The Indiana State Medical Association

Policy Manual

2024-2025

(Includes updates from the 2024 House of Delegates)

ACCESS TO MEDICAL CARE

(RESOLUTION 24-40) RESOLVED, that the ISMA recognize inclusive excellence in health as a top priority and commit to supporting initiatives aimed at reducing disparities in health care access and outcomes in Indiana; and be it further
RESOLVED, that the ISMA support legislation for policies and funding mechanisms that support the expansion of primary care and preventive services in underserved communities, including the use of community health workers and patient navigators to facilitate access to care and resources.

(RESOLUTION 23-06) RESOLVED, that the ISMA opposes legislation that would prosecute or otherwise penalize physicians and other clinicians, patients, and those who aid patients in seeking or receiving health care across state lines.

ADVERTISING

(RESOLUTION 22-69) RESOLVED, that ISMA seek legislation in the Indiana General Assembly for the requirement of photo identification name tags to be worn by all health care workers during direct patient care hours, including limited specified exceptions to this requirement; and be it further
RESOLVED, that ISMA seek legislation in the Indiana General Assembly to require clear and conspicuous public posting of the full name, licensure type, primary board certification type if any, specialty if any, and primary practice address of the collaborating physicians of nonphysician practitioners at all practice sites. This information must be publicly posted in the physical practice locations of nonphysician practitioners and on all practice websites.

(RESOLUTION 22-56) RESOLVED that ISMA support legislation adding physician titles to the list in Senate Enrolled Act 239 from 2022: including but not limited to allergist, electrophysiologist, geriatrician, immunologist, medical geneticist, neonatologist, and pulmonologist.

(RESOLUTION 22-42) RESOLVED, that ISMA adopt as policy and seek legislation that any nonphysician practitioner in an office-based setting clearly display their supervising physician's name and credentials in common areas and on websites that advertise services, as well as provide their supervising physician's name and appropriate professional contact information when establishing care.

(RESOLUTION 21-32) RESOLVED, that the ISMA seek legislation to require that all health care practitioners and physicians identify themselves with name tags that display first and last name, license type, and, if applicable, status as a trainee, resident, or fellow, in a way that is readily and easily identifiable to the general public, and that written or electronic advertising must include the name of the practitioner and type of license in a way that is readily apparent to the general public; and be it further
RESOLVED, that ISMA establish policy and support legislation that prohibits physician assistants and advanced practice registered nurses from being referred to as "doctor" in clinical settings and in advertisements; and be it further
RESOLVED, that ISMA seek legislation that would add terms used by physician specialists to the statutory definition of the "practice of medicine" (e.g., dermatologist, anesthesiologist, cardiologist); and be it further
RESOLVED, that ISMA seek legislation that a health care practitioner who disseminates or communicates false or misleading information about their training, education or license type be subject to disciplinary sanctions by the appropriate Indiana Licensing Board and the state attorney general.

(RESOLUTION 19-07) RESOLVED, that ISMA support initiatives to provide clear, defined guidelines for truth and transparency in advertising and identification of health care practitioners and their roles; and be it further
RESOLVED, that ISMA commend the work of those who have worked so diligently this past year with leaders of medical specialty organizations to develop model legislation and policies that support truth in advertising and identification for health care practitioners.

(RESOLUTION 18-40) RESOLVED, that ISMA work with leaders of other specialty medicine organizations and certifying bodies in Indiana to develop model bill language regarding truth in advertising as it pertains to identification badges and to advertising and marketing of licensure, qualifications, specialty and board certification (if applicable) by physicians and other health care professionals; then seek a member of the Indiana General Assembly to introduce such legislation.

(READOPTED AND AMENDED 17-12, HOD; RESOLUTION 07-26A) RESOLVED, that the ISMA adopt AMA Policy H-360.986 Professional Nurse Staffing in Hospitals (3) encouraging medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials and/or title of the physicians, nurses, allied health personnel and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care.

(RESOLUTION 15-44) RESOLVED, that the ISMA seek to encourage all physicians practicing medicine in Indiana to wear an identification badge that is clearly visible and reads "physician"; and be it further RESOLVED, that the ISMA provide education to its members, patients and other appropriate stakeholders regarding the importance of clearly identifying physicians in various practice settings; and be it further RESOLVED, that the ISMA provide marketing support to inform the public of the importance of and identification of physicians who care for them; and be it further
RESOLVED, that the ISMA provide physician identification badges free of charge to current members and make the badges available for purchase to nonmember physicians.

(6/10/84, BOT) Reaffirmed its position that the ISMA continue to use the American Medical Association's guidelines pertaining to advertising as contained in its "Reference Guide to Policy & Official Statements" and its "Current Opinions of the Council on Ethical and Judicial Affairs."

AFFORDABLE CARE ACT (ACA)/HEALTH CARE REFORM

(RESOLUTION 16-33) RESOLVED, that the ISMA ask the AMA House of Delegates to no longer support the ACA in its current form and to work for replacement or substantial revision of the act to include these changes:

- Allowing health insurance to be sold across state lines
- Allowing all businesses to self-insure and to purchase insurance through business health plans or association health plans
- Improving the individual mandate with a refundable tax credit that would be used to purchase health insurance
- Improving health-related savings accounts so as to help ACA insureds afford their higher deductibles and co-pays
- Reversing cuts to traditional Medicare and Medicare Advantage programs
- Encouraging states to develop alternatives to Medicaid by using federal funds granted under provisions of the ACA
- Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to those who cannot access such breaks in their insurance costs; and be it further

RESOLVED, that the ISMA encourage the AMA to maintain the following provisions to the ACA if it is replaced:

- Full coverage of preventive services
- Family insurance coverage of children living in a household until age 26
- Elimination of lifetime benefit caps
- Guaranteed insurability

ALCOHOL

(READOPTED 21-20, HOD; RESOLUTION 10-48; RESOLUTION 00-27) RESOLVED, that blood alcohol and chemical testing be mandated for all drivers and vehicular occupants involved in all motor vehicle accidents with fatalities or serious bodily injury.

(RESOLUTION 21-17) RESOLVED, that the ISMA continue to support efforts to reduce underage drinking by increasing the minimum age of sellers of alcoholic beverages to 21 and requiring responsible beverage service training for all servers of alcoholic beverages.

(READOPTED 18-07, RESOLUTION 08-24) RESOLVED, that the ISMA support legislation that would provide education for prevention of underage drinking, and treatment of alcohol-related problems.

(READOPTED 17-19, RESOLUTION 07-19) RESOLVED, that the ISMA support increasing the tax on alcohol with revenue from the tax allocated to improving the health of Hoosiers.

ALLIANCE, ISMA

(RESOLUTION 16-30) RESOLVED, that the ISMA continue to financially support the Alliance at $4 per member.

ALTERNATIVE MEDICINE

(1/20/99, BOT) Accepted the ISMA Alternative Medicine Task Force's recommendations for non-licensure of the following activities. Specific recommendations for these activities are noted below.

- Therapeutic Touch - The use of hands to restore areas of blockage in a patient's energy field.
    - *Recommendation*: Specific guidelines for therapeutic touch are neither recommended nor necessary.
- Body-Mind Intervention - The practice of influencing the body's own healing response through psychological interventions.
    - *Recommendation*: Body-mind intervention is broad in spectrum and used in everyday practices of many traditional practitioners and therapists. Appropriate training and certification in the underlying disciplines are recommended. Mind-body interventions are, in general, supported by the scientific literature. However, some mind-body interventions are less studied and not as well documented.
- Chelation - Incorporation of a metal ion into a heterocyclic ring structure -- In alternative medicine practices, chelation refers to the use of chelating agents to reverse atherosclerotic vascular disease and thus decrease angina pectoris and claudication.
    - *Recommendation*: The use of chelation solution for the treatment of atherosclerosis is an off-label use and not approved by the U.S. Food and Drug Administration (FDA). There are no valid scientific studies showing beneficial effects using chelating agents to reverse atherosclerosis. The Task Force recommends chelating agents only be used for FDA approved conditions (e.g. heavy metal poisoning).
- Reflexology – The physical act of applying pressure to the feet and hands with techniques that do not utilize oil, cream or lotion. It is based on the principle that there are no more than seven thousand nerve endings in the feet relative to every organ, gland, tissue or muscle in the body.
    - *Recommendation*: Reflexology seems to be considered most often by people seeking pain relief, but there is no hard data substantiating the claims of the practitioners of reflexology. However, there does not appear to be any substantial harm that could result from treatment.
- Homeopathy – A natural pharmaceutical science utilizing plants, minerals or animals in very small doses to stimulate the sick person's natural defenses. The fundamental belief is that by giving a small amount of the offending substance, the patient's body seeks to reestablish balance. Thus, the homeopathic substances are felt to work with the patient's natural defense mechanisms.
    - *Recommendation*: Homeopathy has limited data supporting its efficacy and safety, though little risk has been identified. Homeopathic principles and treatments may complement allopathic treatment in certain conditions.
- Massage Therapy – The act of treating the body by rubbing the body to stimulate the circulation, to induce suppleness or to release endorphins. Massage therapy is currently a recognized alternative

therapy by the Office of Alternative Therapies under the National Institutes of Health. Practitioners are eligible for certification through the American Massage Therapy Association.

- *Recommendation*: Consumers should verify certification when using this alternative therapy.

(8/25/85, BOT) Support the position of the AMA that there is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, arteriosclerosis, rheumatoid arthritis or cancer; and further, if chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hyper-calcemia, or digitalis toxicity, it is the responsibility of its proponents to: (1) conduct properly controlled scientific studies; (2) adhere to U.S. Food and Drug Administration (FDA) guidelines for the investigation of drugs; and (3) disseminate results of scientific studies in the usual, accepted channels.

BLOOD DONATIONS

(RESOLUTION 22-11) RESOLVED, that ISMA join the AMA in supporting future evidence-based changes to the FDA blood donation time-based deferral policy for men who have sex with men.

(4/10/88, BOT) Approved the following Blood Bank Task Force recommendations:

- Since directed donors are no safer than volunteer donors, directed donor units should not be expected to be processed for emergency situations. Emergency care should not be delayed because of lack of directed donor units.
- Under usual circumstances, three days should be expected from the time the donor unit is drawn until the time that the donor unit arrives at the hospital.
- In order to maintain the integrity of the centralized blood system, the primary responsibility for autologous and directed donations should remain with the blood centers and not with individual hospitals. The blood centers in cooperation with the hospitals should continue to provide ready access and donor convenience for these services.

BREASTFEEDING

(RESOLUTION 18-59) RESOLVED, that ISMA encourage legislation in Indiana to implement a breastfeeding awareness education program (e.g., via Indiana State Board of Health, Family and Social Services Administration); and be it further
RESOLVED, that ISMA encourage legislation in Indiana that would remove sales tax from all items related to breastfeeding; and be it further
RESOLVED, that the ISMA delegation promote resolutions at the AMA for the encouragement of the federal government to legislate appropriate disclosures of the health benefits or limitations of synthetic infant formulas, develop a breastfeeding awareness education program, ensure that our representatives to global meetings comport themselves in an unbiased manner that better represents a compromise of all views of this particular issue, and promote development of an affordable and more equivalent substitute for breast milk for women who absolutely are unable to nurse; and be it further
RESOLVED, that the ISMA delegation to the AMA encourage that organization and all state medical associations to support legislation for workplace accommodation for nursing mothers in those states that do not already have such laws.

CANCER PREVENTION

(RESOLUTION 24-42) RESOLVED, that the ISMA support, in partnership with relevant stakeholders, legislation that expands access to current guideline-directed lung cancer screening.

(READOPTED 22-93, HOD; RESOLUTION 12-44) RESOLVED, that the ISMA adopt policy supporting access to prostate cancer screening in adequately healthy and appropriately counseled men, and reject the United States Preventative Services Task Force recommendations against PSA screening.

(RESOLUTION 17-15) RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring, possess and be given adequate time to apply and to self-apply non-aerosol sunscreen when exposed to UV light without requiring physician authorization and without requiring storage and application in the nurse's office; and be it further
RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring and wear sun-protective clothing when exposed to UV light, including hats and sunglasses that are not otherwise banned from school policy; and be it further
RESOLVED, that ISMA support legislative efforts that incorporate age-appropriate instruction on UV-protective behavior and skin cancer prevention in schools.

(6/7/87, BOT) Approved the ISMA's participation in the Indiana State Board of Health's Breast Screening Awareness Project.

(READOPTED 17-14, HOD; RESOLUTION 07-37) RESOLVED, that the ISMA adopt policy and seek legislation including, but not limited to:

- Prohibiting minors from using tanning devices;
- Posting the surgeon general's warning on all tanning devices;
- Prohibiting a person or facility from advertising the use of any ultraviolet A or ultraviolet B tanning device using such words as "safe", "safe tanning", "no harmful rays", "no adverse effect", or similar wording or concepts.

CERTIFICATE OF NEED

(READOPTED 15-13, HOD; RESOLUTION 05-49) RESOLVED, that the ISMA reaffirm its policy opposing state and local Certificate of Need programs and moratoria.

(1/13/80, BOT) Supported the ISMA continuing to vigorously oppose any certificate of need legislation and seeking the exclusion of physician offices should certificate of need legislation become inevitable.

CHARITY CARE, GUIDELINES FOR DETERMINATION OF

(RESOLUTION 23-55) RESOLVED, that the ISMA recommend to the Indiana General Assembly for the Healthcare Cost Oversight Task Force to:

1. Require nonprofit hospitals to notify and screen uninsured patients, in a format reasonably appropriate to the abilities and understanding of the patient, for financial assistance according to their own eligibility criteria prior to billing; and
2. Establish standards for nonprofit hospital financial assistance eligibility taking family size, ability to pay, insurance status, and current federal poverty guidelines into consideration.

(9/25/09, BOT) Approved the following guidelines for Determination of Charity Care:

- Practices must determine the level of charity care provided to a patient by using consistently applied written guidelines. The physician practice is responsible for tailoring the guidelines based on location, specialty, or patient demographics that are most appropriate for the practice.
- The guidelines should consist of a charity care application, criteria for determining the level of charity care based on family size, ability to pay and insurance coverage. Practices should base charity care on the current year Federal Poverty Guidelines as determined by U.S. Department of Health and Human Services (http://aspe.hhs.gov/poverty/) (HHS). Lastly, charity care guidelines should only extend to those families with income less than four times the Federal Poverty Guidelines or to uninsured patients. In the case of an uninsured patient, practices may determine a fixed write-off percentage that is separate from the normal charity care policy. Only medically necessary services, as determined by the physician, are eligible for charity care.

CLINICS

(7/7/87, BOT) Endorsed opposition to school-based health clinics.

(3/5/78, BOT; 3/28/79, EC) Agreed with the Indiana Medical Licensing Board's interpretation of the Medical Practice Act which opposes independent practice of medicine by non-physicians, including the use of protocols for nurse practitioners and physicians' assistants as a substitute for close physician supervision. Additionally, ISMA opposes the concept of peripheral clinics, which utilize minimal supervision.

COLLECTIVE BARGAINING

(READOPTED ERC 2024; RESOLUTION 14-27) RESOLVED, that the ISMA support the principles of collective bargaining rights and employee associations for physicians in Indiana.

COMMUNICABLE AND SEXUALLY TRANSMITTED DISEASES

(RESOLUTION 22-54) RESOLVED, that ISMA support efforts to reform Indiana law to reflect the contemporary scientific understanding of viral hepatitis and eliminate criminal sanctions based on viral hepatitis status, thereby reducing viral hepatitis-related stigma and helping to eliminate viral hepatitis as a substantial impediment to public health.

(RESOLUTION 22-53) RESOLVED, that ISMA support efforts to reform Indiana law to reflect the contemporary scientific understanding of HIV and to eliminate criminal sanctions based on HIV status, thereby reducing HIV-related stigma and accelerating the end of the HIV epidemic.
(RESOLUTION 21-30) RESOLVED, that ISMA update members as to rules and requirements needed to prescribe expedited partner therapy as ISMA Policy.

(RESOLUTION 21-25) RESOLVED, that the ISMA advocate to the Indiana General Assembly and the Indiana State Department of Health for mandatory HIV testing of all pregnant women and the newborn infant if the mother is HIV positive.

CORONERS

(RESOLUTION 16-39) RESOLVED, the ISMA supports the following:
1) Requiring higher education in the form of an academic degree such as: MD, DO, DDS, DMD, DVM, RN, BSN, NP, DNP, or a masters or doctorate in a life science
2) Expanding the current basic coroner training course to at least 40 hours of classroom and/or web-based training before beginning services as a new coroner
3) Expanding the current ongoing training in the form of web-based and/or classroom-based continuing education to enhance knowledge and competency
4) Requiring consultation with a forensic pathologist in certain cases such as death of a child, unexplained death of an adult less than age 50, apparent overdose death, apparent suicides and death as a consequence of a crime
5) Requiring additional qualifications to be a coroner for Indiana counties with a population greater than 100,000
6) Establishing a policy that the ideal coroner for an Indiana county, especially a county with a large population, would be a forensic pathologist.

DAYLIGHT SAVINGS TIME

(RESOLUTION 16-31) RESOLVED, that the ISMA initiate policy to end the observance of Daylight Savings Time in Indiana.

DEATH, DEFINITION OF

(READOPTED 22-82, HOD; RESOLUTION 12-02) RESOLVED, that the ISMA adopt the attached guidelines for the Determination of Brain Death in Infants and Children, and the Checklist for Infants and Children for use in Indiana medical facilities. (Find the guidelines at www.ismanet.org/convention/2012/Peds-Death-Guidelines.pdf.)

(RESOLUTION 17-04) RESOLVED, that ISMA adopt updated brain death guidelines for adults and children, as provided by the Ad Hoc Committee to establish Brain Death Guidelines for the state of Indiana for 2017.

Revision of ISMA Adult Brain Death Guidelines of 2017

ADULT GUIDELINES FOR DETERMINATION OF BRAIN DEATH

ADULT DIAGNOSTIC CRITERIA-
PATIENTS ABOVE 18 YEARS OF AGE

I. **Diagnostic criteria for clinical diagnosis of brain death.**

A. Prerequisites. Brain death is the absence of clinical brain function when the proximate cause is known and demonstrably irreversible.

1. Clinical or neuroimaging evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death.
2. Exclusion of complicating medical conditions that may confound clinical assessment (no severe electrolyte, acid-base, or endocrine disturbance)
3. No drug intoxication or poisoning.
4. Core temperature $\geq$ 32° C (90° F).
5. In any patient who has a recorded core body temperature of 34° C or lower, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 36° C or higher should be maintained for at least 24 hours prior to initiating the brain death examination.

B. The three cardinal findings in brain death are coma or unresponsiveness, absence of brainstem reflexes and apnea.

1. Coma or unresponsiveness-no cerebral motor response to pain in all extremities (nail-bed pressure and supraorbital pressure).
2. Absence of brainstem reflexes
   a) Pupils
      i. No response to bright light
      ii. Size: midposition (4mm) to dilated (9mm).
   b) Ocular movement
      i. No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)
3. Apnea-testing performed as follows:
   a) Prerequisites
      I. Core temperature $\geq$36° C or 97° F
      II. Systolic blood pressure $\geq$ 90 mm HG
      III. Euvolemia. Option: positive fluid balance in the previous 6 hours
      IV. Normal pCO_2, *Option*: arterial pCO_2 $\geq$ 40 mm Hg
      V. Normal pO_2. *Option*: preoxygenation to obtain arterial $pO_2 \geq$ 200 mm Hg
   b) Connect a pulse oximeter and disconnect the ventilator.
   c).
   c) If oxygen saturation falls to 85 % or less, abort the apnea test and reconnect the respirator; otherwise, continue with apnea test.
   d) Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).
   e) Measure arterial pO_2, pCO_2 and pH after approximately 8 minutes and reconnect the ventilator.
   f) If respiratory movements are absent and arterial $pCO_2$is > 60 mm Hg (option: 20 mm Hg increase in pCO_2 over a baseline normal pCO_2), the apnea test result is positive (i.e., it supports the diagnosis of brain death).
   g) If respiratory movements are observed, the apnea test result is negative (i.e., it does not support the clinical diagnosis of brain death), and the test should be repeated.
   h) Connect the ventilator if, during testing, the systolic blood pressure becomes $\leq$ 90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial

ii. No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side) c) Facial sensation and facial motor response i. No corneal reflex to touch with a throat swab ii. No jaw reflex iii. No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint d) Pharyngeal and tracheal reflexes i. No response after stimulation of the posterior pharynx with tongue blade ii. No cough response to bronchial suctioning	blood sample and analyze arterial blood gas. If pCO_2 is $\geq$ 60 mm Hg or pCO_2 increase is $<$ 20 mm Hg over baseline normal pCO_2, the result is indeterminate, and an additional confirmatory test can be considered. C. Brain Death Declaration in Patients Who Cannot Be Examined. In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates unequivocally there is no blood flow to the brain. This study must be read by two (2) radiologists certified in the interpretation of cerebral blood flow studies. **II. Pitfalls in the diagnosis of brain death** The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made

GUIDELINES FOR DETERMINATION OF BRAIN DEATH

with certainty on clinical grounds alone. Confirmatory tests are recommended.

