Harmful Algal Bloom and Hypoxia Research and Control. Office of the Law Revision Counsel of the United States Code.
259 https://uscode.house.gov/view.xhtml?path=%2Fprelim%40title33%2Fchapter53&edition= prelim
261 27. LeBoeuf, N. R., & Spinrad, R. W. Harmful Algal Blooms and hypoxia in the Great Lakes: An interagency progress and implementation report. *National Oceanic and Atmospheric Administration*. 2022.
264 https://cdn.coastalscience.noaa.gov/page-attachments/research/FINAL_HABHRCA_Gre atLakes_ProgressReport_November_2020.pdf
267 28. Why do harmful algal blooms occur? *National Oceanic and Atmospheric Administration.* National Ocean Service. US Department of Commerce. 2015.
269 https://oceanservice.noaa.gov/facts/why_habs.html
270 29. Assessing environmental and economic impacts. *National Centers for Coastal Ocean Science.* 2023.
272 https://coastalscience.noaa.gov/science-areas/habs/assessing-environmental-and-econo mic-impacts/
274 30. AMA Policy: H-135.939 – Green Initiatives and the Health Care Community
275 31. AMA Policy: H-135.928 – Safe Drinking Water
276 32. AMA Policy: H-135.934 – EPA and Green House Gas Regulation

277 33. H-135.943 – Expansion of Hazardous Waste Landfills Over Aquifers
278
279
280 OSMA Policy:
281
282 **Policy 12 – 2023 – Supporting Environmental Sustainability in Hospitals and**
283 **Physician Offices**
284 The OSMA (1) supports initiatives to promote environmental sustainability by
285 healthcare facilities and entities across Ohio, and (2) supports physicians seeking to
286 adopt programs for environmental sustainability in their practices.
287
288 **Policy 7 – 2023 – Establishing Support for the Regulation of Endocrine**
289 **Disrupting Chemicals in Food, Agricultural, and Household Products**
290 OSMA supports the investigation and regulation of the use of endocrine-disrupting
291 chemicals in food, agricultural, and household products.
292
293 **Policy 24 – 2010 – Updating of the Safe Drinking Water Act**
294 (reaffirmed at the 2019 OSMA House of Delegates)
295 The OSMA shall petition the appropriate state agencies to identify those local water
296 utilities at risk and to take appropriate steps to assure safe drinking water.
297
298 **Policy 03 – 2018 – Pursuit of a Strategic Partnership with the Ohio Public**
299 **Health Association**
300 1. The OSMA create a formal partnership, establishing an open line of communication,
301 with the Ohio Public Health Association for medical students and physicians. 2. The
302 OSMA support policies and initiatives that may, based on reasonable evidence,
303 produce population health improvements, as well as incentivize healthcare providers,
304 hospitals, clinics, and other healthcare facilities to engage in health promotion
305
306 **Policy 27 – 2022 – Recognition of Climate Change as a Threat to Ohio's Health**
307 1. The OSMA encourages the development of policy to combat climate change and its
308 health effects in Ohio and to mitigate the undesirable environmental conditions that
309 damage Ohioans' health. 2. The OSMA encourages education of the broader Ohio
310 medical community to the serious adverse health effects of climate change and local
311 conditions of climate variation.
312

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 36 – 2024

Introduced by: Medical Student Section

Subject: Support for Environmental Justice Initiatives

Referred to: Resolutions Committee No. 2

- -

WHEREAS, environmental justice is defined by the Environmental Protection Agency (EPA) as the equal treatment and involvement of all people in decision-making about the development, implementation, and enforcement of environmental law and policy, regardless of race, color, national origin, or income[1]; and

WHEREAS, environmental injustice is the increased exposure to pollution and other environmental health risks, limited access to environmental services, and loss of land and resource rights that are disproportionately experienced by low-income communities and communities of color[2]; and

WHEREAS, due to historic redlining and other racist housing policies, communities of color are often located near heavily polluted areas, with Black people 75 percent more likely to live near facilities that produce hazardous waste[5]; and

WHEREAS, concentrations of known toxic and carcinogenic metals are nearly 10 times higher in racially segregated communities[6]; and

WHEREAS, Black, Hispanic, and Native American people experience higher rates of negative health impacts with extreme heat events and temperature fluctuations than their White counterparts[7]; and

WHEREAS, according to the 2021 Health Value Dashboard, Ohio is ranked 43rd out of 50 states and D.C. on environmental metrics related to air quality, water quality, and toxic substance exposure[3]; and

WHEREAS, in an environmental justice policy scorecard, the Northeast-Midwest Institute ranked Ohio as one of the lowest states in the Midwest due to its lack of legislation on environmental justice[4]; and

WHEREAS, Michigan's Department of Environment, Great Lakes, and Energy has an Office of the Environmental Justice Public Advocate with its own funding and staff that is dedicated to advancing environmental justice in the state[8]; and