A. Severe facial trauma
B. Preexisting pupillary abnormalities
C. Toxic levels of any sedative drugs, aminoglycosides, tricyclic antidepressants, anti-cholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents
D. Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2
E. Pregnancy is a special situation

III. Clinical observations compatible with the diagnosis of brain death

These manifestations are occasionally seen and should not be misinterpreted as evidence for brainstem function.

A. Spontaneous movements of limbs other than pathologic flexion or extension response
B. Respiratory-like movements (shoulder elevation and adduction, back arching, intercostals expansion without significant tidal volumes)
C. Sweating, blushing, tachycardia
D. Normal blood pressure without pharmacologic support or sudden increases in blood pressure
E. Absence of diabetes insipidus
F. Deep tendon reflexes; superficial abdominal reflexes; triple flexion response
G. Babinski reflex

IV. Confirmatory laboratory tests (options)

Brain death is a clinical diagnosis. A repeat clinical evaluation 6 hours later is recommended, but this interval is arbitrary. A confirmatory test is not mandatory but is desirable in patients in whom specific components of clinical testing cannot be reliably performed or evaluated. It should be emphasized that any of the suggested confirmatory tests may produce similar results in patients with catastrophic brain damage who do not (yet) fulfill the clinical criteria of brain death. The following confirmatory test findings are listed in the order of the most definitive test first. Consensus criteria are identified by individual tests.

A. Conventional angiography. No intracerebral filling at the level of the carotid bifurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.
B. Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16-channel EEG instruments.
C. Transcranial Doppler ultrasonography
    1. Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.
    2. Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.
D. Technetium-99m hexamethylpropyleneamineoxime (HMPAO or Ceretec) or Technetium 99m (ethyl cysteinate dimmer (ECD, Bicisate or Neurolite) brain perfusion scintigraphy; otherwise known as isotope flow study with brain scan. No flow to brain and no uptake of isotope in brain parenchyma (hollow skull phenomenon) is consistent with brain death.
E. Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

V. Medical record documentation (standard)

A. Etiology and irreversibility of condition
B. Absence of brainstem reflexes
C. Absence of motor response to pain
D. Absence of respiration with $pCO_2 > 60$ mm Hg
E. Justification for confirmatory test and result of confirmatory test
F. Optional: Repeat neurologic examination. The interval is arbitrary, but a six-hour period is reasonable.
G. Document repeat neurological examination if performed.

See Checklist for Determination of Brain Death on back.

Checklist for Determination of Brain Death in Patients 18 Years of Age or Older in the State of Indiana

Patient's Name: _____ Room No.: _____ Medical Record No.: _____

Patient's Age: _____ Sex: Male ☐ Female ☐ Attending Physician: _____, MD, DO

Has the cause of patient's present neurological state been determined? Yes ☐ No ☐

Have metabolic diseases or toxins been ruled out by history? Yes ☐ No ☐

Exclude: Hypothermia, Hypotension, depressant medication and correctable metabolic imbalance.

Temperature: Fahrenheit _____ or Centigrade _____ Blood Pressure: _____ mm. Hg

Barbiturate level and Depressant Medication Survey:

Blood drawn: Date: _____ Time: _____ Barbiturate Level: _____

Significant levels of other depressants: Yes ☐ No ☐

Movements	Present (✓)	Absent (✓)
Spontaneous		
Evoked		
Pectoral pinch		
Pressure on supraciliary ridge		
Pressure on sternum		
Pressure on tibia		

Reflexes	Right Pupil		Left Pupil	
Pupils – Size:	mm.		mm.	
	Yes (✓)	No (✓)	Yes (✓)	No (✓)
Reaction to light				
Reaction to facial pinch				
Corneal Reflex				
	Right Eye		Left Eye	
	Yes (✓)	No (✓)	Yes (✓)	No (✓)
Response to head turning (Doll's Eye Maneuver)				
Response to ice water stimulation (50 ml. each ear 3 min. apart)				

Pontomedullary Reflexes	Yes (✓)	No (✓)
1. Chewing movements		
2. Tongue movements		
3. Gag reflex		
4. Jaw jerk		
5. Response to loud noise		

Apnea Test	Any Breath Taken Yes (✓)	Any Breath Taken No (✓)
Patient's temperature must be at least 36.5° C (97° F) to perform this test.		
1st Date _____ Time _____		
Arterial pCO_2 before disconnection _____		
Arterial pCO_2 after disconnection _____		
2nd Date (if needed) _____ Time _____		
Arterial pCO_2 before disconnection _____		
Arterial pCO_2 after disconnection		

CONFIRMATORY TESTS, if needed – Results

Is the patient brain dead?	Yes ☐ (✓)	No ☐ (✓)

Date: _____ Time: _____ Signed: _____, MD, DO

Pediatric Brain Death Diagnostic Criteria – 37 Weeks Gestational Age to 18 Years of Age

Only qualified physicians caring for seriously ill ~~neonatal~~ patients under one year of age should establish brain death in patients under one year of age.

Issues to be considered and protocol to be followed relating to brain death examination:

1. Determination of brain death in neonates, infants, and children relies on a clinical diagnosis that is based on the absence of neurologic function with a known irreversible cause of coma. Coma and apnea must coexist to diagnose brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations.

2. Prerequisites for initiating a brain death evaluation:
   a. Hypotension, hypothermia, and metabolic disturbances that could affect the neurologic examination must be corrected before examination for brain death.
   b. Sedatives, analgesics, neuromuscular blockers, and anticonvulsant agents should be discontinued for a reasonable time period based on elimination half-life of the pharmacologic agent to ensure they do not affect the neurological examination. Knowledge of the total amount of each agent (mg/kg) administered since hospital admission may provide useful information concerning the risk of continued medication effects. Blood or plasma levels to confirm high or supratherapeutic levels of anticonvulsants with sedative effects that are not present should be obtained (if available) and repeated as needed or until the levels are in the low to midtherapeutic range. See Medications sheet, Appendix A.
   c. The diagnosis of brain death based on neurologic examination alone should not be made if supratherapeutic or high therapeutic levels of sedative agents are present. When levels are in the low or in the midtherapeutic range, medication effects sufficient to affect the results of the neurologic examination are unlikely. If uncertainty remains, an ancillary study should be performed. In patients who cannot be examined, refer to # 6 of Physical Examination To Determine Brain Death section in the Guidelines For the Determination of Brain Death in Infants and Children in the State of Indiana.
   d. Assessment of neurologic function may be unreliable immediately after cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for a minimum of 24 hours if there are concerns or inconsistencies in the examination.
   e. In any patient who has a recorded core body temperature of 34 $^{\circ}$ C or less, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 35° C or greater should be maintained for at least 24 hours prior to initiating brain death examinations.

3. Number of examinations, examiners, and observation periods:
   a. Two examinations including apnea testing with each examination separated by an observation period are required.
   b. The examinations should be performed by different attending physicians involved in the care of the child. The apnea test may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.
   c. Recommended observation periods:
      1. Twenty-four hours for neonates (37 weeks gestation to term infants 30 days of age)
      2. Twelve hours for infants and children (>30 days to 18 years)

d. The first examination determines the child has met neurologic examination criteria for brain death. The second examination, performed by a different attending physician, confirms that the child has fulfilled criteria for brain death.
e. Physicians attesting to brain death cannot be part of the organ procurement team.

4. Apnea testing:
   a. Apnea testing must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline $Paco_2$ and $\geq$60 mm Hg with no respiratory effort during the testing period to support the diagnosis of brain death. Some infants and children with chronic respiratory disease or insufficiency may only be responsive to supranormal $Paco_2$ levels. In this instance, the $Paco_2$ level should increase to $\geq$20 mm Hg above the baseline $Paco_2$ level.
   b. If the apnea test cannot be performed as a result of a medical contraindication or cannot be completed because of hemodynamic instability, desaturation to <85%, or an inability to reach a $Paco_2$ of $\geq$60 mm Hg, an ancillary study should be performed.

5. Ancillary studies:
   a. Ancillary studies (electroencephalography, cerebral angiography, and radionuclide cerebral blood flow) are not required to establish brain death unless the clinical examination or apnea test cannot be completed.
   b. Radionuclide cerebral blood flow study must be performed with a lipophilic isotope. Both dynamic and static phases of the study must be performed. Two of these isotopes available in the United States are:
      1. Technetium – 99m hexamethylpropylene-amineoxime (HMPAO or Ceretec)
      2. Technetium – 99m ethyl cysteinate dimer (ECD, Bicisate, or Neurolite)
   c. An EEG (electroencephalogram) demonstrating electrocerebral silence in the absence of other causative factors (i.e. drugs) is supportive of brain death.
   d. Ancillary studies are not a substitute for the neurologic examination.
   e. It must be recognized that both EEG and cerebral blood flow studies are less sensitive and less reliable in infants <30 days of age. A cerebral blood flow may be preferred over EEG in this age group.
   f. For all age groups, ancillary studies can be used to assist the clinician in making the diagnosis of brain death to reduce the observation period or when 1) components of the examination or apnea testing cannot be completed safely as a result of the underlying medical condition of the patient; 2) if there is uncertainty about the results of the neurologic examination; or 3) if a medication effect may interfere with evaluation of the patient. If the ancillary study supports the diagnosis, the second examination and apnea testing can then be performed. When an ancillary study is used to reduce the observation period, all aspects of the examination and apnea testing should be completed and documented.
   g. When an ancillary study is used because there are inherent examination limitations (i.e., 1-3 in 5d), then components of the examination done initially should be completed and documented.
   h. If the ancillary study is equivocal or if there is concern about the validity of the ancillary study, the patient cannot be pronounced dead. The patient should continue to be observed until brain death can be declared on clinical examination criteria and apnea testing or a follow-up ancillary study can be performed to assist with the determination of brain death. A waiting period of 24 hours is recommended before further clinical re-evaluation or repeat ancillary study is performed. Supportive patient care should continue during this time period.

6. Declaration of death
   a. The time of death is declared after the second clinical examination and apnea test are completed and confirm brain death.
   b. When ancillary studies are used, documentation of components from the second clinical examination that can be completed must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented.

PHYSICAL EXAMINATION TO DETERMINE BRAIN DEATH

Reversible conditions or conditions that can interfere with the neurologic examination must be excluded before brain death testing.

1. **Coma**.

The patient must exhibit complete loss of consciousness, vocalization, and volitional activity.

Patients must lack all evidence of responsiveness. Eye opening or eye movement to noxious stimuli is absent.

Noxious stimuli should not produce a motor response other than spinally mediated reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.

2. **Loss of all brain stem reflexes, including:**

Midposition or fully dilated pupils which do not respond to light.

Absence of pupillary response to a bright light is documented in both eyes.

Usually the pupils are fixed in a midsize or dilated position (4-9mm).

When uncertainty exists, a magnifying glass should be used.

Absence of movement of bulbar musculature including facial and oropharyngeal muscles.

Deep pressure on the condyles at the level of the temporomandibular joints and deep pressure at the supraorbital ridge should produce no grimacing or facial muscle movement.

Absent gag, cough, sucking, and rooting reflex.

The pharyngeal or gag reflex is tested after stimulation of the posterior pharynx with a tongue blade or suction device. The tracheal reflex is most reliably tested by examining the cough response to tracheal suctioning. The catheter should be inserted into the trachea and advanced to the level of the carina followed by one or two suctioning passes.

Absent corneal reflexes.

Absent corneal reflex is demonstrated by touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water. No eyelid movement should be seen. Care should be taken not to damage the cornea during testing.

Absent oculovestibular reflexes.

The oculovestibular reflex is tested by irrigating each ear with ice water (caloric testing) after the patency of the external auditory canal is confirmed. The head is elevated to 30 degrees. Each external auditory canal is irrigated (one ear at a time) with approximately 10-50mL of ice water. Movement of the eyes should be absent during 1 minute of observation. Both sides are tested with a minimum interval of five (5) minutes.

3. **Apnea.**
   The patient must have the complete absence of documented respiratory effort (if feasible) by formal apnea attesting demonstrating a $Paco_2 \geq 60$ mm Hg and $\geq$ 20 mm Hg increase above baseline.
   Normalization of the pH and $Paco_2$ measured by arterial blood gas analysis, maintenance of core temperature >35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing.
   The patient should be preoxygenated using 100% oxygen for 5-10 minutes before initiating this test.
   Intermittent mandatory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved.
   The patient's heart rate, blood pressure, and oxygen saturation should be continuously monitored while observing for spontaneous respiratory effort throughout the entire procedure.
   Follow-up blood gases should be obtained at 5-10 minute intervals to monitor the rise in $Paco_2$ while the patient remains disconnected from mechanical ventilation.
   If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2 \geq 60$ mm Hg and ≥ 20 mm Hg above the baseline level, the apnea test is consistent with brain death.
   The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed.
   If oxygen saturations fall <85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of ≥ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. Another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death.
   Evidence of any respiratory effort is inconsistent with brain death and the apnea test should be terminated.

4. **Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.**
   The patient's extremities should be examined to evaluate tone by passive range of motion assuming that there are no limitations to performing such an examination (e.g., previous trauma, etc.) and the patient observed for any spontaneous or induced movements.
   If abnormal movements are present, clinical assessment to determine whether these are spinal cord reflexes should be done.

5. **Brain Death Declaration.**
   After the second physical examination demonstrates no brain life, the patient is brain dead and is to be declared brain dead at that time.

6. **Brain Death Declaration in Patients Who Cannot be Examined**
   In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates unequivocally no blood flow to the brain. This study must be read by two (2) radiologist certified in the interpretation of cerebral blood flow studies.

DRUG ELIMINATION TABLE TO SERVE AS REFERENCE FOR PRACTITIONERS WHEN DEALING WITH PATIENTS RECEIVING SPECIFIC PHARMACOLOGICAL AGENTS AND WHO ARE UNDERGOING BRAIN DEATH TESTING

Appendix A

MEDICATIONS ADMINISTERED TO CRITICALLY ILL PEDIATRIC PATIENTS AND RECOMMENDATIONS FOR TIME INTERVAL TO TESTING AFTER DISCONTINUATION OF MEDICATIONS

Medication	Infants/Children Elimination Half-Life	Neonates Elimination Half-Life
Intravenous induction, anesthetic, and sedative agents		
Thiopental	Adults: 3-11.5 hrs (shorter half life in children)	
Ketamine	2.5 hrs	
Etimodate	2.6-3.5 hrs	
Midazolam	2.9-4.5 hrs	4-12 hrs
Propofol	2-8 mins, terminal half-life 200 mins (range, 300-700 mins)	
Dexmedetomidine	Terminal half-life 83-159 mins	Infants have faster clearance
Antiepileptic drugs		
Phenobarbital	Infants: 20-133 hrs* Children 37-73 hrs*	45-500 hrs*
Pentobarbital	25 hrs*	
Phenytoin	11-55 hrs*	63-88 hrs*
Diazepam	1 mo. to 2 yrs: 40-50 hrs 2-12 yrs: 15-21 hrs 12-16 yrs: 18-20 hrs	50-95 hrs
Lorazepam	Infants: 40.2 hrs (range 18-73 hrs) Children: 10.5 hrs (range 6-17 hrs)	40 hrs
Clonazepam	22-33 hrs	
Valproic acid	Children >2 months: 7-13 hrs* Children 2-14 yrs: mean 9 hrs; range, 3.5-20 hrs	10-67 hrs*
Levetiracetam	Children 4-12 yrs: 5 hrs	
Intravenous narcotics		
Morphine sulfate	Infants 1-3 months: 6.2 hrs (5-10 hrs) 6 months to 2.5 yrs: 2.9 hrs (1.4-7.8 hrs) Children: 1-2 hrs	7.6 hrs (range, 4.5-13.3 hrs)
Meperidine	Infants <3 months: 8.2-10.7 hrs (range, 4.9-31.7 hrs); Infants 3-18 months: 2.3 hrs Children: 5-8 yrs: 3 hrs	23 hrs (range, 12-39 hrs)
Fentanyl	5 months to 4.5 yrs: 2.4 hrs (mean); 0.5-14 yrs: 21 hrs (range, 11-36 hrs for long-term infusions)	1-15 hrs
Sufentanil	Children 2-8 yrs: 97 + 42 mins	382-1,162 mins
Muscle relaxants		
Succinylcholine	5-10 mins; prolonged duration of action in patients with pseudocholinesterase deficiency or mutation	
Pancuronium	110 mins	
Vecuronium	41 mins	65 mins
Atracurium	17 mins	20 mins
Rocuronium	3-12 months: 1.3 ± 0.5 hrs 1 to <3 yrs: 1.1 ± 0.7 hrs 3 to <8 yrs: 0.8 ± 0.3 hrs Adults: 1.4-2.4 hrs	

*Elimination half-life does not guarantee therapeutic drug levels for longer-acting medications or medications with active metabolites. Drug levels should be obtained to ensure that levels are in a low to midtherapeutic range before neurologic examination to determine brain death. In some instances, this may require waiting several half-lives and rechecking serum levels of the medication before conducting the brain death examination.

Metabolism of pharmacologic agents may be affected by organ dysfunction, age, patient condition, and hypothermia. Physicians should be aware of total amounts of administered medication that can affect drug metabolism and levels.

Checklist for Documentation of Brain Death in Infants and Children

Two physicians must perform independent examinations separated by specified intervals.

Age of Patient	Timing of First Exam	Inter-exam, Interval
Term newborn 37 weeks gestational age and up to 30 days old	☐ First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury.	☐ At least 24 hours ☐ Interval shortened because ancillary study (Section 4) is consistent with brain death
31 days to 18 years	☐ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	☐ At least 12 hours OR ☐ Interval shortened because ancillary study (Section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Known metabolic disorder ☐ Other (specify)

B. Correction of contributing factors that can interfere with the neurologic examination	Examination One		Examination Two	
a. Core body temp is over 95°F (35°C)	☐ Yes	☐ No	☐ Yes	☐ No
b. Systolic blood pressure or MAP in acceptable range (systolic BP not less than 2 standard deviations below age appropriate norm) based on age	☐ Yes	☐ No	☐ Yes	☐ No
c. Sedative/analgesic drug effect excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
d. Metabolic intoxication excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
e. Neuromuscular blockade excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No

☐ If ALL prerequisites are marked YES, then proceed to Section 2, OR

☐ Confounding variable was present. Ancillary study was therefore performed to document brain death (Section 4)

Section 2. Physical Examination (Please check) **Note: SPINAL CORD REFLEXES ARE ACCEPTABLE.**	Examination One Date / Time		Examination Two Date / Time	
a. Flaccid tone, patient unresponsive to deep painful stimuli	☐ Yes	☐ No	☐ Yes	☐ No
b. Pupils are midposition or fully dilated and light reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
c. Corneal, cough, gag reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
Sucking and rooting reflexes are absent (in neonates and infants)	☐ Yes	☐ No	☐ Yes	☐ No
d. Oculovestibular reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
e. Spontaneous respiratory effort while on mechanical ventilation is absent	☐ Yes	☐ No	☐ Yes	☐ No

☐ The _____*(specify)* element of the exam could not be performed because_____

Ancillary study (EEG or radionuclide (CBF) was therefore performed to document brain death (Section 4).

Section 3. APNEA Test	Examination One Date / Time	Examination Two Date / Time
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination One)		
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination Two)		

Apnea test is contraindicated or could not be performed to completion because _____

_____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death (Section 4).

Section 4. ANCILLARY testing	Date / Time
Ancillary testing is required when: 1. Any components of the examination or apnea testing cannot be completed; 2. If there is uncertainty about the results of the neurologic examination; or 3. If a medication effect may be present. Ancillary testing can be performed to reduce the inter-examination period; however, a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test.	
☐ Electroencephalogram (EEG) report documents electrocerebral silence OR	☐ Yes ☐ No
☐ Cerebral Blood Flow (CBF) study report documents no cerebral perfusion	☐ Yes ☐ No

Section 5. Signatures

Examiner One

I certify that my examination is consistent with cessation of function of the brain and brainstem. Confirmatory exam to follow.

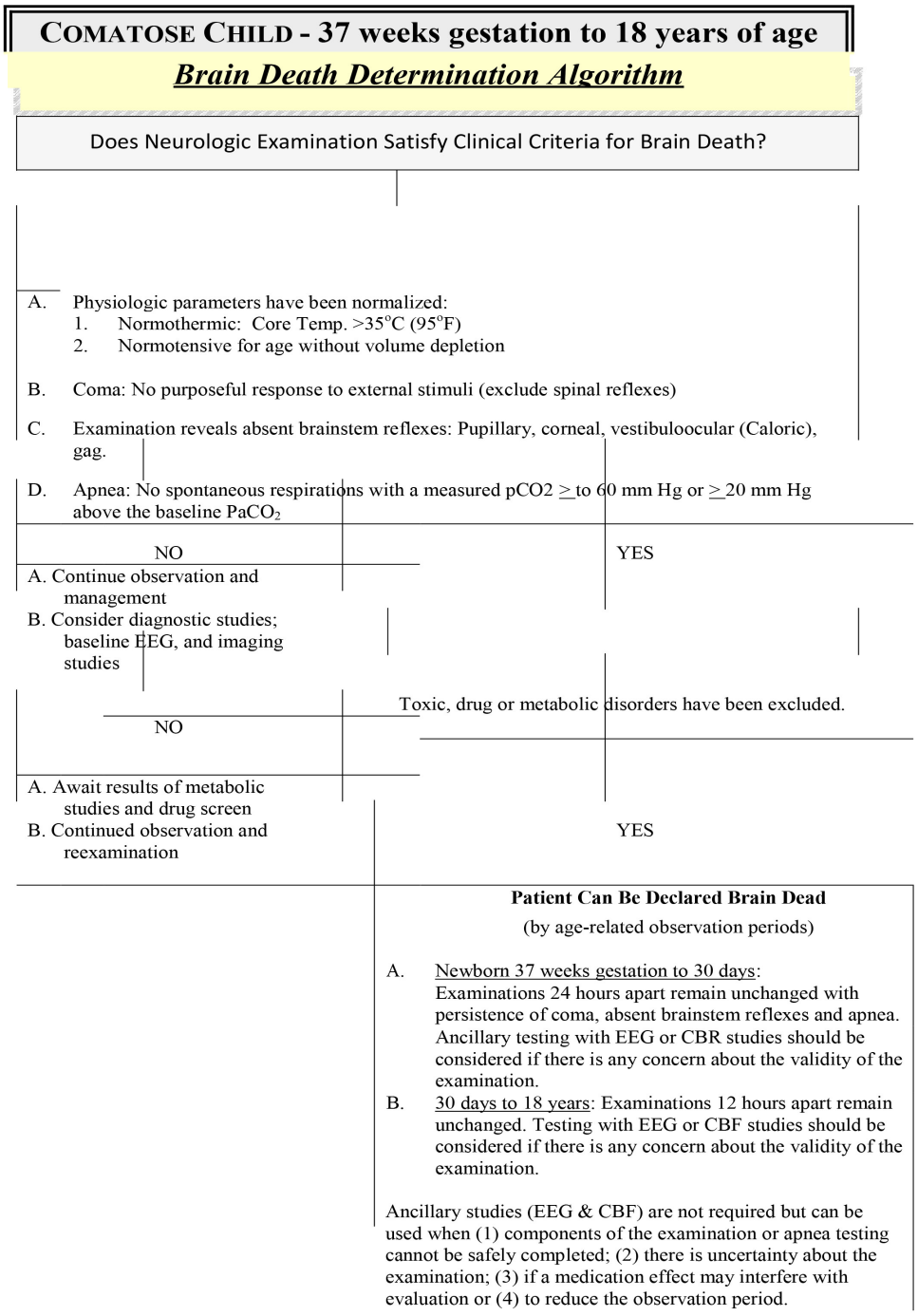
(Printed Name)		(Signature)	
(Specialty)	(Pager # /License #	(Date mm/dd/yyyy)	(Time)

Examiner Two

I certify that my examination ☐ and/or ancillary test report ☐ confirms unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this time.

Date/Time of death: _____

(Printed Name)		(Signature)	
(Specialty)	(Pager # /License #	(Date mm/dd/yyyy)	(Time)



The content of these Brain Death Guidelines is largely excerpted from an article published in *Critical Care Medicine* 2011 Vol. 39, No. 9, entitled "Guidelines for the determination of brain death in infants and children; An update of the 1987 Task Force recommendations." For documentation and supportive information, including an extensive bibliography, please refer to the aforementioned publication.

(RESOLUTION 15-02) RESOLVED, that the ISMA seek legislation and support efforts to change Indiana's Surrogate Consent Statute § 16-36-1-5-(a)(2) that:

- Provides a more inclusive list of eligible individuals who can serve as surrogate decision makers
- Establishes a hierarchy or dispute resolution process for cases in which more than one legal surrogate is present and they cannot agree on patient care; and be it further

RESOLVED, that the ISMA delegation ask the AMA to support a surrogate consent statute that:

- Provides a more inclusive list of eligible individuals who can serve as surrogate decision makers
- Establishes a hierarchy or dispute resolution process for cases in which more than one legal surrogate is present and they cannot agree on patient care.

DRIVING – SAFETY

(RESOLUTION 21-29) RESOLVED, that the ISMA continue to support graduated licensing requirements for young drivers consistent with recommendations from the National Highway Traffic Safety Administration.

(RESOLUTION 17-38) RESOLVED, the ISMA send this resolution to the AMA House of Delegates for consideration with the recommendation that it is referred to the Council of Science and Public Health for study, and report back to the House of Delegates; and be it further
RESOLVED, ISMA ask the AMA to study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risk; and be it further
RESOLVED, the ISMA ask the AMA to advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle head light is detected.

(READOPTED 17-13, HOD; RESOLUTION 07-29A, BOT; RESOLUTION 97-51) RESOLVED, that ISMA work with all groups to educate the public about the hazards of using a cell phone and electronic messaging while driving; and be it further
RESOLVED, that ISMA work with groups trying to create legislation to make using a hand-held cell phone and electronic text messaging while driving a fineable offense and support such legislation to the extent supported by scientific data, with appropriate exemptions for law enforcement, public safety workers and medical professionals.

(RESOLUTION 17-09) RESOLVED, that ISMA promote educational efforts against impaired driving, including operating a passenger vehicle in Indiana with a blood alcohol concentration (BAC) of 0.04 percent or greater.

(3/75, BOT) That physicians be willing to submit data and do physical examinations for third parties but not be responsible for judging a person's insurability or ability to drive.

DRUG ABUSE

(RESOLUTION 24-38) RESOLVED, that the ISMA support legislation which removes the designation of fentanyl test strips as drug paraphernalia.

(RESOLUTION 23-51) RESOLVED, that the ISMA (1) support the modification of IC-20-34-4.5 to require the storage of "emergency stock medications," such as naloxone, in schools, and (2) support, in partnership with relevant stakeholders, programs which increase naloxone storage in places of business and educational contexts, and (3) support legislation which requires naloxone to be stocked in government buildings.

(RESOLUTION 22-09) RESOLVED, that ISMA instruct our AMA delegation to introduce a resolution to the American Medical Association to seek policy and legislation that would limit social media's promotion and dissemination of corporate advertisement on usage of commercial and illicit drugs to our youth.

(READOPTED 22-03, HOD; RESOLUTION 12-26A) RESOLVED, that the ISMA seek and support methods to reduce the sale of products containing dextromethorphan to minors; and be it further

RESOLVED, that the ISMA request the AMA to also seek and support methods to reduce the sale of products containing dextromethorphan to minors.

(RESOLUTION 21-44) RESOLVED, that our ISMA support enhanced community outreach efforts to improve knowledge on the protections of Aaron's Law (IC 16-42-27-1 et seq.) or other such federal and state Good Samaritan laws, such as signage presented at state-regulated alcohol retailers, counseling at publicly funded addiction recovery meetings and attached labeling addenda on over-the-counter medications that are often purchased by opioid users (e.g., laxatives); and be it further
RESOLVED, that our ISMA support the adoption of AMA Policy D-95.977, 911 Good Samaritan Laws, and support expanded legal protections for both the individual who calls 911 at the scene of the overdose and the individual who overdosed.

(RESOLUTION 17-36) RESOLVED, that ISMA support expanding naloxone training for the lay population in order to decrease the risk of fatal overdose. Additionally, the training program and naloxone supply that is funded by the Indiana State Department of Health should be expanded to provide two separate doses of naloxone because of the risk posed by fentanyl and carfentanyl with overdose relapse; and be it further
RESOLVED, that ISMA support the continuing availability of over-the-counter naloxone either through order by the Indiana State Health Commissioner or legislative action; and be it further
RESOLVED, that the ISMA support the expansion of programs linking users of Naloxone for the purpose of reversing opioid overdose to long-term addictions management; and be it further
RESOLVED, that the AMA be asked to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

(RESOLUTION 17-35) RESOLVED, the ISMA support increased funding for inpatient and outpatient treatment of drug addiction; and be it further
RESOLVED, ISMA support the establishment of a mandatory registry that contains inpatient bed census data so that available inpatient drug-addiction treatment beds would be easily identifiable. This would enhance the speed of treatment and provide a more efficient use of inpatient resources. It is expected that these facilities would readily accept these patients from more distant locations.

(RESOLUTION 16-38) RESOLVED, that the ISMA ask the Indiana legislature to strongly promote and fund an anti-drug campaign across the state, including an anti-drug curriculum for grade schools that has proven effective in promoting primary prevention; other measures are:

- Expanding awareness, education and funding for Narcan use by laypersons and first responders in order to help mitigate overdose deaths
- Enhancing drug interdiction efforts
- Enhancing funding for drug addiction therapy, both outpatient and inpatient, but especially for inpatient programs. (Tobacco settlement funds could help fund part of this program.)
- Support and fund validated programs that begin drug rehabilitation while incarcerated and while on probation; and be it further

RESOLVED, that the ISMA strongly support the development of mandatory, age-appropriate evidenced-based drug (specifically to include opiates) education for Indiana students and interested parties.

(RESOLUTION 16-34) RESOLVED, that the ISMA and the AMA support the requirement that medical facility needle/syringe disposal devices be as theft-proof and tamper-proof as possible; this requirement could be established by rule or by statute; and be it further
RESOLVED, that the ISMA and AMA support the requirement that stored used needles/syringes be properly secured so as to discourage theft; and be it further
RESOLVED, that the ISMA and the AMA support the requirement that theft and tamper-proof containers be placed in public restrooms for the purpose of needle/syringe disposal; an ideal device would crush the syringe as part of the disposal process; and be it further
RESOLVED, that the ISMA and AMA encourage those communities with a significant IV drug abuse population to establish a needle exchange program, since this helps eliminate the demand for used needles/syringes; and be it further

RESOLVED, that Resolution 16-34 be forwarded to the AMA for consideration if adopted by the ISMA.

(RESOLUTION 15-51) RESOLVED, that the ISMA support federal legislative efforts to curb the growing prescription drug and heroin abuse epidemics through the following efforts:

- Develop best practices in pain medication prescribing and related pain management
- Develop the National All Schedules Prescription Electronic Reporting system (NASPER)
- Support federal assistance for programs that specialize in prevention and drug treatment programs
- Increase the education and preparedness of local first responders to administer Naloxone to overdose patients
- Support state and national education programs that focus attention on the link between prescription drug abuse and heroin use.

(RESOLUTION 15-46) RESOLVED, that the ISMA discourage the over-use of extended-release opioids and when prescribed, an abuse-deterrent formulation should be utilized for the treatment of chronic non-cancer related pain.

(RESOLUTION 15-29) RESOLVED, that the ISMA seek and support legislation consistent with the following statement: "The results of prenatal verbal screening for substance use and toxicology screening shall be confidential and shall not be released or disclosed to anyone, including any local state or federal agency for any reason other than medical care or data analysis of high risk and at-risk pregnancies for planning purposes by public health officials," and that the ISMA collaborate with the ISDH and any other interested parties in support of such legislation.

(RESOLUTION 15-01) RESOLVED, that the ISMA encourage the voluntary use of a document such as the *Advance Directive for Addiction in Remission and to Ensure Continued Recovery* to facilitate communication between patients with a history of opiate addiction and physicians prior to an event (e.g. surgery) requiring the use of medications with addictive potential.

EARLY CHILDHOOD EDUCATION

(RESOLUTION 18-26) RESOLVED, that ISMA seek legislative efforts to increase the number of teachers with credentials sufficient to meet Level 3-4 early child care centers by advocating for access to college-level certification and setting competitive pay scales to attract high-quality applicants for teachers with appropriate certification; and be it further
RESOLVED, that ISMA encourage legislative efforts to expand "On My Way Pre-K" legislation to include children from birth to 5 years of age with access to Level 3 (planned curriculum guide, child development and school readiness), preferably working for Level 4 (national accreditation is achieved) certification.

ELECTRONIC MEDICAL RECORDS

(RESOLUTION 23-35) RESOLVED, that the ISMA support legislation subjecting digital health companies' data mining activities to the same patient privacy and confidentiality protections afforded by HIPAA as it applies to covered entities, or at minimum requiring disclosure of data usage.

(RESOLUTION 21-04) RESOLVED, that the Indiana State Medical Association work with the Indiana Hospital Association to revive the concise dictated (or use of Dragon or other equivalent technologies) history and physical, consult note, procedure note and discharge summary that existed prior to electronic medical records for the sake of much-improved patient care and safety.

EMERGENCIES, MEDICAL

(RESOLUTION 24-48) RESOLVED that ISMA seek legislation to substantively amend Indiana Code 16-21-2-14.5 to more fully reflect ISMA public policy that all facilities in the state of Indiana which bear the designation of emergency department must have at least one physician on site and on duty who is responsible for the

emergency department at all times;

"A ~~hospital~~ facility with an emergency department must have at least one (1) physician on site and on duty who is responsible for the emergency department at all times the emergency department is open;" and be it further

RESOLVED that Indiana's delegation to the AMA advocate for the creation of model legislation for all states, as a matter of truth and transparency in the scope of available emergency medical services, which requires that all facilities using the designation "emergency department" mandate the presence of at least one physician on-site and on-duty who is responsible for the emergency department at all times.

(RESOLUTION 23-36) RESOLVED, that the ISMA encourages awareness of the impact of ambulance funding on patient outcomes and health care costs in rural areas; and be it further
RESOLVED, that the ISMA support the work of the Indiana Department of Health, Indiana Department of Homeland Security, Indiana Rural Health Association and the Indiana Hospital Association to improve avalibility of EMS resources throughout rural Indiana; and be it further
RESOLVED, that the ISMA relate the specific needs of critical access care hospitals pertaining to ambulance services to the Indiana Legislature; and be it further
RESOLVED, that the ISMA support legislation that provides sustainable funding for ambulance services and addresses other barriers to emergency care in rural areas.

(RESOLUTION 21-42) RESOLVED, that the Indiana State Medical Association, in order to promote truth and transparency in the services available to patients seeking emergency medical care, pursue the enactment of legislation or regulation requiring that all facilities in the state of Indiana that bear the designation of emergency department, ED, emergency room, ER or other title, facility logo or design implying provision of emergency medical care must have the real-time, onsite presence of and supervision of nonphysician practitioners by a licensed physician with training and experience in emergency medical care, 24 hours a day and seven days a week whose primary duty is dedicated to patients who seek emergency medical care in that specific ED, whether it serves the general population or a special population. Physician collaboration with a nonphysician practitioner will not fulfill this requirement; and be it further
RESOLVED, that the Indiana State Medical Association advocate for similar legislation or regulation promoting truth and transparency for patients in regard to availability and scope of emergency medical services at all health care facilities and seeking appropriate designations, at a federal level with the American Medical Association.

(RESOLUTION AND AMENDED 19-21, BOT) RESOLVED, that ISMA support legislation to protect emergency medical technicians who transport patients who are judged, on the good faith evaluation of the technician or in coordination with online medical direction, to lack decision-making capacity and require transport to a health care facility for life- or limb-saving treatment.

(RESOLUTION 19-08) RESOLVED, that ISMA encourage all Indiana hospitals, ground emergency medical services agencies and 911 centers to create protocols to determine which air medical service should be contacted when requested. The factors that should be taken into consideration include: geographical distance, helicopter size, weather capabilities (IFR vs. VFR), blood products and specialized equipment; and be it further
RESOLVED, that ISMA explore contacting the Indiana State Department of Health, Homeland Security and the Indiana Hospital Association to communicate the importance of creating protocols to determine which air medical service should be contacted when requested.

(RESOLUTION 18-30) RESOLVED, that ISMA work with the Indiana State Department of Health to develop standardized criteria to complete on autopsies in all trauma cases; and be it further
RESOLVED, that ISMA seek legislation to provide funding for autopsies in cases of trauma and not require families to pay for autopsies; and be it further
RESOLVED, that ISMA seek legislation to require the Indiana State Department of Health to maintain autopsy results in trauma cases and report these results annually.

(READOPTED ERC 2024; RESOLUTION 14-13) RESOLVED, that the ISMA continues to work with the Indiana State Department of Health, Homeland Security, the American College of Surgeons and interested parties toward the goal of a statewide trauma care system for Indiana; and be it further
RESOLVED, that the ISMA continue to encourage hospitals and physicians wherever they are credentialed to be involved in trauma care; and be it further
RESOLVED, that the ISMA work with the American College of Surgeons and interested parties with legislative input to seek funding crucial to the complete implementation and maintenance of a statewide trauma care system.

(READOPTED 18-21, HOD; RESOLUTION 08-37) RESOLVED, that the ISMA support state legislation as well as federal requiring all facilities in Indiana rendering emergency care to provide on-site, comprehensive services to sexual assault patients in accordance with widely accepted standards of care, without exemption for sectarian reason. Such services must include all the following:

- Treatment of trauma
- Testing and prophylaxis for sexually transmitted disease
- Collection of forensic evidence
- Timely availability of emergency contraception for patients capable of pregnancy
- Information and written materials about a patient's right to emergency contraception. Information shall be scientifically accurate, factual and objective. It shall be clearly written and readily comprehensible in a culturally competent manner. It shall explain the nature of emergency contraception, including its use, safety, efficacy and availability, and shall state that this form of contraception does not cause abortion of an established pregnancy.

(8/11/82, EC) General support for the several emergency medical identification systems (jewelry); however, no endorsement for any particular manufacturer.

(8/15/79, EC) Discourages the use of hospital emergency rooms for non-emergency problems.

ENVIRONMENT

(RESOLUTION 24-32) RESOLVED, that the ISMA support initiatives and legislation which promote utility disconnection moratoria.

(RESOLUTION 23-54) RESOLVED, that the ISMA support legislation increasing radon surveillance and radon soil ventilation mitigation system installation within dwellings across Indiana.

(RESOLUTION 23-16) RESOLVED, that the ISMA support legislation requiring businesses that store or dispose of lithium batteries to notify local first responders/health departments of the locations where discarded lithium batteries are located; and be it further
RESOLVED, that the ISMA work with interested stakeholders (including, but not limited to, the Indiana Department of Health, the Indiana Department of Environmental Management, the Indiana Department of Homeland Security, and local fire departments) to improve public safety regulations concerning lithium battery storage and disposal facilities from storage and to prepare for and prevent hazards and fires connected with lithium batteries; and be it further
RESOLVED, the Indiana delegation to the AMA carry forward a resolution to the AMA to seek legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries.