WHEREAS, the Biden-Harris Administration granted $2 million in funding for environmental justice projects in Ohio through the U.S. EPA's Environmental Justice Collaborative Problem Solving Cooperative Agreement[9]; and

WHEREAS, Ohio House Bill 429, a bill introduced in the 2022 legislative session by Representatives Casey Weinstein and Stephanie Howse, sought to launch environmental justice programs and build clean energy policy that recognizes equity for historically marginalized communities, but it failed in committee[10]; and

WHEREAS, the U.S. Attorney for the Southern District of Ohio, Kenneth L. Parker, established a new environmental justice initiative for the district in October 2022 to enforce environmental laws and prosecute violations leading to discriminatory environmental and health impacts[11]; and

WHEREAS, the AMA has policies recognizing the harmful impacts to health that environmental pollution and destruction may have and supports the development of environmental committees as well as programs to combat racism (H-65.952; H-135. 931; H-135.932; H 135.973; H-135.969; 135-997); and

WHEREAS, the OSMA "encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health" (Policy 27 – 2022); and therefore

BE IT RESOLVED, that the OSMA encourages state action to address and remediate environmental injustice and other environmental conditions adversely impacting health in marginalized communities.

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

References:

1. United States Environmental Protection Agency. "Learn about Environmental Justice." *US EPA*, 7 Nov. 2018, www.epa.gov/environmentaljustice/learn-about-environmental-justice. Accessed 30 Nov. 2023.
2. "Environmental Justice Factsheet." *Center for Sustainable Systems*, University of Michigan, 2023, css.umich.edu/publications/factsheets/sustainability-indicators/environmental-justice-factsheet. Accessed 30 Nov. 2023.
3. Health Policy Institute of Ohio. "2021 HEALTH VALUE DASHBOARD." *Health Policy Institute of Ohio*, Apr. 2021.
4. Griffin, Nicholas. Scorecard of Environmental Justice Policies in Northeast-Midwest States. *Northeast-Midwest Institute*, July 2022.
5. Lazaroff, Marissa. *The Crossroads of Environmental Racism and Public Housing*. The Ohio Environmental Council, 2020.

6. Kodros, John K., et al. “Unequal Airborne Exposure to Toxic Metals Associated with Race, Ethnicity, and Segregation in the USA.” Nature Communications, vol. 13, no. 1, 1 Nov. 2022, https://doi.org/10.1038/s41467-022-33372-z.
7. Berberian, Alique G., et al. “Racial Disparities in Climate Change-Related Health Effects in the United States.” *Current Environmental Health Reports*, vol. 9, no. 3, 28 May 2022, pp. 451–464, https://doi.org/10.1007/s40572-022-00360-w. Accessed 30 Nov. 2023.
8. A “Office of the Environmental Justice Public Advocate.” *Department of Environment, Great Lakes, and Energy*, State of Michigan, www.michigan.gov/egle/about/organization/environmental-justice. Accessed 1 Dec. 2023.
9. EPA Press Office. “Biden-Harris Administration Announces $2 Million for Environmental Justice Projects in Communities across Ohio as Part of Investing in America Agenda.” *US EPA*, 24 Oct. 2023, www.epa.gov/newsreleases/biden-harris-administration-announces-2-million-environmental-justice-projects-0. Accessed 1 Dec. 2023.
10. Weinstein, Casey, and Stephanie Howse. Regards Clean Energy and Energy Justice. 21 Sept. 2021, www.legislature.ohio.gov/legislation/134/hb429. Accessed 1 Dec. 2023.
11. U.S. Attorney's Office, Southern District of Ohio. “Southern District of Ohio | U.S. Attorney Parker Launches Environmental Justice Initiative.” *United States Attorney's Office Southern District of Ohio*, US Department of Justice, 4 Oct. 2022, www.justice.gov/usao-sdoh/pr/us-attorney-parker-launches-environmental-justice-initiative. Accessed 1 Dec. 2023.
12. AMA Policy: Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
13. AMA Policy: Racism as a Public Health Threat H-65.952
14. AMA Policy: 135.024MSS Environmental Health Equity in Federally Subsidized Housing
15. AMA Policy: Stewardship of the Environment H-135.973
16. AMA Policy: Environmental Health Programs H-135.969

OSMA Policy:

Policy 27 – 2022 – Recognition of Climate Change as a Threat to Ohio's Health
1. The OSMA encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health.
2. The OSMA encourages education of the broader Ohio medical community to the serious adverse health effects of climate change and local conditions of climate variation.

132 **Policy 09 – 2019 – Impact of Climate Change on Human Health**
133 1. That the Ohio State Medical Association supports efforts at the state level for expansion of
134 renewable sources of energy.
135