(RESOLUTION 22-27) RESOLVED, that the ISMA support legislation requiring those residing upon or within one mile of a superfund site, a site listed by the Indiana Clean Up or Immediate Removal programs, or those who use contaminated drinking water, be notified immediately upon its discovery; and be it further
RESOLVED, that ISMA advocate for increasing the Indiana Department of Environment Management budget for the purpose of enforcing laws and cleanups to prevent health and financial detriment to those exposed to toxic pollution in the state of Indiana.

(RESOLUTION 16-32) RESOLVED, that the ISMA issue a statement officially recognizing that pollution and environmental factors contribute to public health morbidity and mortality.

FAMILIES

(RESOLUTION 24-15) RESOLVED, that the ISMA support legislation seeking the exemption of essential family care items, including, but not limited to feminine hygiene products, maternity clothing, breast milk pumping products, pediatric and adult diapers, baby wipes, baby bottles, and wound care dressings from sales and use taxes in Indiana to support Hoosier families at every stage of life.

(READOPTED AND AMENDED 21-52, HOD; RESOLUTION 10-02A) RESOLVED, that the ISMA:

1. Recognize that same sex households may involve social determinants that can facilitate a disparity in the access to the same health care opportunities as opposite sex households, and
2. Will continue to work to reduce such health care disparities among members of same-sex households, including minor children; and
3. Will support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits, as afforded opposite-sex households.

FAMILY/DOMESTIC VIOLENCE

(RESOLUTION 24-03) RESOLVED, that the ISMA recognizes sex trafficking especially with children and exploitation as a public health concern, oppose all such trafficking practices, and oppose any and all forms of pedophilia, and oppose underage pornography; and be it further
RESOLVED, that the ISMA encourage its members and medical community to be educated, knowledgeable, and equipped to identify victims of sex trafficking, especially children, and familiar with the resources and policies available to them to report such incidences.

(RESOLUTION 22-29) RESOLVED, that ISMA support legislation for the ban of conversion or reparative therapy for minors.

(RESOLUTION 19-14) RESOLVED, that ISMA support the dissemination of resources and services by the Department of Child Services (DCS) to families dealing with substance use disorder; and be it further
RESOLVED, that ISMA support the ability of DCS to refer families dealing with substance use disorder who have entered the DCS system, with or without substantiation of abuse or neglect, to a community program that provides resources and services; and be it further
RESOLVED, that ISMA support increased standardization of Department of Child Services case management and execution of its policies, with the goal of decreasing negative long-term outcomes and minimizing the psychological trauma of the children and families involved.

(READOPTED 17-08, HOD; READOPTED 07-07, HOD; RESOLUTION 97-17) RESOLVED that the ISMA support and advocate for measures that will strengthen the protection of children and endangered adults from acts of abuse; and be it further,
RESOLVED that the ISMA oppose all state and federal legislation and actions that will in any way hinder, obstruct or weaken the ability of law enforcement agencies to investigate suspected cases of abuse of children and endangered adults.

(READOPTED 15-17, HOD; RESOLUTION 05-26) RESOLVED, that the ISMA support legislation that designates a child as a "child in need of services" who is a passenger in a vehicle operated by the child's parent, guardian or custodian while that adult is intoxicated.

FINANCIAL FRAUD

(READOPTED 21-22, HOD; RESOLUTION 11-23) RESOLVED, that the ISMA support, endorse and promote the Elder Investment Fraud and Financial Exploitation Prevention Program through the Securities Commissioner of the Indiana Secretary of State's Office to empower ISMA members in identifying and referring older patients who may be most vulnerable to financial/investment fraud abuse.

FIREARMS

(RESOLUTION 23-39) RESOLVED, that the ISMA seek the increased provision of firearm safety-related continuing medical education (CME) for physicians in the state of Indiana, either by the direct creation of its own CME material or by the identification and promotion of relevant CME from other organizations; and be it further
RESOLVED, that the ISMA vigorously oppose legislation that attempts to restrict or prohibit the discussion of firearms between physicians and their patients in health care settings.

(RESOLUTION 23-38) RESOLVED, that the ISMA support child access prevention legislation to require all caregivers in the state of Indiana to keep all unattended firearms stored separately from ammunition in locked, inaccessible areas whenever children are present and penalizes caregivers who store firearms unsafely in a manner that makes it likely that a minor could access them; and be it further
RESOLVED, that the ISMA support the provision of trigger locks and safe storage education material with all firearm sales in the state of Indiana; and be it further
RESOLVED, that the ISMA support the distribution of educational materials on the safe use and secure storage of firearms and ammunition among all health care settings through the distribution of educational materials developed by other organizations/sources directly to ISMA members and the encouragement of ISMA members to distribute the materials to their health care institutions.

(READOPTED AND AMENDED 21-26, HOD; RESOLUTION 10-49; RESOLUTION 00-30A) RESOLVED, that the ISMA support responsible firearm ownership and education through the following:

- Continue to advocate for educational programs based on research from epidemiological and other scientific sources relating to firearm-related statistics for the responsible use and storage of firearms; and
- Advocate comprehensive health education as a means of addressing social issues such as crime, mental well-being, poverty or low education achievement in the nature of firearm-related violence and urge incorporation of such health education into our societal framework; and
- Support scientific research and objective discussion aimed at identifying causes and finding solutions to and prevention of the crime and violence problem; and
- Support vigorous enforcement of existing gun laws; and
- Support free enjoyment of rights granted under the Constitution to law-abiding citizens.

(RESOLUTION AND AMENDED 19-39, BOT) RESOLVED, that ISMA, in the spirit of AMA policy H-145.993 Restriction of Assault Weapons, supports appropriate legislation that would ban the civilian sale and distribution of all assault-type weapons (such as high-rate-of-fire automatic and semi-automatic firearms modified to operate as such) and high-capacity magazines.

(READOPTED AND AMENDED 18-05, HOD; RESOLUTION 08-09) RESOLVED, that the ISMA support legislation to require that a statement be provided with the sale of each firearm about the increased risk of suicide associated with bringing a firearm into a home and how that risk can be reduced with safe storage; and be it further,
RESOLVED, that the ISMA support efforts with non-profit organizations for a public awareness campaign on the risk of suicide associated with firearm ownership; and be it further,
RESOLVED, that ISMA support efforts of physicians to provide medical counsel to their patients regarding firearm safety and risks of suicide in homes with firearms; and be it further,

RESOLVED, that the ISMA support legislation requiring the Indiana State Department of Health to prepare and publish an annual report on suicide in Indiana based on available data collected by coroners that would include:

- The means used
- Gender, age, race and county of residence of the victim
- Any use of firearms in a suicide
- Whether or not the victim owned the firearm
- How the firearm was stored and obtained.

(READOPTED 18-04, HOD; RESOLUTION 08-08B) RESOLVED, that the ISMA support legislation to require the Indiana State Department of Health to provide an annual report on criminal firearm violence in Indiana, including the number, age, race, gender and ZIP code of victims; circumstances of the incident; type of weapon; and whether the weapon was legally owned by the user and, if not, how it was obtained; and be it further RESOLVED, that ISMA support legislation to change the reporting of deaths by coroners and police to include data on the type and source of firearms involved in injuries and deaths.

(READOPTED AND AMENDED 18-03, HOD; RESOLUTION 08-08A) RESOLVED, that the ISMA establish policy recognizing that criminal firearm violence is a major public health problem; and be it further,
RESOLVED, that the ISMA support legislation that would:

- Improve the reporting of felony convictions and mental health commitments to the federal database; and be it further,

RESOLVED, that the ISMA oppose legislation that prevents schools, hospitals and businesses from restricting the presence of firearms on their property.
RESOLVED, that ISMA support legislation for universal background checks for gun sales.

FOOD AND BEVERAGES

(READOPTED 22-01, HOD; RESOLUTION 12-61) RESOLVED, that the ISMA encourage the restriction of raw milk sales in Indiana for the health of Hoosiers.

(RESOLUTION 19-11) RESOLVED, that ISMA support legislation that would implement a tax on sugar-sweetened beverages including soda, energy, sports and fruit-flavored drinks and juices, as a means to curb sugar overconsumption among Hoosiers.

(RESOLUTION 18-18) RESOLVED, that the ISMA delegation to the American Medical Association (AMA) request that the AMA petition the Food and Drug Administration (FDA) to pursue more obvious labeling on food packaging containing the eight most common food allergens: milk, eggs, peanuts, tree nuts, wheat, soy, fish and crustacean shellfish.

(RESOLUTION 18-10) RESOLVED, that ISMA oppose the marketing, sale and use of energy/caffeinated drinks for children and adolescents; and be it further
RESOLVED, that the ISMA Board of Trustees study the issue of caffeinated drinks and youth and report to the 2019 ISMA House of Delegates with findings and recommendations to eliminate/reduce the marketing, sale and use of energy/caffeinated drinks for Hoosier children and adolescents.

(RESOLUTION 18-09) RESOLVED, that ISMA continue to support the AMA's efforts to (1) seek necessary regulatory action through the U.S. Food and Drug Administration to regulate potentially hazardous energy beverages; (2) seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol; and (3) support a ban on the marketing of "high stimulant/caffeine drinks" to anyone younger than 18.

HEALTH CARE SYSTEM

(RESOLUTION 24-50) RESOLVED, that the ISMA delegation to the American Medical Association (AMA) carry forward a resolution to the AMA calling on the Federal Trade Commission to prevent a monopoly in health care payments by requiring United Health care to divest its ownership interest in InterQual.

(RESOLUTION 24-10) RESOLVED, that the ISMA support actions and legislation by elected officials that prohibit the World Health Organization or any other multinational organization from having any jurisdiction or power within the state of Indiana, including on rules, regulations, fees, taxes, policies, or mandates.

(RESOLUTION 24-02) RESOLVED, that the ISMA support legislation for long-term funding of provider-to-provider psychiatry consultation programs staffed by board-certified psychiatrists, including those modeled after other states.

(RESOLUTION 23-69) RESOLVED, that the ISMA support legislation or regulation that would allow patients to use Health Savings Account (HSA) funds for direct primary care (DPC) membership or other physician retainer practice fees.

(RESOLUTION 22-78) RESOLVED that ISMA prioritize working with the Indiana Department of Health and Indiana General Assembly to improve public health outcomes and infrastructure in the state of Indiana.

(RESOLUTION 24-39; REAFFIRMED RESOLUTION 22-75) RESOLVED that ISMA express its support for universal access to comprehensive, affordable, high-quality health care.

(RESOLUTION 22-55, BOT) RESOLVED, that ISMA support efforts to provide transportation opportunities for health care service needs (i.e., medical appointments, prescription pick-ups, and other daily needs) for all individuals without reliable transportation; and be it further
RESOLVED, that ISMA support efforts to further fund and aid in better publicizing and developing easy to use, accessible transportation services for all Hoosiers in need, such as Indiana 2-1-1 (IN211) and Thrive West Central; and be it further
RESOLVED, that ISMA support legislation that requires insurance companies to provide health plans that include easy to use, timely, and accessible medical transportation benefits for all patients in need.

(RESOLUTION 22-31) RESOLVED, that ISMA support and advocate for increased public health spending.

(RESOLUTION 22-17) RESOLVED, that the ISMA encourage health systems to adopt strategies to combat racism and implicit bias to address health disparities among their patient populations; and be it further
RESOLVED, that the ISMA encourage health systems to create and enact implicit bias protocols to support the promotion and retention of their minoritized workforce.

(RESOLUTION 22-16) RESOLVED, that ISMA adopt AMA Policy H-65.952; Racism as a Public Health Threat, as modified, as follows: ISMA

1. Acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Encourages health care institutions, physician practices and academic medical centers to implement current best practices to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. (a) Supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Supports and encourages efforts to combat the influences of racism and bias in innovative health technologies.

(RESOLUTION 21-70) RESOLVED, that the ISMA partner with the Indiana Department of Health, American Medical Association and the Centers for Disease Control and Prevention to expand the dialogue with vested parties to envision the threats to our state and nation, plan strategically for those threats and assess our resources and capabilities to respond to the potential epidemic or pandemic threats; and be it further
RESOLVED, that the ISMA delegation to the American Medical Association (AMA) carry forward to the AMA a resolution to work now with the scientific community, the ISMA and the Centers for Disease Control and Prevention to disseminate accurate information about infectious agents and epidemiology.

(RESOLUTION 24-39; AMENDED READOPTED RESOLUTION 19-27; RESOLUTION 9-67)
RESOLVED, that ISMA support the following principles regarding health care reform:

- Extending coverage to all Americans.
- Essential health insurance reforms that eliminate coverage denials based on pre-existing conditions.
- Medicare reforms that protect and enhance physician reimbursement.
- Chronic disease management and care coordination through additional funding for primary care services, without imposing offsetting payment reductions on specialty care.
- Addressing the growing physician workforce concerns.
- Prevention, wellness and patient responsibility initiatives designed to keep Americans healthy.
- The private practice of medicine on a fee-for-service basis within a pluralistic system of health care delivery.
- Medical liability reform (with the understanding that it will not adversely affect Indiana or other states effective tort reforms).
- Responsible physician investment in technology, facilities, services and equipment that results in high quality, efficient, effective health care.
- Physicians' voluntary participation in any health plan.
- Health reform that is meaningful, fair and sustainable.
- Reducing oppressive and arbitrary administrative regulations set by insurers and government agencies that compromise patients' safety and health.
- Health reform that includes improved responsiveness to physicians' concerns from insurance companies and government agencies.

RESOLVED, that the ISMA support a health insurance model that would provide unified, equitable financing to ensure affordable, comprehensive coverage and timely access to care for all Hoosiers.

(READOPTED AND AMENDED 18-19, HOD; RESOLUTION 08-32) RESOLVED, that the ISMA review and support, when appropriate, health care regulation to advance legitimate patient care, patient safety, or quality issues and oppose regulation that does not.

(RESOLUTION 15-24) RESOLVED, that the ISMA educate Indiana House and Senate budget committees on the need to significantly increase the budget for public health services, as well as educate the governor and legislators on the need to increase public health funding by rule and statute; and be it further
RESOLVED, that the ISMA encourage state leaders to redouble their efforts to collect more federal dollars for public health funding.

(READOPTED 15-14, HOD; RESOLUTION 05-16) RESOLVED, that the ISMA support patients' rights to choose their physicians and any proposed legislation supporting these principles.

(7/15/79, BOT) That the optimal patient-physician relationship is founded in freedom of choice and mutual responsibility--a relationship best achieved under a fee-for-service system for the delivery of medical services.

HEALTH PROFESSIONS BUREAU (PROFESSIONAL LICENSING AGENCY)/ LICENSING ISSUES

(READOPTED 23-64, HOD; RESOLUTION 13-28) RESOLVED, that the ISMA seek legislation requiring physician licensure in Indiana not be conditioned upon or related to physician participation in any public or private insurance plan, public health care system, public service initiative or emergency room coverage.

(READOPTED AND AMENDED 23-63, HOD; READOPTED 13-45, HOD; RESOLUTION 03-38) RESOLVED, that the ISMA continue to recognize the benefits of placing a psychiatrist on the Medical Licensing Board or Indiana; and be it further
RESOLVED, that the ISMA encourage the Medical Licensing Board (MLB) of Indiana to collaborate with the president of the Indiana Psychiatric Society when appointing a psychiatrist as a member of the MLB.

(RESOLUTION 23-60, BOT) RESOLVED, that the ISMA collaborate with the Indiana Professional Licensing Agency to require every licensed physician in Indiana (1) be notified within 30 days of any requested changes to their medical license including, but not limited to, addition or deletion of collaborative practice agreements with nonphysician practitioners, and (2) be capable of securely authorizing the changes; and be it further
RESOLVED, that the ISMA collaborate with the Indiana Professional Licensing Agency to provide a written physician licensure summary no less than 30 days from the license renewal date to every renewing physician; such a physician licensure summary shall include the current status of the license, any changes which occurred over the most recent renewal period, including any sanctions placed on the license (such as probation), and the collaborative practice agreements actively assigned to the physician license, noting all additions or deletions since the most recent license renewal; and be it further
RESOLVED, that the ISMA collaborate with the Indiana Professional Licensing Agency (1) to have procedures in place to verify the authenticity of collaborative practice agreements to protect physicians and patients from fraudulent delegation of medical authority to nonphysician practitioners (for example, notarized signatures for the initial agreement, or equivalent level of security for electronic submission), and (2) to maintain adequate records for a minimum of four years for all collaborative practice agreements such that if an unauthorized collaborative practice agreement is discovered the source of the submission can be traced.

(RESOLUTION 23-47) RESOLVED, that in the circumstance when a physician is relocating who was previously credentialed by an insurance company continue to be approved on a conditional basis by that company until the full process is completed.

(RESOLUTION 23-21) RESOLVED, that the ISMA work with the Indiana Medical Licensing Board to change the impairment screening question on the medical licensure application to read as follows:

> "Are you currently suffering from any ~~Do you have any~~ condition ~~or impairment~~ for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ~~*(including a history of alcohol or substance abuse)* the currently intereferes, or if left untreated may interfere, with your~~ ability to practice medicine in a competent, ethical, and professional manner?"

(RESOLUTION 23-19) RESOLVED, that the ISMA encourage all hospitals and health care facilities and other organizations involved in credentialing and/or privileging, to eliminate language in physician credentialing and/or privileging applications related to past mental health conditions and to include language, consistent with that recommended by the Federation of State Medical Boards, which reads "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)"; and be it further
RESOLVED, that the ISMA encourage medical specialty boards, hospitals and other organizations that grant credentials or privileges to do the following:

- Assure confidentiality of requested information.
- Limit requested information to only what is relevant to medical practice.
- Exclude information related to mental health services received during medical training;

and be it further

RESOLVED, that the Indiana delegation to the AMA support national efforts to ensure confidentiality of information included in credentialing and privileging applications; and be it further
RESOLVED, that the Indiana delegation to the AMA support national efforts to change requirements to disclose physical or mental conditions on credentialing and privileging applications to include only those which currently impair the physician's ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.

(RESOLUTION 22-67) RESOLVED, that ISMA seek legislation that any healthcare entity and insurer operating in the state of Indiana that requires board certification recognize physicians participating in and completing the requirements as set forth by National Board of Physicians and Surgeons (NBPAS) be considered "board certified" just as they would by the American Board of Medical Specialties (ABMS).

(RESOLUTION 22-04, BOT) RESOLVED, that the ISMA support increased funding for the Medical Licensing Board, by retaining a greater amount of its collected fees, to support the Medical Licensing Board having its own investigators.

(RESOLUTION 21-105) RESOLVED, that the ISMA Board of Trustees study the Interstate Medical Licensure Compact and, if appropriate, act on whether to support or oppose potential legislation proposing Indiana join the compact.

(RESOLUTION 21-102) RESOLVED, that the ISMA support legislation regulating tattooing and body piercing via the Professional Licensing Agency, in a manner similar to other such professions.

(RESOLUTION 21-99) RESOLVED, that the ISMA continue to offer the Attorney General's Office and other interested agencies volunteer physicians who can serve to render consultations to the agencies free of charge and in an expeditious manner.

(RESOLUTION 21-96) RESOLVED, that the ISMA seek, with the assistance of the Indiana Academy of Ophthalmology and the Indiana Society of Anesthesiology, to facilitate a discussion with the Medical Licensing Board of Indiana as to whether or not to retain or exclude from their rule regarding office-surgery retrobulbar and peribulbar anesthetic procedures when performed appropriately by board certified ophthalmologists.

(READOPTED AND AMENDED 21-89, HOD; READOPTED 10-20, HOD; RESOLUTION 00-48) RESOLVED, that the ISMA seek support from the governor and the legislature to adequately fund and improve the operation of the Indiana Professional Licensing Agency.

HEALTHY LIFESTYLES

(RESOLUTION 24-06) RESOLVED, that the ISMA support awareness of enhanced South Asian cardiovascular disease risk in Indiana.

(READOPTED 15-12, HOD; RESOLUTION 05-08) RESOLVED, that the ISMA develop further efforts to educate and encourage healthy lifestyles.

HEIMLICH MANEUVER

(4/9/80, EC) Supports the Heimlich Maneuver as an appropriate emergency procedure for choking victims.

HELMETS – BICYCLE/MOTORCYCLE

(READOPTED 18-28, HOD; READOPTED 08-14, HOD; RESOLUTION 98-04) RESOLVED, that the ISMA support legislation calling for mandatory use of bicycle helmets for minors and consider it mandatory for adults.

HIV

See: **COMMUNICABLE AND SEXUALLY TRANSMITTED DISEASES**

HMOs

(7/15/79, BOT) The ISMA in its support of pluralistic health care delivery systems recognizes freestanding, prepaid capitation programs as one form of delivery of medical services. The presence of such programs in a community may provide a choice to the individual patient under certain circumstances. However, an objective evaluation of all forms of medical care delivery systems can only exist in an atmosphere free of artificial restraints on or advantages to any one delivery system. Therefore, the ISMA strongly objects to federal subsidization, either fiscally or legislatively, of any one form of delivery system as being inconsistent with an objective analysis and supports the concept of neutral public policy and free market competition.

HOME DELIVERIES

(READOPTED 19-30, HOD; READOPTED 09-28, HOD; READOPTED 99-41, HOD; RESOLUTION 81-27) RESOLVED, that ISMA encourage the delivery of all pregnancies in a hospital or in those settings best suited to minimize the risk to the mother and infant.

(READOPTED 19-26, HOD; READOPTED 09-33, HOD; READOPTED 99-41, HOD; RESOLUTION 86-36) RESOLVED, that ISMA support continued enforcement of existing laws that prohibit midwifery by unlicensed or uncertified individuals.

HOSPITALS

(RESOLUTION 24-24A) RESOLVED, that the ISMA collaborate with relevant stakeholders to ensure:

(1) Adequate stocking of diverse lead apron sizes for all radiation-exposed personnel and medical trainees, and

(2) Consistent implementation of evidence-based radiation safety principles to keep exposure as low as reasonably achievable (ALARA) in accordance with specialty society guidelines, in order to promote optimal protection practices; and be it further

RESOLVED, that the ISMA delegation to the American Medical Association (AMA) carry forward this resolution to the AMA for consideration.

(RESOLUTION 24-14) RESOLVED, that the ISMA support legislation requiring health systems, hospitals, and clinics in Indiana to provide patients with itemized bills that clearly delineate charges for all services and supplies provided.

(RESOLUTION 23-43) RESOLVED, that the ISMA support the inclusion of high-quality nutritional patient instruction at discharge.

(RESOLUTION 23-02) RESOLVED, that the ISMA support a standard model to provide basic printed information on care provided and follow-up directions for in-patients upon discharge or soon thereafter; and be it further

RESOLVED, that ISMA encourage the Indiana Hospital Association to work with their members to encourage medical staffs to adopt a model providing meaningful discharge information to patients upon discharge.

(READOPTED 23-01, HOD; RESOLUTION 13-13) RESOLVED, that the ISMA, with other health and hospital groups, promote the importance of proper hand cleansing for all health care providers in order to reduce hospital-associated infections and deaths.

(READOPTED AND AMENDED 21-92, HOD; READOPTED 10-47, HOD; RESOLUTION 00-15) RESOLVED, that the ISMA support legislation to amend Indiana Code 16-22-2-2 to mandate or require active medical staff physician representation on the respective county hospital governing boards; and be it further,
RESOLVED, that any and all active medical staff physician members of county hospital governing boards not be contracted employees of their respective county hospitals, its governing board, or any of its public or privately developed corporations.

(RESOLUTION 16-37) RESOLVED, that the ISMA adopt policy similar to that of the AMA, reaffirming the rights of employed physicians, that includes:

- Every employed physician has a right to be treated with dignity and respect.
- The physician-patient relationship is sacred and should be preserved when possible, even when physicians leave a practice, group or facility. That is, both parties should be allowed to continue the professional relationship.
- Employed physicians, when they quit or are terminated, are entitled to their patients' addresses, phone numbers and the content of their medical record.
- Employed physicians' patients have a right to access information about their prior physician including their physicians' new locations and phone numbers.
- Employed physicians should be afforded adequate training so as to maintain skills, knowledge and competency.
- Employed physicians should receive a salary commensurate with their work effort and professionalism.
- Employed physicians should receive reasonable vacations and time on call. Excessive on-call time reduces productivity and physician satisfaction and increases the risk of medical error.
- Employed physicians should not be penalized for time off for pregnancy and child care; and be it further

RESOLVED, that the ISMA adopt policies, in addition to AMA policies, stating that:

- Employed physicians should not be penalized for the diminished productivity and utility of electronic medical records (EMR) and server inefficiencies. Employers should strive to acquire an efficient and fully functional EMR and, when possible, provide a scribe to help improve physician efficiency.
- Employed physicians have a right to their medical practice financial data and to their peers' comparison data, including ancillary income generated by the employed physician, as well as referral physicians. It is important for employed physicians to know their contribution to the financial health of their organization and/or medical facility.
- Employed physicians should not be subjected to non-compete clauses or contracts.

(RESOLUTION 16-26) RESOLVED, that the ISMA formally engage in discussions, at any promising level, with Indiana hospitals regarding the impact on physicians of federally mandated payment programs (e.g. MACRA); and be it further
RESOLVED, that the ISMA share current clinical research regarding trends in physician depression, burnout and suicide with Indiana hospitals as it becomes available (the AMA Steps Forward Program, for example), along with examples of "best efforts" to change or improve any harmful factors; and be it further
RESOLVED, that the ISMA explore a means for a representative group (e.g. our Board of Trustees or Executive Committee) to formally interact with Indiana hospitals in any future organizational structure of the ISMA. This would occur on at least a yearly basis to discuss physician practice options to help maintain/retain sufficient physicians to provide appropriate patient care in Indiana (e.g. promoting use of scribes, voice recognition software, more skilled medical staff). This should include open discussions on the financial implications (costs) of such choices and their impact on physician retention.

(RESOLUTION 16-01) RESOLVED, that ISMA policy and legislative efforts support physician-owned hospitals.

(2/15/95, EC) Approved the following policy relating to anti-trust laws covering hospitals:

- The state of Indiana should only grant two waivers (exempting certain hospitals from anti-trust laws).
- The state cannot provide an exemption unless they get a resolution from the medical staffs stating support for the merger.

- The EC would support future ISMA efforts to get state action exempted if such is deemed necessary by the ISMA. This support should be written to the ISMA Board of Trustees.

HOUSEHOLD SAFETY

(RESOLUTION 21-71) RESOLVED, that the ISMA support legislation that requires property owners, managers, and rental agencies to install and maintain carbon monoxide detectors in their existing residential properties that are fuel-burning, use fuel-burning appliances, or have attached garages; and be it further
RESOLVED, that the ISMA support public health initiatives that would increase awareness among patients and providers of the signs, symptoms, causes and prevention of carbon monoxide poisoning, in order to decrease the incidence of such poisonings in our state.

IMMUNIZATIONS

(RESOLUTION 21-100) RESOLVED, that the ISMA support legislation requiring employed childcare providers and health care workers of children less than 12 months of age to be vaccinated against pertussis, absent an objection on religious grounds or a determination by a physician that the vaccination would be detrimental to the person's health; and be it further
RESOLVED, that the ISMA support vaccination status of a facility's childcare providers and health care workers be available upon request; and be it further
RESOLVED, that the ISMA support pertussis vaccination for all childcare providers and family members.

(READOPTED 21-78, HOD; READOPTED 10-61, HOD; RESOLUTION 00-24) RESOLVED, that the ISMA support efforts, legislative, administrative and educational, that seek to ensure Indiana children receive all CDC-recommended vaccinations.

(READOPTED AND AMENDED 21-72, HOD; READOPTED 11-18, HOD; RESOLUTION 01-32) RESOLVED, that the ISMA use every means at its disposal to assure that all public and third-party payers reimburse for vaccinations recommended by the CDC; and be it further,
RESOLVED, that the ISMA identify third-party payers that fail to fully reimburse the cost of vaccinating patients; and be it further,
RESOLVED, that the ISMA use every means at its disposal to assure that physicians are properly reimbursed for the cost of procuring and the cost of administering vaccinations in addition to added equipment mandated for vaccine storage and administration; and be it further,
RESOLVED, that the ISMA use every means at its disposal to assure additional reimbursement for evaluations or treatments given on the same day as the vaccinations are administered.

(RESOLUTION 15-43) RESOLVED, that the ISMA support education and appropriate use of the Human Papillomavirus vaccines in both male and female individuals.

(READOPTED 15-16, HOD; RESOLUTION 05-23) RESOLVED, that ISMA staff work with the appropriate Indiana State Department of Health staff and the suppliers of vaccines to develop a plan for the distribution of vaccines in case another disaster occurs regarding availability, so that physicians will be involved in the provision of care to their patients.

INFANTS

(RESOLUTION 24-37) RESOLVED, that the ISMA opposes legislation granting "personhood" to a fetus as these laws lead to jeopardization of IVF care, criminalization of miscarriage, criminalization of substance use in pregnancy, and criminalization of self-managed abortion.

(RESOLUTION 21-13) RESOLVED, that ISMA support legislation and public health programs to improve medical and dental care in children by encouraging physicians to discuss medical and dental care with families

according to the recommendations of the American Dental Association, which encourages routine visits beginning with the emergence of the first tooth.

(RESOLUTION 19-12) RESOLVED, that ISMA seek to amend, either through legislation or rule, 410 Indiana Administrative Code 3-3-3.5 as follows:

- Identify or define special populations of infants who are admitted to the neonatal intensive care unit and/or who require oxygen in the first 48 hours of life;
- Modify the screening population either by allowing for exclusion of those special populations from testing at 24 to 48 hours of age or by including all infants in the screening program, but modifying the screening algorithm to account for those special populations; and
- Clarifying what constitutes a "cardiology evaluation."

(RESOLUTION 17-34) RESOLVED, that the ISMA seek and/or support legislation to expand the collection of all applicable data related to the identification and treatment of infants at risk for Neonatal Abstinence Syndrome (NAS) from all Indiana hospitals where such patients have been identified, with the information to be collected and submitted to the Indiana State Department of Health.

INCARCERATED PERSONS

(RESOLUTION 23-14) RESOLVED, that the ISMA support legislation that explicitly mandates access to sexually transmitted infection screening tests, not just physical exams, for incarcerated individuals.

(RESOLUTION 22-72) RESOLVED, that ISMA support legislation that improves access to comprehensive physical and behavioral health care services for juveniles and adults throughout the incarceration process from intake to re-entry into the community; and be it further
RESOLVED, that ISMA support legislation that removes barriers and increases access to social services and benefits apropos to the respective situations of incarcerated individuals and re-entering individuals, such as: (a) food subsidies; (b) health care, including Medicare and/or Medicaid; and (c) housing; and be it further
RESOLVED, that ISMA work with relevant stakeholders to create discharge planning and programs that connect re-entering individuals with primary care providers and medical homes within the community.

(RESOLUTION 22-23) RESOLVED, that ISMA recognize that disproportionate racial and ethnic disparities exist in policing, sentencing, and mass incarceration among Black, indigenous, and other people of color (BIPOC) and have devastating impacts on BIPOC communities.

(RESOLUTION 22-15) RESOLVED, that ISMA seek and support legislation that improves access to comprehensive re-productive and physical health care services to women throughout their incarceration from in-take to re-entry into the community; and be it further,
RESOLVED, that ISMA seek and support legislation that increases allocation of healthcare for women's prisons within the Indiana Department of Corrections and local county jails in Indiana.

(RESOLUTION 16-04) RESOLVED, that the ISMA actively support a coordinated drug and alcohol program funded by the state for treatment of inmates in local jails to help stop the current recycling of inmates who, upon release, return to their old habits of drug and alcohol use.
(RESOLUTION 15-31) RESOLVED, that the ISMA ask the AMA to study health care for incarcerated individuals and to identify the best health care models for local, state and federal facilities. Once this study is complete, the ISMA Board of Trustees shall determine which health care options for incarcerated persons are most practical for Indiana jails and prisons; and be it further
RESOLVED, that the ISMA advocate for improved health care of incarcerated individuals to the public, governor, legislature, Indiana Department of Correction, Indiana Sheriff's Association and other vested parties and individuals.

INSPECT

(READOPTED 22-94, HOD; RESOLUTION 12-48) RESOLVED, that the ISMA seek and support legislation that will adequately fund INSPECT.

(RESOLUTION 22-61) RESOLVED, the ISMA support INSPECT login security policy in line with current information technology standards.

(RESOLUTION 22-12) RESOLVED, that ISMA seek legislation to change the INSPECT program by adding an exemption from checking INSPECT before prescribing an opioid or benzodiazepine to a patient enrolled in hospice.

INSURANCE – CODING

(RESOLUTION 24-30) RESOLVED, that the ISMA delegation to the American Medical Association (AMA) support and/or move for the creation of a task force to submit an ICD-10-PCS code request to the Medicare Electronic Application Request Information System (MEARIS) for the creation of an ICD-10 code specifically designating counseling for firearm storage, as well as apply to the AMA CPT Editorial Panel for new Current Procedural Terminology (CPT) coding, which specifically encompasses the provision of Firearm Storage Counseling, its minimum requirements for qualification, and its reimbursement.

(READOPTED 22-95, HOD; READOPTED 12-51, HOD; RESOLUTION 02-24) RESOLVED, that the ISMA continue to confront unilateral code-collapsing and recoding practices by insurers; and be it further,
RESOLVED, that the ISMA request that Anthem no longer require physicians to sign a contract that permits Anthem to reassign and rebundle CPT codes.

(RESOLUTION 21-95) RESOLVED, that the ISMA support the correct use of AMA CPT guidelines for coding and payment by payers.

INSURANCE – COVERAGE

(RESOLUTION 24-55) RESOLVED, that the ISMA support the development of new incentive programs by innovators, public and private payers, and other health care stakeholders to encourage patients to adopt wearable and at-home health monitoring technologies for the purpose of increasing preventive care and reducing the chronic disease burden for Hoosiers; and be it further
RESOLVED, that the ISMA support legislation that includes health monitoring technologies as reimbursable expenses under health insurance plans to reduce the financial burden on individuals and encourage widespread adoption.

(RESOLUTION 24-25) RESOLVED, that the ISMA support legislation to require that insurers cover gender-affirming care, including care in the case of detransition.

(RESOLUTION 24-22) RESOLVED, that the ISMA support the Indiana Behavioral Health Commission's recommendation for Indiana to implement legislation modeled after "Timothy's Law" to further promote accessibility of mental health resources for communities across Indiana.

(READOPTED 22-97, HOD; READOPTED 12-53, HOD; RESOLUTION 02-31) RESOLVED, that the ISMA use whatever means possible to encourage and/or require third-party payers to notify physicians and insurees of services or diagnoses that will not be covered by their plans prior to membership or participation in said plans; and be it further,
RESOLVED, that third-party payers be required to make available to physicians and insurees a list of all services that will not be covered by their plans. This list should be available prior to membership or participation in said plans. Physicians and insurees should be notified immediately of any changes; and be it further,
RESOLVED, that physicians shall not be prohibited from collecting from patients for non-covered services.

(RESOLUTION 22-51) RESOLVED, that ISMA support legislation to reduce out-of-pocket cost and improve insurance coverage of hearing assistive devices for the general adult population of Indiana.

(RESOLUTION 22-48) RESOLVED, that ISMA support legislation requiring insurers to provide comprehensive coverage for colorectal cancer screening and all related costs, including bowel preparation kit, anesthesiology, and pathology services.

(RESOLUTION 22-45) RESOLVED, that ISMA support legislation requiring insurers to provide full coverage for follow-up colonoscopies after polypectomy as recommended by the most recent consensus statement by the U.S. Multi-System Task Force on Colorectal Cancer.

(RESOLUTION 21-87) RESOLVED, that the ISMA support state legislation requiring: An employer to have a 30-day time limit to notify an insurance company/network that an employee is no longer eligible under their medical plan; a health plan to enter the non-eligibility of the employee within 10 days of notification from the employer, enabling the provider to verify coverage before services are rendered.

(RESOLUTION 21-86) RESOLVED, that if a reasonable pattern of requesting and obtaining prior authorizations can be confirmed, the ISMA seek and/or support any and all efforts, including legislative efforts if necessary, to mandate that care provided in good faith by physicians or other providers CANNOT be denied SOLELY on the basis of failure to have an authorization. Full consideration of medical necessity and appropriateness of services provided MUST be factored into any denial decision; and be it further,
RESOLVED, that this resolution be carried forward by the ISMA delegation to the AMA.

(READOPTED AND AMENDED 21-73, HOD; READOPTED 10-56, HOD; RESOLUTION 00-22) RESOLVED, that the ISMA support efforts by the Indiana Legislative Commission on Autism, the Indiana Resource Center for Autism and other appropriate agencies in their efforts to legislate health care insurance for autistic children and diagnosed developmental delays; and be it further,
RESOLVED, that the ISMA encourage and support appropriate state agencies, advocates and legislators in their efforts to extend legislated health care insurance coverage for treatment of children with autism spectrum disorders and diagnosed developmental delays to all state and federally regulated health insurance programs.

(RESOLUTION 19-03) RESOLVED, that ISMA support legislation to mandate parity of coverage for mental illness and substance use disorders; and be it further
RESOLVED that ISMA support legislation to provide increased state-level accountability and enforcement of the Mental Health Parity and Addiction Equity Act.

(RESOLUTION 18-45) RESOLVED, that ISMA encourage Indiana Medicaid, the Healthy Indiana Plan and commercial insurance providers to revise their policies on hepatitis C treatment such that they allow treatment of F0 or at least F1 cases; and be it further
RESOLVED, that ISMA promote education of Indiana's population about the risk factors for and the consequences of untreated hepatitis C, as well as encourage aggressive screening of those with increased risk.

(RESOLUTION 18-02) RESOLVED, that ISMA seek legislation that requires insurance companies to cover weight-loss management without regard to co-morbid conditions, including appropriate laboratory testing, nutritional counseling and dietary education by dietitians or licensed health care providers, office visits for weight loss and coverage of prescription medications indicated for weight-loss management.

(RESOLUTION 18-01) RESOLVED, that ISMA seek legislation that requires any health care entity providing health insurance coverage to always provide an alternative list of covered same class or similar medications upon denying any prescribed medication.

(RESOLUTION 17-30) RESOLVED, that ISMA support medical competency at health-plan medical-director levels by defining and creating policy that coverage decisions are indeed the practice of medicine and, therefore, subject to all laws and regulations attached to that designation; and be it further

RESOLVED, ISMA seek legislation that requires health-plan medical directors to be physicians with a broad knowledge of medical services, or a physician of the same specialty as the requesting physician (when feasible) to make care determinations impacting patients and practicing physicians.

(RESOLUTION 17-25) RESOLVED, that consistent with AMA Policy H-185.931 *Coverage for Chronic Pain Management*, ISMA advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician-led, and recognize the interdependency of treatment methods in addressing chronic pain; and be it further
RESOLVED, that ISMA advocate for private and government-sponsored health plans that provide coverage that gives patients access to the full range of evidence-based chronic pain-management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits; and be it further
RESOLVED, that ISMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process; and be it further
RESOLVED, that ISMA seek legislation to require health insurers and government-sponsored plans to cover the full range of physician-led, evidence-based chronic pain management modalities at a level commensurate to other medical or surgical benefits.

(RESOLUTION 16-17) RESOLVED, that the ISMA support adoption of the AMA model legislation "Ensuring Transparency in Prior Authorization Act."

(RESOLUTION 15-39) RESOLVED, that the ISMA support and engage in state legislation that will improve step therapy protocols by ensuring they are safe for patients, clinically grounded and transparent to patients and health care providers. State legislation should: 1) ensure step therapy programs are based on clinical guidelines developed by independent clinical experts, 2) ensure the exceptions process for step therapy is transparent and accessible for patient and health care providers, and 3) establish a basic framework for when it is medically appropriate to exempt patients from step therapy.

(RESOLUTION 15-32) RESOLVED, that the ISMA support and engage in legislation requiring counties to provide adequate insurance for public health medical liability for county health officers that would cover the expanded scope of health officers' orders, policies and services where necessary.

(11/19/78, BOT) Reaffirmed the necessity of working for the development of a catastrophic insurance program in the private sector that would be available to all citizens of the state of Indiana and to take the lead in publicizing this program and assuring coverage.

INSURANCE - PATIENT/PHYSICIAN PROTECTIONS

(RESOLUTION 21-84) RESOLVED, that ISMA continue to support protecting patients from surprise bills, so they are responsible only for their in-network cost-sharing amounts, including deductibles, when receiving unanticipated medical care; and be it further
RESOLVED, that ISMA seek the addition of a statutory mechanism by which out-of-network physicians can challenge the payments they receive from insurers for their services, to ensure they receive a fair and reasonable amount; and be it further
RESOLVED, that a statutory mechanism for out-of-network physicians to challenge payments received from insurers should ideally consist of an independent dispute resolution (IDR) process in which:

1. Claims of any amount are eligible for submission, to maximize accessibility, and batching of claims is allowed, to maximize administrative efficiency.
2. The physician and the insurer submit information regarding the amount that should be paid for a service.
3. An independent arbiter determines the most reasonable proposal and makes a determination within 30 days.

4. The arbiter may consider a number of factors when determining which proposed payment is most reasonable, including:
    a. rates for comparable services in the same geographic region that are considered reasonable based on commercial insurance rates from an independent and transparent database of all commercial payer claims data;
    b. any previous contracting history;
    c. demonstration of good-faith efforts (or lack thereof) made by either party (i.e., the out-of-network provider or the health plan) to enter into network contracts;
    d. market share held by the out-of-network health care provider or the health plan;
    e. level of training, education, experience, outcomes, and quality metrics of the physician providing the service;
    f. complexity of the services rendered;
    g. individual patient characteristics; and
    h. any additional relevant factors contributed by either party.
5. The party whose proposal was not selected is liable for the cost of the arbitration.
6. The arbiter's decision is final and binding on all parties;

and be it further
RESOLVED, that ISMA support legislation that would prohibit hospitals and facilities from advertising in-network status with a particular health plan unless all the physicians and providers within that facility are in-network with the same health plan; and be it further
RESOLVED, that the patient should be entirely removed from the independent dispute resolution process by allowing out-of-network physicians to bill the patient's insurance company directly and requiring the insurance company to pay the out-of-network physician directly.

(RESOLUTION 21-83) RESOLVED, that ISMA adopt the AMA's Price Transparency Policy D-155.987, which "encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible"; and be it further
RESOLVED, that ISMA support payment reform to increase payment to physicians by basing it on the service provided and not the location in which the service is provided (or "site neutral" payments); and be it further
RESOLVED, that ISMA support legislation to enact the AMA's "Hospital Self-Referral Disclosure and Communications Act" to ensure that hospitals may not prohibit, interfere with or in any way limit or restrict a referring health care provider's communications with a patient or patient representative concerning any service, provider, facility or entity that may provide items or services that are the subject of a referral, regardless of whether that service, provider, facility or entity is in any way owned, or controlled, by the hospital.

INSURANCE – REIMBURSEMENT

(RESOLUTION 24-51) RESOLVED, that the ISMA support legislation to require all payors to use one payment denial appeal process that includes external review for all Medicare plans, regardless of whether the physician or provider has a contract with the payor; and be it further,
RESOLVED, that the ISMA delegation to the American Medical Association (AMA) carry forward a resolution to the AMA to seek legislation to require all payors, including Medicare Advantage plans, to use one payment denial appeal process, that includes external review, for all Medicare plans regardless of whether the physician or provider has a contract with the payor.

(RESOLUTION 24-49) RESOLVED, that the ISMA support the Indiana Chapter of the American College of Emergency Physicians in their legislative or regulatory efforts to ensure payment for emergency medical services are reimbursed based on the actual services provided, including reforming the prudent layperson review process and the state autopay list.

(READOPTED 23-65, HOD; RESOLUTION 13-14) RESOLVED, that the ISMA delegation to the AMA present a resolution to the AMA that seeks federal legislation requiring full insurance coverage for ALL eating disorders, including inpatient and outpatient care, as well as maintenance care.

(RESOLUTION 23-20) RESOLVED, that the ISMA support legislation for payment of interpretation services.

(READOPTED 22-98, HOD; READOPTED 12-54, HOD; RESOLUTION 02-33) RESOLVED, that the ISMA seek and support legislation that would prevent health insurance companies, health maintenance organizations and third-party administrators (payers) from denying reimbursement for services that are covered services eligible for reimbursement under the patient's health benefit plan solely on the basis that administrative rules of the payer were not followed.

(READOPTED 22-96, HOD; READOPTED 12-52, HOD; RESOLUTION 02-26) RESOLVED, that the ISMA acts to make it mandatory for all insurance companies to send payments to the physician once the patient assigns benefits, whether or not the doctor is a preferred provider in the insurance plan.

(READOPTED 22-90, HOD; RESOLUTION 12-29) RESOLVED, that the ISMA seek legislation requiring that all health insurance companies, HMOs and health plans provide physicians, as part of their proposed and final network agreements, all relevant fee schedules; and be it further,
RESOLVED, that the ISMA seek legislation requiring that all health insurance companies, HMOs and health plans make their entire fee schedules accessible upon formal written request to all providers in an electronic usable format.

(READOPTED 22-86, HOD; RESOLUTION 12-22) RESOLVED, that the ISMA seek legislative and/or regulatory reform that requires equal enforcement of the "Indiana Prompt Pay Act," closing the loopholes that allow ERISA plans and companies that are self-insured to escape enforcement to the financial detriment of health care providers.

(RESOLUTION 22-66) RESOLVED, that ISMA support legislation to enforce a minimum cost of living increase from private health insurance companies to small group practices on a yearly basis. If small group practices have not received an increase in payments over the last five years, then for the first year, the cost of living increase will be adjusted to include the last five years (2017 - 2021) or 13.4%.

(RESOLUTION 22-63) RESOLVED, that ISMA support legislation that would prohibit any private health care payer from sending a v-pay credit card number in lieu of an EFT, ACH or check without first obtaining written permission from the health care provider or group administrator, including significant fines for noncompliance; and be it further
RESOLVED, that ISMA support legislation that would forbid private health insurance companies from charging providers fees for providing reimbursement by paper checks, electronic funds transfers (EFT) or automated clearing house (ACH) payments.

(RESOLUTION 21-93) RESOLVED, that the ISMA work with the legislature to support laws for payment of services rendered with penalties to insurance companies for improper denials, including but not restricted to denials based on multiple physician visits on the same day.

(RESOLUTION 21-91) RESOLVED, that the ISMA formally take measures to have the insurance industry reimburse physicians for services rendered, as it relates to excessive time spent obtaining prior authorizations.

(RESOLUTION 21-43) RESOLVED, that the ISMA support initiatives to educate physicians and medical students on the appropriate use of medical interpreters; and be it further
RESOLVED, that ISMA encourage the use of qualified interpreters as a primary resource for patients with limited English proficiency, when available, instead of untrained staff or a patient's family members and friends; and be it further
RESOLVED, that the ISMA encourage policy to fairly reimburse medical providers for the use of qualified medical interpreters for patients with limited English proficiency or who have hearing impairment.

(RESOLUTION 18-41) RESOLVED, that the ISMA House of Delegates adopt policy that Indiana physicians should be compensated for reviewing and responding to new after-hour patient messages; and be it further RESOLVED, the ISMA House of Delegates consider referring Resolution 18-41 to the American Medical Association House of Delegates for its consideration.

(RESOLUTION 17-31) RESOLVED, that ISMA promote the appropriate use of prior authorization primarily for initial requests and services that fall outside the standard of care; and be it further
RESOLVED, that ISMA implement and promote policy that minimizes the need for prior authorization annually or on any other schedule when the request is for continuity of care and the prior authorization is for regimens that are working well to control a patient's condition; and be it further
RESOLVED, the ISMA create a policy that prior authorizations need to be completed within three working days by the health plan or pharmacy if approved, or if the prior authorization is denied, the denial must include an explanation, unique and specific to the individual patient, and, if no answer is obtained within three days, the prior authorization is deemed approved and patient care may proceed; and be it further
RESOLVED, that ISMA create a policy for the prior authorization process that, unless a health plan, pharmacy vendor or other payer source can document that medical care or a specific service or pharmaceutical is NOT appropriate or medically-indicated based on nationally recognized evidence-based guidelines, the health plan, pharmacy vendor or other payer source shall approve the request of the attending physician; and be it further
RESOLVED, that ISMA schedule quarterly meetings with insurance companies to discuss any prior authorization issues, as well as any other matters pertinent to physicians and patients; and be it further
RESOLVED, that ISMA support any effort to allow the physician to bill the insurance company directly for prior authorization time, and that the cost not be a pass-through charge to the patient; and be it further
RESOLVED, that the ISMA-AMA Delegation take this resolution to the AMA meeting for consideration and advocacy action both by administrative and/or legislative means; and be it further
RESOLVED, that the ISMA and the AMA work to address the problem of excessive burden from prior authorizations and meaningful use regulations by regulatory and/or legislative means; and be it further
RESOLVED, that the AMA delegation from the ISMA take the information to the AMA that Medicare Advantage plans follow Medicare guidelines if the plan chooses to follow their own guidelines. The plan must be transparent on the criteria for approval or denial.

(RESOLUTION 15-27) RESOLVED, that the ISMA support state legislation requiring insurance companies to reimburse providers for services provided during the ACA insured's grace period; and be it further
RESOLVED, that our AMA delegation take Resolution 15-27 to the AMA for consideration if they do not have this policy currently or if federal law changes are necessary to eliminate the abuse.

(RESOLUTION 15-23) RESOLVED, that the ISMA seek administrative rule or legislation that would require fair reimbursement for vaccines and administration for all health care providers in Indiana. This administrative rule or legislation would:

- Address the inadequate and timely reimbursement relative to the purchase price of vaccines as reflected on the updated CDC vaccine price website at: www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm.
- Mandate health plans and insurance company payment to private sector physicians and all mid-level providers of current ASP (Average Sales Price), PLUS adjusted quarterly and retro back to date of price change.
- Mandate vaccine payments to the above providers for vaccine administration at a standardized rate (cost PLUS).

(RESOLUTION 15-22) RESOLVED, that ISMA seek legislation to allow a medical practice to opt in or out, in writing, on the use of virtual credit cards before insurers can use them; and be it further
RESOLVED, that legislation sought by the ISMA include a provision that insurers cannot penalize a medical practice for opting out of accepting virtual credits cards as payment.

(READOPTED 15-18, HOD; RESOLUTION 05-05) RESOLVED, that the ISMA House of Delegates encourage the Indiana General Assembly to assist the physicians of Indiana by enacting assignment of benefits legislation.

(READOPTED 15-15, HOD; RESOLUTION 05-56) RESOLVED, that the ISMA work with the Indiana Academy of Family Physicians to enact state legislation making complete payer fee schedules and reimbursement practices readily available.

INTERNET MEDICINE

(RESOLUTION 22-74) RESOLVED, that ISMA encourage the placement of virtual healthcare devices in rural clinics, hospitals, and EMS as a means of reducing the burden of access to special-ty healthcare in rural communities; and be it further
RESOLVED, that ISMA encourage initiatives promoting the implementation of medical devices, such as videoconferencing software, high-definition cameras, stethoscopes, otoscopes, and ophthalmoscopes compatible with medical video conferencing software.

(RESOLUTION 22-65) RESOLVED, that ISMA support legislation that would reduce the cost to build interfaces between large health care groups, laboratory and imaging facilities, and small physician practices.

(RESOLUTION 21-74) RESOLVED, that the ISMA support legislation increasing access to the internet, especially in underserved and rural areas; and be it further
RESOLVED, that the ISMA support legislation that increases quality of internet speed and reliability, especially in underserved and rural areas; and be it further
RESOLVED, that the ISMA support legislation ensuring that learners at all levels of the education system have access to fast, reliable internet.

(RESOLUTION 21-40) RESOLVED, that the ISMA support increased access to internet services at low or no cost across all Indiana communities; and be it further
RESOLVED, that the ISMA support efforts to develop infrastructure that provides Internet access for health care and other vital services to 99% of all Hoosiers within five years; and be it further
RESOLVED, that the ISMA support continued expansion of telemedicine services and reimbursement outlined in public health policy initiated during the COVID-19 federal and state health emergency.

(RESOLUTION 19-05) RESOLVED, that ISMA support the following exemptions to any future e-prescribing mandate at the state level:

- Physicians who write no more than 100 applicable prescriptions per year.
- Locum tenens physicians or physicians practicing in a location other than their primary office on a temporary basis.
- If the physician determines that it is in the best interest of the patient, or the patient requests a written prescription, to compare prescription drug prices among area pharmacies and documents such in the medical record.
- If the physician reasonably determines that it would be impractical for the patient to obtain an electronic prescription in a timely manner and such delay would adversely affect the patient's medical condition.
- Physicians who do not utilize electronic medical records.
- Compounded prescriptions.
- Prescriptions with directions longer than 140 characters.
- Physicians who are volunteering or providing uncompensated care.

LASERS

(RESOLUTION 21-50) RESOLVED, that ophthalmologic laser surgery should only be performed by physicians licensed to practice medicine and trained to perform ophthalmologic surgical procedures; and be it further
RESOLVED, that ISMA oppose legislation that would allow any nonphysician to perform ophthalmology laser surgery.

(RESOLUTION 18-22) RESOLVED, that ISMA support enforcement of existing regulations to:

1. Require accurate labeling of any laser pointers sold in Indiana according to Department of Energy/Food and Drug Administration guidelines.
2. Require that this labeling indicate an accurate measurement of the average power output of the laser pointer, appropriate laser classification (CLASS 3R), and a warning of potential risk for permanent ocular injury and vision loss; and be it further

RESOLVED, that ISMA seek legislation to prohibit the sales of laser pointers to persons 17 years of age or younger, unless accompanied and supervised by a parent, legal guardian or any other adult 18 years of age or older; and be it further

RESOLVED, that ISMA seek modification of current Indiana statute IC 35-47-4.5 to prohibit anyone from shining, pointing or focusing a laser pointer, directly or indirectly, upon or at another person in a manner that can reasonably be expected to cause harassment, annoyance or fear of injury to such other person.

LGBTQ+

(RESOLUTION 23-57) RESOLVED, that the ISMA encourage its members to use gender-neutral language when preferred by patients to better care for individuals excluded by gender-specific language.

(RESOLUTION 22-28) RESOLVED, that ISMA support legislation that would ban use of the LGBTQ+ panic defense in Indiana.

MATERNAL AND INFANT MORTALITY

(RESOLUTION 21-34) RESOLVED, that the ISMA support initiatives to implement perinatal nurse navigators in rural counties in Indiana; and be it further

RESOLVED, that the ISMA commend the work of perinatal navigators and other staff currently working so diligently to decrease the infant mortality rate in Indiana.

(RESOLUTION 15-45) RESOLVED, that the ISMA actively support efforts of the Indiana State Department of Health, the Indiana chapters of ACOG, AAP, AAFP and others to reduce preventable premature births in Indiana through the promotion of:

- Screening of all pregnant women for risk of premature delivery by obtaining:
  - A history of a prior premature delivery, and
  - Cervical length measurement for pregnant women at risk, and
- Timely use of progesterone in all appropriate pregnant women; and be it further

RESOLVED, that the ISMA support all efforts to reduce financial and administrative barriers to the appropriate use of progesterone in pregnant women.

MEDICAID

(RESOLUTION 24-04) RESOLVED, that the ISMA support legislation in Indiana that allows Legally Responsible Individuals (LRIs) to provide attendant care to their waiver-recipient via the Medicaid waiver; and be it further

RESOLVED, that the ISMA support legislation on expanding access to the Medicaid waiver for qualifying people, improving transparency regarding access to services provided by the Medicaid waiver and the waitlist time for the Medicaid waiver, and increasing efforts to recruit and retain qualified home health aids, non-Legally Responsible Individuals (LRI) attendants, and individuals to provide nursing services.

(READOPTED 22-99, HOD; READOPTED 12-56, HOD; RESOLUTION 02-42) RESOLVED, that the ISMA seek through any means available to have the Office of Medicaid Policy and Planning rescind the revised crossover claims methodology to more appropriately reimburse physicians for services provided.

(RESOLUTION 22-13) RESOLVED, that ISMA join the AMA in opposing Medicaid lockouts, which disenroll Hoosiers and prevent re-enrollment for a six-month timeframe following missed premium payments; and be it further

RESOLVED, that ISMA call on the FSSA to better communicate any changes to Healthy Indiana Plan concerning the end of the COVID-19 Public Health Emergency, including communicating in languages other than English and using multiple forms of communication.

(RESOLUTION 21-88) RESOLVED, that ISMA policy is to increase Medicaid reimbursement to at least 100% of the greater of the Medicare reimbursement formula as of July 1, 2010, or the current level of reimbursement.

(RESOLUTION 19-10) RESOLVED, that ISMA encourage and support legislation to facilitate access to care in Indiana and to provide fee schedule parity for physicians who treat patients through Medicaid and Hoosier Healthwise plans to match Healthy Indiana Plan (HIP) 2.0 commensurate with Medicare.

(RESOLUTION 18-38) RESOLVED, that ISMA support, if introduced, or seek an author for, if needed, state legislation to promote the same concepts of HEA 1143 (P.L.77-2018) and apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- Listing services that require a PA on a website.
- Notifying providers of any changes at least 45 days prior to change.
- Standardizing a PA request form.
- Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.
- Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans in the 2019 long session;

and be it further
RESOLVED, that ISMA request additional components in state legislation to promote the same concepts of HEA 1143 (P.L. 77-2018) and apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

- Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.
- Minimizing PA requirements as much as possible within each plan.
- Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider;

and be it further
RESOLVED, that ISMA take Resolution 18-38 to the AMA to be applied to Medicare Advantage plans at the federal level.

(RESOLUTION 18-14) RESOLVED, that ISMA seek state legislation creating a pilot allowing Medicaid patients and/or state employees to use direct primary care (DPC) practices without typical regulation from Medicaid or the state of Indiana, to see if it can reduce state health care spending.

(RESOLUTION 18-13) RESOLVED, that ISMA work with the AMA to seek federal changes to the Internal Revenue Code allowing health savings accounts to be used with direct primary care (DPC).

(RESOLUTION 17-05) RESOLVED, that the ISMA delegation to the AMA encourage the AMA to adopt policy that exempts self-employed small practices, defined as solo practitioners up to five physician providers, from the burdensome regulation of the merit-based incentive payment system (MIPS).

(RESOLUTION 17-02) RESOLVED, that ISMA petition the secretary of the Indiana Family and Social Services Administration and the commissioner of the Indiana Department of Insurance to require Medicaid and insurance companies to provide and compensate providers' offices for one nurse-education visit in the early second trimester of pregnancy and one nurse-education visit in the early third trimester of pregnancy to discuss signs and symptoms of preterm labor, preterm premature rupture of membranes, incompetent cervix and the dangers to an infant of low or very low birth weight. Reimbursement would be in addition to the global prenatal care reimbursement.

(RESOLUTION 16-41) RESOLVED, that the ISMA seek state legislation creating a mechanism to allow Medicaid patients to use Direct Primary Care (DPC) practices; and be it further
RESOLVED, that the ISMA seek state legislation defining DPC to be outside the scope of state insurance regulation; and be it further
RESOLVED, that the ISMA work with the AMA to seek federal changes to Internal Revenue Code 213(d) and 223(c) allowing health savings accounts to be used with Direct Primary Care, and allowing payments to DPC physicians to be considered a "qualified medical expense."

(RESOLUTION 16-09) RESOLVED, that the ISMA encourage the AMA to support an exemption from MIPS and MACRA for small practices since these rules will hasten the demise of small private practice in the U.S.

(RESOLUTION 15-38) RESOLVED, the ISMA advocate that the Office of Medicaid Policy and Planning pay for the medication-assisted treatment of nicotine-use disorders beyond three months in a 12-month period.

(1/17/93, BOT) Approved the following report, as amended, from the ISMA Medicaid Reform Task Force:
A case management system should be implemented, including co-payments and deductibility of co-payments from other state support payments to the patient, if the patient fails to comply with co-payment requirements. Optional benefits should be reduced and a basic benefits package should be provided. The Health Professions Bureau (HPB) should be responsible for investigating fraud and abuse in the Medicaid program, and funding should be provided to the HPB to undertake these activities. The proposals here should be financed with an income tax increase, a sin tax on alcohol and cigarettes, eliminating the scheduled physician payment increase, and implementation of an RBRVS reimbursement schedule for Medicaid.

MEDICAL EDUCATION

(RESOLUTION 24-09) RESOLVED, that the ISMA seek legislation for the implementation of a preceptor tax incentive program for preceptors residing in the state of Indiana, through legislation or addition to rules and regulations.

(RESOLUTION 23-33) RESOLVED, that the ISMA support CME programming for courses including but not limited to:

- Assessing, understanding, and applying biomedical and other data in the care of patients.
- Integration of artificial intelligence in the clinic.
- Recognition of bias and critical appraisal of AI output.
- Ethical issues to consider when using AI.

(RESOLUTION 22-68) RESOLVED that ISMA support AMA Policy H-135.919 "Climate Change Education Across the Medical Education Continuum."

(RESOLUTION 22-58) RESOLVED, that ISMA support initiatives of the AMA and other entities that increase exposure to dermatological conditions in skin of color during medical education and residency; and be it further
RESOLVED, that ISMA support efforts that increase the representation of diverse skin tones in physical exam teaching as well as images included in medical education teaching materials, which would thereby better reflect the demographics of patients throughout the state; and be it further
RESOLVED, that ISMA support the implementation of guidelines within medical education to provide an education that allows for the accurate diagnosis of a variety of conditions that may manifest on the integumentary system in a variety of patient populations.

(RESOLUTION 21-54) RESOLVED, that the ISMA regularly communicate with both Indiana University School of Medicine and Marian University College of Osteopathic Medicine about student needs and scholarship opportunities and assist the schools by informing the ISMA membership of such opportunities for individual financial support and participation as a means for easing part of the student debt load facing our medical students; and be it further

RESOLVED, that the ISMA continue to support Indiana University School of Medicine and its regional medical campuses and Marian University College of Osteopathic Medicine through continued personal participation, local legislative contact for adequate funding, and patient contact to improve community awareness of the need for adequate state funding to ensure high-quality medical education and physicians to care for Indiana citizens, now and into the future.

(RESOLUTION 21-46) RESOLVED, that the ISMA encourage that the education of health care trainees include cultural competency, gender-affirming care and physical health needs for lesbian, gay, bisexual, transgender, queer, asexual, intersex and other gender minority populations (LGBTQAI+); and be it further
RESOLVED, that the ISMA oppose any action taken by the Indiana legislature, Indiana hospital boards or other health policy entities to remove protections for transgender patients in health care.

(RESOLUTION 21-41) RESOLVED, that the ISMA encourage the expansion of rural education and rural medical exposure for all Indiana medical students.

(RESOLUTION 21-07) RESOLVED, that ISMA support legislation that prohibits the use of the terms "residency," "resident," "fellowship," and "fellow" by midlevel health care providers or postgraduate training programs in which they are enrolled because it creates a false equivalence between their training and physician expertise in a specific field of medicine, and because these terms have clear historical significance and are well known to the layperson as referring to an ACGME accredited residency or fellowship program, their participants or physicians who have completed them; and be it further
RESOLVED, that the ISMA adopt a position and advocate that advertisements for postgraduate training programs for midlevel health care providers must make clear that such programs are structured to train midlevel providers to work as part of a physician-led health care team and not imply that these programs are providing the skills to work independently of a physician; and be it further
RESOLVED, that the ISMA adopt a position that midlevel health care providers enrolled in postgraduate training programs should not be paid at a higher level than PGY-1 residents at the same institution, in order to accurately reflect the value that each provides; and be it further
RESOLVED, that the ISMA engage with appropriate stakeholders on ensuring that postgraduate training programs for midlevel health care providers will not compromise the training of residents or fellows in any way, including by reducing the number of their patient encounters, the procedures they perform or any other learning opportunities.

(RESOLUTION 19-34) RESOLVED, that ISMA work with our AMA and ask the Federation of State Medical Boards (FSMB)/United States Medical Licensing Examination (USMLE) to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to help avoid unnecessary expenses; and be it further
RESOLVED, that ISMA and the American Osteopathic Association (AOA) ask the National Board of Osteopathic Medical Examiners (NBOME) to reduce the cost of the COMLEX Level 2 PE exam and allow medical students to take this exam locally to help avoid unnecessary expenses.

(RESOLUTION 19-24) RESOLVED, that ISMA help seek continued expansion and additional funding from the Indiana General Assembly for graduate medical education as directed by the Indiana Commission for Higher Education; and be it further
RESOLVED, that ISMA request our AMA delegation to confirm/verify that AMA Policy D-305.967 is being followed.

(RESOLUTION 18-50) RESOLVED, that ISMA support efforts to have physicians and/or their staffs, including nurse practitioners, physician assistants and nurses, review advance care directives (ACDs) with each active patient once a year; and be it further
RESOLVED, that ISMA support health care partners in developing educational programs for medical students, residents and physicians to better prepare them to discuss advance care directives (ACDs) in their future careers.

(RESOLUTION 16-11) RESOLVED, that the ISMA support mandatory domestic violence curriculum in residency programs educating physicians to identify, screen and counsel patients who may be victims of such violence.

(RESOLUTION 16-05) RESOLVED, that the ISMA collaborate with all stakeholders in identifying opportunities for improvement in the education of Indiana practitioners in prescribing opioids.

(RESOLUTION 15-50) RESOLVED, that the ISMA explore developing a responsible prescribing program through continuing medical education focused on the responsible prescribing of controlled substances.

(RESOLUTION 15-08) RESOLVED, that our ISMA request the AMA develop a national campaign to educate the public on the definition and importance of Graduate Medical Education, student debt and the state of the medical profession today and in the future; and be it further
RESOLVED, that the ISMA continue to support and facilitate postgraduate medical education and CME in Indiana and help educate the Indiana public on the long-term economic and health benefits.

(3/5/00, BOT) The ISMA opposes the establishment in Indiana of any medical education facility that seeks to provide instruction leading to a medical doctor (M.D.) or doctor of osteopathy (D.O.) degree if the facility is not accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA).

(7/10/85, EC) Approved the Commission on Medical Education's recommendation to delegate provider responsibility to the ISMA Section on Directors of Medical Education/Association of Indiana Directors of Medical Education (AIDME). (The ISMA is the accrediting body for all intrastate institutions and organizations.)

(11/23/80, BOT) The ISMA supports federal grants for the IU School of Medicine and opposes any abrupt withdrawal of federal funds to medical schools.

(6/12/77, BOT) The ISMA will encourage CME on a voluntary basis and voice objection to CME being made a requirement for membership in the ISMA, as well as CME being made mandatory for relicensure and re-registration.

MEDICAL LIABILITY ISSUES

(8/2/92, BOT) Expressed the opinion that it is not unreasonable for a hospital medical staff to have, as a condition of medical staff privileges, that an Indiana physician is a "qualified health care provider" under Indiana's Medical Malpractice Act.

MEDICAL MARIJUANA

(RESOLUTION 22-24) RESOLVED, that the ISMA request the state legislature to reschedule cannabis from Schedule I to II if legally possible.

(RESOLUTION 16-18) RESOLVED, that the ISMA support a lesser DEA controlled substance schedule for cannabis, only to promote/facilitate research on the possible medical benefits of cannabis.

(READOPTED ERC 2024; RESOLUTION 14-22, Reaffirmed 11/22/15 BOT) RESOLVED, that the ISMA support research regarding the medical use of marijuana and its chemical components in controlled drug studies.

MEDICAL NUTRITION

(RESOLUTION 21-98) RESOLVED, that the ISMA seek coverage by Medicare, Medicaid and private insurers for dietary referrals to a registered dietitian by a physician for medical diagnoses that require a specialized diet; and be it further
RESOLVED, that the ISMA recommend that the AMA delegation seek Medicare, Medicaid and private insurance reimbursement for dietary referrals to a registered dietitian by a physician for medical diagnoses that require a specialized diet.

MEDICAL RECORDS/INFORMATION

(RESOLUTION 24-17) RESOLVED, that the ISMA actively oppose legislative and regulatory attempts to release terminated pregnancy reports from the Indiana Department of Health.

(RESOLUTION 16-27) RESOLVED, that the ISMA make available, on a trial basis, a list of resources to facilitate the completion of physician secretarial duties. This could include a list of current "best equipment" available for dictation, documentation and scheduling. It also could include an option for ISMA members to comment or add reviews (anonymously, as appropriate) of currently used equipment and software – whether selected by that physician or mandated by a group or hospital organization. The list could be reviewed annually.

(RESOLUTION 16-13) RESOLVED, that the ISMA ask the AMA to support federal legislation that will replace current meaningful use with common sense meaningful use developed by the medical profession that is user friendly and practical.

MEDICAL STUDENTS

(READOPTED 22-92, HOD; RESOLUTION 12-42) RESOLVED, that the ISMA support the efforts of IU School of Medicine students and the Medical Student Section to address the needs of uninsured patients at the IU Student Outreach Clinic; and be it further
RESOLVED, that the ISMA encourage its members to donate their time and clinical experience to help ensure the continued success of the IU Student Outreach Clinic.

(RESOLUTION 17-29) RESOLVED, that ISMA collect data from various medical schools in Indiana regarding demographics of acceptance into medical schools, graduation, specialty, residency and practice location.

(RESOLUTION 17-17) RESOLVED, that ISMA allocate annual funding in the sum of $6,000 in support of the Health Policy Fellowship, $3,000 for a student from the Indiana University School of Medicine and $3,000 for a student from the Marian University College of Osteopathic Medicine, to sustain the program in future years and keep it competitive among other opportunities students might explore; and be it further
RESOLVED, that the ISMA Board of Trustees re-evaluate the Health Policy Fellowship every five years to keep the program competitive.

(RESOLUTION 15-34) RESOLVED, that the ISMA support the provision of on-campus mental health care in Indiana medical schools and residency programs that goes beyond supportive counseling; and be it further
RESOLVED, that the ISMA encourage ongoing and future initiatives by Indiana medical schools and residency programs to provide urgent and emergent access for all medical trainees to psychiatrists that could include an in-house board-certified psychiatrist; and be it further
RESOLVED, that the ISMA forward this resolution to our AMA for interim 2015 to encourage similar support for all medical students and residents across the country.

MEDICARE

(RESOLUTION 22-81) RESOLVED, that ISMA advocate for removing budget neutrality for Medicare physician payments; and be it further

RESOLVED, that our AMA delegation work with the AMA's legislative team to remove budget neutrality for Medicare physician payments, which would result in regular positive updates for physicians so that the payments can keep up with inflation and practice expenses.

(RESOLUTION 19-35) RESOLVED, that ISMA ask the state attorney general and/or insurance commissioner to scrutinize insurance companies offering Medicare Advantage plans for accuracy in their advertisements and clarity of their presentation to seniors and their family members; and be it further
RESOLVED, that ISMA ask the AMA, AARP, insurance companies and other vested parties to develop simplified tools and guidelines on how to compare and contrast Medicare Advantage plans.

(RESOLUTION 18-44) RESOLVED, that ISMA contact the AMA about the deficiencies of Medicare Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits. Full transparency about the cost and coverage of the plan, as well as communication about plan limitations, should be required; and be it further
RESOLVED, that ISMA ask the AMA for an opinion on whether Medicare Advantage plans should be limited to healthier seniors with both a short problem list and short medication list, and whether there should be a cap on administrative costs for these plans; and be it further
RESOLVED, that ISMA send the recommendations of Resolution 18-44 to the Indiana Department of Insurance if they have any authority related to Medicare Advantage plans.

(RESOLUTION 17-03) RESOLVED, that ISMA encourage the AMA to actively work to remove the sequester provision for Part B Medicare reimbursement.

(RESOLUTION 16-51) RESOLVED, that the ISMA work with the AMA to make seamless conversion enrollment into a Medicare Advantage Plan an opt-in rather than an opt-out process.

MENTAL HEALTH

(RESOLUTION 24-44) RESOLVED, that ISMA support legislation for, in collaboration with relevant stakeholders, the establishment of a sustainable funding model for the 988 National Suicide Prevention Lifeline in Indiana to ensure the Lifeline's operational efficacy and the expansion of mental health crisis services; and be it further
RESOLVED, that ISMA support legislation for the sequestration of revenue generated for the 988 National Suicide Prevention Lifeline in a dedicated trust, to be used exclusively for the support and enhancement of 988 services, in accordance with national guidelines for crisis services.

(RESOLUTION 24-35) RESOLVED, that the ISMA support legislation that improves accessibility and availability of mental health services and resources tailored to first responders, including, but not limited to, subsidization of services such as counseling, therapy, peer support programs, and other resources aimed at promoting mental well-being; and be it further
RESOLVED, that the ISMA support the promotion of mental health services amongst first responders including, but not limited to, on-the-clock training for stress management, peer support groups, resources for family members and colleagues to recognize warning signs, and ongoing educational opportunities to alleviate the social stigma that may be associated with it; and be it further
RESOLVED, that the ISMA support state legislation aimed at increasing mental health services for first responders in Indiana.

(RESOLUTION 24-23) RESOLVED, that the ISMA will support programs and resources that improve the mental health, physical health, and social support of pediatric siblings of chronically ill pediatric patients. (AMA policy H-60.899, as modified)

(RESOLUTION 24-20) RESOLVED, that the ISMA support legislation that increases funding for the Indiana Department of Health Refugee Health Program to study and target specific barriers to mental health screenings and treatments for refugees within Indiana; and be it further

RESOLVED, that the ISMA encourage relevant stakeholders to develop state-level guidance for improving coordination between mental health providers and Indiana refugee resettlement agencies, with the goal of enhancing refugee' awareness of and access to mental health services; and be it further
RESOLVED, that the ISMA support the creation of refugee health-specific physician education through evidence-based practices that train mental health providers on culturally and linguistically responsive, trauma-informed mental health care that addresses the specific needs of refugee populations.

(READOPTED 22-88, HOD; READOPTED AND AMENDED 12-27, HOD; RESOLUTION 02-27) RESOLVED, that the ISMA endorse the General Assembly's decision to keep the Evansville Psychiatric Children's Center operational; and be it further,
RESOLVED, that if any state agency/official or private organization attempts to encourage closure of the Evansville Psychiatric Children's Center, the ISMA will use its resources to discourage this, so long as it sees a continued need for the facility in Indiana.

(RESOLUTION 22-32) RESOLVED, that ISMA support the Indiana Family and Social Services Administration (FSSA) effort in the 9-8-8 crisis hotline overhaul to ensure timely creation, reform, and proper response to the expected in-crease in phone traffic; and be it further
RESOLVED, that ISMA further support the formation of "mobile crisis teams" that can respond to moments of crisis that require more assistance than a phone call alone can provide.

(RESOLUTION 19-03) RESOLVED, that ISMA support legislation to mandate parity of coverage for mental illness and substance use disorders; and be it further
RESOLVED that ISMA support legislation to provide increased state-level accountability and enforcement of the Mental Health Parity and Addiction Equity Act.

(RESOLUTION 18-61) RESOLVED, that ISMA ask the AMA to create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with:

1. Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction.
2. Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help.
3. Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges.
4. Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service.

(RESOLUTION 18-56) RESOLVED, that ISMA take Resolution 18-56 to the AMA House of Delegates, asking the AMA to officially object to policies separating undocumented immigrant parents and/or guardians from children as well as allowing unaccompanied undocumented minors access to the U.S.; and be it further
RESOLVED, that ISMA ask the AMA to condemn the practice of administering psychotropic drugs to immigrant children without parental or guardian consent or court order except in the case of imminent danger to self or others; and be it further
RESOLVED, that ISMA ask the AMA to support a position whereby federal immigration officials would become more aware of the emotional decompensation in this immigrant population, with the establishment of policies designed to decrease stress and emotional trauma.

(RESOLUTION 18-55) RESOLVED, that ISMA support a policy whereby the state of Indiana and medical schools in Indiana work together to increase the number and funding of psychiatry residencies within the state.

Promotion of psychiatry would also involve scholarships and payback incentives for practicing in underserved areas; and be it further
RESOLVED, that ISMA ask the AMA to support increasing reimbursement for psychiatric services through direct funding adjustments or changes in CPT codes.

(RESOLUTION 18-51) RESOLVED, that ISMA support legislation and state funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in local jails; and be it further
RESOLVED, that ISMA support legislation and state funding for establishing, implementing, and strengthening crisis intervention training programs across Indiana; and be it further
RESOLVED, that ISMA work with relevant societies and stakeholders, including but not limited to the National Alliance on Mental Illness (NAMI), and mental health providers across Indiana to encourage widespread participation and adoption of evidence-based mental health training and crisis intervention team (CIT) programs across the state for corrections officers and law enforcement, respectively; and be it further
RESOLVED, that the ISMA delegation consider a resolution to the AMA to support legislation and federal funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in federal prisons.

(READOPTED ERC 2024; RESOLUTION 14-44) RESOLVED, that the ISMA advocate for improving access to psychiatric services by improving reimbursement; and be it further
RESOLVED, that the reimbursement for psychiatric services for Medicaid patients be increased to Medicare levels; and be it further
RESOLVED, that the ISMA advocate for the addition of psychiatry to family practice, internal medicine, pediatrics and obstetrics and gynecology as those specialties require additional reimbursement for Medicaid patients to Medicare levels; and be it further
RESOLVED, that this increased reimbursement for Medicaid patients to Medicare levels be continued beyond the two years as stipulated in the Affordable Care Act; and be it further
RESOLVED, that the ISMA Government Relations staff work with the AMA and all other stakeholders and members of Indiana's Congressional delegation to accomplish this goal through legislative means.

METHADONE /NARCOTICS

(RESOLUTION 22-08) RESOLVED, that ISMA acquire information about supervised consumption sites to distribute to its membership; and be it further
RESOLVED, that ISMA initiate dialogue with the state legislature and regulators on possible regulations concerning supervised consumption sites; and be it further
RESOLVED, that ISMA instruct our AMA delegation to introduce a resolution to the American Medical Association to seek information and consider policy and legislation regarding the federal legalization of supervised consumption sites.

(RESOLUTION 21-82) RESOLVED, that ISMA support the principles set forth in the American Medical Association's model "Act to Support Patient Health and Reduce Harm from Overdose;" and be it further
RESOLVED, that ISMA support evidence-based public health practices in Syringe Exchange Programs designed to eliminate the spread of HIV, hepatitis C, and other infectious diseases within communities and coordinate support for such policies with the Indiana State Health Commissioner; and be it further
RESOLVED, that ISMA support the availability of comprehensive wraparound services at Syringe Exchange Programs; and be it further
RESOLVED, that ISMA support repealing the expiration of Indiana's Syringe Exchange Program (SEP) statute so that SEPs can continue to operate in Indiana for as long as needed; and be it further
RESOLVED, that ISMA support allowing the state government to activate a Syringe Exchange Program if and when local governments are unable to do so in a crisis; and be it further
RESOLVED, that ISMA support allowing private entities to provide Syringe Exchange Program services.

(RESOLUTION 21-21) RESOLVED, that the ISMA encourage legislation to require methadone clinics operating in Indiana to enter prescribing data into INSPECT.

(RESOLUTION 19-16) RESOLVED, that ISMA support legislative action for a statewide syringe service program under the auspices of the Indiana State Department of Health; and be it further
RESOLVED, that ISMA work with the Indiana University Fairbanks School of Public Health for dissemination of information to counties on currently available initiatives and best practices for establishing syringe service programs, as well as the benefits of these programs; and be it further
RESOLVED, that ISMA support legislative action requiring any needle exchange initiative in Indiana to solely distribute single-use syringes.

(RESOLUTION 18-49) RESOLVED, that the ISMA House of Delegates endorse the following opioid mitigation strategies based on validation of their effectiveness in both Huntington, W. Va., and Clark County, Ind. There are six components that appear to be most effective in dealing with opioids:
(1) The opioid overdose team decreases the risk of future overdose and overdose death, increases access to opioid-related services and increases the likelihood that an individual will pursue drug rehabilitation.
(2) A needle exchange program that is open multiple days a week and is mobile offers not only a source for needles but also Narcan, other supplies, health care and information.
(3) Most Indiana counties would benefit from a drug court that allows a judge to have greater flexibility in determining the legal consequences of an arrest for an opioid-related crime. It also allows for the judicial patience necessary to deal with the recidivism of this population.
(4) Most parts of Indiana urgently need more acute-care inpatient drug rehab beds, although those ready for treatment need to be willing to travel significant distances to get to a treatment bed.
(5) Narcan intranasal spray should be readily available OTC through pharmacies and the syringe exchange, overdose team, etc.
(6) One of the most important strategies related to opioids is prevention education. We need a validated K-12 program that uses multiple media with anti-drug messaging delivered in the school system but also in the home; and be it further
RESOLVED, that Resolution 18-49 be sent to the American Medical Association for review and feedback as to its utility. Other best practices across the U.S. may cause a different set of guidelines to be recommended.

(RESOLUTION 18-43) RESOLVED, that ISMA ask the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for an opinion and ultimately stricter regulations related to: (1) protocols for clinic operation, to help ensure adequate treatment and enrollment of the proper population; (2) optimum size for a clinic based on a community's needs, with a maximum client limit established; and (3) an opinion on the best practices to prevent methadone abuse by clinic clients and diversion of methadone on the clinic grounds and in the nearby community, but also in any community. Rules eventually would be adopted to require these best practices.

(RESOLUTION 17-39) RESOLVED, the ISMA send this resolution to the AMA House of Delegates to support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis; and be it further
RESOLVED, the ISMA restate some of our current methadone clinic policies and add new ones as follows:
1) The medical director of an Indiana-based methadone clinic should be licensed in Indiana and have admitting privileges at a local hospital that is most appropriate for this patient population.
2) Indiana-based methadone clinics should have substantial counseling and drug rehab programs with the expectation that these would occur with every visit.
3) Indiana-based methadone clinics may benefit from limiting the number of clients served because of the logistics and efficiency issues that come in a crowded clinic operation.
4) Indiana-based methadone clinics should be required to periodically taper opioids provided to their clients. Pregnant clients should be tapered or referred to a program that specializes in managing pregnancy in opioid-addicted women.

5) All opioids dispensed by Indiana-based methadone clinics should be reported to INSPECT, along with a periodic INSPECT query.

(READOPTED 17-18, RESOLUTION 07-15A) RESOLVED, that the ISMA support inclusion of methadone clinic patients in the INSPECT program; and be it further,
RESOLVED, that the ISMA support development of a statewide physician narcotic educational program with prescribing and patient monitoring guidelines.

(RESOLUTION 16-28) RESOLVED, that the ISMA support appropriate laws and/or policy to be propagated to assure that physicians are routinely notified of narcotic overdose or death of patients for whom they have prescribed narcotics in the preceding six months.

NURSING

(11/23/80, BOT) Supports retention of hospital-based, three-year nursing programs, as well as other levels of nursing education, until the results of studies on nursing supply are available to define a course of action.

NURSING HOMES

(READOPTED 23-66, HOD; RESOLUTION 13-46) RESOLVED, that the ISMA work at the state and national level with The Center for Medicare Advocacy (who supports this change) to eliminate the distinction between in-patient and observation status, so that all time spent in the hospital counts toward the skilled nursing and nursing home coverage.

(RESOLUTION 23-03) RESOLVED, that the ISMA encourage and collaborate with other agencies, associations, and organizations to consider and implement appropriate recommendations and principles, such as those published by the National Academies of Sciences, Engineering and Medicine, to improve the quality of care for patients in Indiana's nursing homes.

ORGAN DONATION/TRANSPLANTS

(RESOLUTION 23-56) RESOLVED, that the Indiana delegation to the AMA seek AMA action urging the FDA to reexamine its regulations for cornea donations for men who have sex with men in light of the Assessing Donor Variability and New Concepts in Eligibility (ADVANCE) study findings, changes to blood donation policy, and the lack of evidence for HIV transmission from corneal transplants.

(READOPTED 22-91, HOD; READOPTED 12-34, HOD; RESOLUTION 02-6) RESOLVED, that the ISMA encourage all physicians and more Hoosiers to become organ donors.

(RESOLUTION 18-29) RESOLVED, that ISMA seek legislation to provide state funding to the Indiana Donor Network (IDN) to develop education for Indiana residents regarding organ donation; and be it further
RESOLVED, that ISMA seek legislation to provide state funding to the Indiana Donor Network (IDN) to develop formal education pieces to offer Indiana residents for review prior to determining whether to be an organ donor-similar to informed consent. Distribution sites for this information could include the Indiana Bureau of Motor Vehicles, physician offices, hospitals and others to be determined; and be it further
RESOLVED, that ISMA encourage the Indiana Donor Network (IDN) to partner with the Indiana Bureau of Motor Vehicles to provide detailed education to its employees regarding organ donation.

PATIENT-CENTERED MEDICAL HOME

(READOPTED 22-84, HOD; RESOLUTION 12-11) RESOLVED, that the ISMA support the Joint Principles of the Patient-Centered Medical Home as a guideline for states to improve the health of their citizens; and be it further,

RESOLVED, that the ISMA encourage Medicaid and other payers to implement and fund programs that demonstrate the quality, safety, value and effectiveness of the patient-centered medical home, and to reward efficient programs.

PEER REVIEW

(3-22-81, BOT) That peer review of physicians be done by physicians rather than by administrative or third-party carrier interests.

PHARMACEUTICALS

(RESOLUTION 24-18) RESOLVED, that the ISMA actively oppose legislation that attempts to define Mifepristone and Misoprostol as controlled substances.

(RESOLUTION 24-01) RESOLVED, that the ISMA seek and support legislation for the allowance of Schedule II substances to be transferred between pharmacies within the state of Indiana for implementation earlier than the federal guidelines; and be it further
RESOLVED, that the ISMA work with the Indiana Board of Pharmacy and Indiana General Assembly to pass changes to the Indiana Board of Pharmacy Section 856 IAC 1-32-2(c) adding Schedule II substances, and removing Section 856 IAC 1-32-2(d).

(RESOLUTION 23-41) RESOLVED, the ISMA support legislation that allows medications used intraoperatively that are relevant to patient recovery to be dispensed to a patient post-operatively in accordance with safe handling and dispensing protocols; and be it further
RESOLVED, the ISMA support legislation that permits the use of multi-dose eye drop bottles pre-operatively in accordance with safe handling and dispensing protocols.

(RESOLUTION 23-40) RESOLVED, that the ISMA support decreasing barriers to researching medicinal uses of psychedelics in ways such as rescheduling from Schedule I drugs to supporting ways to decrease the stigma surrounding psychedelics.

(RESOLUTION 23-26) RESOLVED, that the ISMA support the use of medications, including antipsychotic medications, in hospice patients with behavioral conditions refractory to alternative pharmacologic treatments; and be it further
RESOLVED, that the ISMA encourage the use of non-pharmacologic activities to ease distress alongside the use of antipsychotic medication; and be it further
RESOLVED, that the ISMA seek legislation to exempt hospice patients from limitations on the use of antipsychotic medications for behavioral changes; and be it further
RESOLVED, that the ISMA delegation to the AMA carry forward a resolution to the AMA to lobby at the federal level for the use of antipsychotic medications for hospice patients.

(RESOLUTION 23-25) RESOLVED, that the ISMA develop a CME/podcast to educate physicians, particularly those collaborating with nonphysician providers, regarding of the risks of Compounded "Bioidentical" Hormone Therapy (cBHT); and be it further
RESOLVED, that the ISMA support legislation creating a program to review adverse events related to the use of Compounded "Bioidentical" Hormone Therapy (cBHT). This program will allow confidential collection, investigation, and review of adverse events related to the use of cBHT.

(RESOLUTION 21-39) RESOLVED, that ISMA study protective options and encourage any remaining physicians in the office from which the patient or physician leaves, to provide a 90 day supply of maintenance medication and or a 30 day supply of controlled medication as long as the patient has been compliant with office visits and protocols, has been compliant with controlled substance agreements and drug screens, and that the remaining physicians are comfortable with medication protocols.

(RESOLUTION 21-33) RESOLVED, ISMA support legislation opposing "white bagging" and "brown bagging" of medications because these practices compromise patient safety, delay patient care, can lead to poorer outcomes and do not reduce the cost of specialty medications. For these purposes, the definition of "white bagging" is the process by which a drug is procured through the pharmacy benefit and filled and shipped or transported to the final infusion destination by a specialty pharmacy and "brown bagging" the process by which a drug is procured through the pharmacy benefit and shipped or transported to the patient's home and the patient transports the drug to the place of infusion and, in both cases, the provider only bills an administration fee using the patient's medical benefit.

(RESOLUTION 19-22) RESOLVED, that ISMA support legislation providing that a patient who is established on a drug may remain on that drug within a plan year without an increase in co-pay or formulary inclusion; and be it further
RESOLVED, that ISMA support legislation that requires greater reporting of drug prices and the reasons behind them by pharmacy benefit managers, pharmaceutical manufacturers, health care insurers and other relevant entities; and be it further
RESOLVED, that ISMA support the creation of state programs for disclosure of effective drug prices:

(1) to patients, such as through clear explanations of pharmacy benefits and reasonable limits on formulary changes;
(2) to physicians, such as through integration of pricing and formulary data in electronic medical record systems; and
(3) to other stakeholders, such as through establishment of an independent auditor who will verify and prepare drug pricing information to the state legislature and the public.

(RESOLUTION 18-54) RESOLVED, that ISMA advocate for state legislation that investigates all drug pricing. This includes setting up a drug pricing task force that will report to state legislators in order to produce legislation allowing for drug pricing transparency; and be it further
RESOLVED, that the ISMA delegation ask that the AMA advocate to the Surgeon General for federal legislation that investigates all drug pricing.

(RESOLUTION 18-39) RESOLVED, that ISMA seek legislation through the Indiana General Assembly or regulation with the Indiana State Board of Pharmacy making it illegal to dispense auto-injectable epinephrine or auto-injectable Glucagon with an expiration date of less than 12 months to anyone obtaining a prescription for these devices in Indiana.

(READOPTED AND AMENDED 18-08, HOD; RESOLUTION 08-25) RESOLVED, that the ISMA collaborate with other agencies and organizations to educate Hoosiers about prescription medicine abuse; and be it further,
RESOLVED, that the ISMA inform Hoosier physicians of the magnitude of prescription medicine abuse with helpful hints to reduce abuse, such as talking to patients about the handling and safe-keeping of drugs, using INSPECT, etc.; and be it further,
RESOLVED, that the ISMA collaborate with pharmacists, pharmacies and pharmaceutical companies and organizations to reduce prescription medicine abuse; and be it further,
RESOLVED, that ISMA support efforts for county coroners/medical examiners to notify health care providers when their patients have died of an opioid overdose; and be it further,
RESOLVED, that INSPECT share de-identified data with providers so that we may see how we compare to our peers.

(RESOLUTION 16-29) RESOLVED, that the ISMA seek pharmacy board regulation or, if necessary, legislation and involve other interested parties to require locations that dispense medications to have a mechanism for patients to return unused medications; and be it further
RESOLVED, that such disposal shall be at no additional cost or significant inconvenience to the patient.

(RESOLUTION 16-28) RESOLVED, that the ISMA support appropriate laws and/or policy to be propagated to assure that physicians are routinely notified of narcotic overdose or death of patients for whom they have prescribed narcotics in the preceding six months.

(RESOLUTION 15-25) RESOLVED, that the ISMA House of Delegates work with the governor, legislature, or appropriate state agencies to review the structure and function of the Indiana State Board of Accounts with the goal of improving the board such that its recommendations are more practical and workable, while promoting accurate accounting and decreasing the risk of loss.

(1/21/98, BOT) Reaffirmed support for the current generic substitution statute.

(1/17/96, BOT) Approved not opposing the following policy regarding pharmacists:

- That drug therapy management should be limited to acute care hospitals.
- Pharmacists should not manage hyperalimentation.
- Drug therapy management may occur only when the physician acts to allow it.

(4/10/88, BOT) Registered opposition to the multiple copy prescription program; but if the program goes into effect, the 10 recommendations, as outlined in the April 10 "Suggested Report" from the ISMA Department of Government Relations, be submitted to the Education Forum Subcommittee, the Prescription Pad Subcommittee, as well as the Prescription Abuse Study Committee for consideration.

(1/17/88, BOT) Approved the restriction of amphetamine use in that Schedule II not be used for weight control and that Schedules III and IV (anorectic) be limited in their use, to be determined by the Indiana Medical Licensing Board.

PHYSICIAN AS HEALTH ADVOCATE

(RESOLUTION 24-47) RESOLVED, that the ISMA strongly oppose regulatory or legislative interference in the patient-doctor relationship (in further support of ISMA House Resolution 22-06), except when doing so directly conflicts with a more specific ISMA policy.

(RESOLUTION 23-29A) RESOLVED, that the ISMA support our members and our profession from harrassment while discharging their ethical responsibilities as physician advocates as outlined in the AMA Code of Ethics (Chapter 1.2.10).

(RESOLUTION 22-77) RESOLVED, that ISMA establish policy that licensed physicians (MD/DO/MBBS) should be the ultimate authority for health policy and health care decisions; and be it further
RESOLVED, that ISMA establish policy that county health officers and the state health commissioner should remain physician-only positions.

(READOPTED AND AMENDED 21-77, HOD; READOPTED 10-45, HOD; RESOLUTION 00-03) RESOLVED, that the ISMA each year sponsor either a physician or a medical student applicant on a medical mission trip; and be it further,
RESOLVED, that the physician be chosen by lottery from nominations from county alliances and medical societies.

(RESOLUTION 21-60) RESOLVED, that the ISMA delegation to the American Medical Association (AMA) carry forward to the AMA a resolution that would establish a special committee or use a current committee to identify controversial medical issues of the day, then publicly and officially state what the science shows and the position of the AMA.

(RESOLUTION 21-14) RESOLVED, that the ISMA support efforts to ban in Indiana the sale and use of herbal products, also known as synthetic marijuana and “spice,” as well as other similar products.

(RESOLUTION 18-48) RESOLVED, that ISMA propose to the Indiana legislature to make the political office application simple and brief, and the same for most political positions; and be it further

RESOLVED, that ISMA encourage the Indiana legislature to simplify the code related to political campaigns and office finances to ease the burden on both candidates and office-holders, and again, to promote interest in holding political office.

PHYSICIAN, USE OF THE TERM

(RESOLUTION 24-12A) RESOLVED, that the ISMA advocate for the use of specific terms like "physician" or "doctor of medicine/osteopathic medicine" in all communications; encourage members to identify as such; and educate the public on physicians' unique roles to enhance patient understanding and informed decision-making; and be it further
RESOLVED, that the ISMA promote clear distinction between physicians and non-physician practitioners (NPP) in health care communications and public education efforts.

(3/22/98, BOT) Supported a proposal calling for the ISMA to petition the Indiana legislature to enact legislation that would limit the use of the term "physician" to only those practitioners who hold degrees of Doctor of Medicine or doctor of osteopathy.

PHYSICIAN ASSISTANTS (PAs)

(READOPTED 22-85, HOD; RESOLUTION 12-20) RESOLVED, that the ISMA endorse the AMA suggested "Guidelines for Physician/Physician Assistant Practice;" and be it further,
RESOLVED, that the ISMA work with the Indiana Academy of Physician Assistants to enhance patient care through effective collaboration between physicians and physician assistants.

(RESOLUTION 21-12) RESOLVED, that the ISMA vigorously oppose any legislation at the state level that would change the term "physician assistant" to "physician associate;" and be it further
RESOLVED, that the ISMA discourage the change of the term "physician assistant" to "physician associate" by any hospital system, medical practice, provider organization or insurance company (health or malpractice).

(7/8/87, EC) Endorsed the concept for the necessity of PA rules with emphasis toward improving supervision of PAs and that the diagnosis or the prescription for drugs, etc., should originate with the physician.

PHYSICIAN-ASSISTED SUICIDE

(RESOLUTION 16-12) RESOLVED, that the ISMA affirm its support against physician-assisted suicide as stated in the AMA Code of Ethics; and be it further
RESOLVED, that the ISMA oppose legislation advocating physician-assisted suicide.

PHYSICIAN EDUCATION AND BOARD CERTIFICATION

(RESOLUTION 24-21) RESOLVED, that the ISMA support centralized and accessible trauma-informed care training for practicing physicians across the state of Indiana by promoting trauma-informed training programs and continued medical education opportunities by collaborating with relevant stakeholders, such as the Indiana Trauma Care Commission.

(RESOLUTION 24-11 RESOLVED, that the ISMA delegation to the American Medical Association (AMA) support physician disclosure of private equity relationship(s), including employment, shareholder status, or medical directorship(s) at any accredited education function that bears continuing AMA medical education credit or approval through the Accreditation Council for Continuing Medical Education (ACCME); and be it further
RESOLVED, that the ISMA delegation to the American Medical Association (AMA)
support physician disclosure of private equity relationship(s) for any committee member that reviews state or federal government (i.e. RVS Update Committee) resource allocation as it pertains to provision of medical services.

(RESOLUTION 19-18) RESOLVED, that ISMA advocate for continuous lifelong learning educational standards for physicians; and be it further
RESOLVED, that until better evidence-based data is available (see current AMA deliberations on this topic), maintenance of certification should not be the sole criterion for hospital staff privileging and/or insurance reimbursement; and be it further
RESOLVED, that ISMA support nationally determined board certification that is evidence-based and has sole focus on what is best for patient care.

(RESOLUTION 16-46) RESOLVED, that there is a benefit to members of the ISMA in forming an ad hoc committee to review the option of removing MOC as a condition of licensure, reimbursement, employment or hospital privileging, and yet have a way to ensure continued education and advancement of our physicians.

(RESOLUTION 15-37) RESOLVED, that the ISMA oppose further requirements for physician board certification of Indiana physicians beyond the 10-year board re-certification exams, placing on hold any additional Maintenance of Certification (MOC) requirements until objective study of the validity and cost-effectiveness of such additional requirements are complete.

PHYSICIAN EMPLOYMENT

(RESOLUTION 23-23) RESOLVED, the ISMA support and advocate for the rights of physicians and residents to practice medicine, and medical students in training in medicine, to act in accordance with their conscience, including their recommendation for or against any pharmacological or procedural treatments, without professional or financial repercussions (e.g., loss of licensure or exclusion from federal funding programs) so long as such practice is based upon available evidence and/or traditional standard of care, does not violate existing state or federal law, and the physician will promptly provide the appropriate referral for a second opinion, as it may be requested by the patient.

(RESOLUTION 23-17) RESOLVED, that the ISMA opposes the practice of nonphysician practitioners employing physicians if the employed physician delegates or collaborates with the employing nonphysician practitioner; and be it further
RESOLVED, that the ISMA seeks legislation prohibiting physicians in Indiana from being employed by nonphysicians if the physician delegates to, supervises, or collaborates with the employing nonphysician.

(AMENDED 22-18, HOD; RESOLUTION 19-09, BOT) RESOLVED, that the ISMA adopt AMA Policy H-65.961, Principles for Advancing Gender Equity in Medicine:
Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician

employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas;

and be it further

RESOLVED, that the ISMA encourage Indiana medical schools to:

a. Adhere to equitable gender representation when hiring teaching faculty and when planning student teaching exposure, emphasizing female instructors who may serve as role models and mentors for medical students.

b. Adhere to equitable gender representation when inviting community physicians to lecture and/or be on panels, intentionally seeking out women community physicians representing the heavily male-dominated fields (>90% male), whereby female medical students can have role models and mentorship in considering these specialties.

c. Annually report diversity statistics, as required by accrediting bodies.

(RESOLUTION 19-13) RESOLVED, that ISMA oppose health care reform initiatives that divert physician time away from clinical care and are not patient-centered, such as those requiring increased administrative burden; and be it further

RESOLVED, that ISMA endorse value-based health care initiatives that align with the AMA Pay for Performance Principles and Guidelines (Policy H-450.947).

(RESOLUTION 17-28) RESOLVED, that ISMA support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of *locum tenens* coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region; and be it further

RESOLVED, that Resolution 17-28 is referred through our Indiana AMA Delegation to both the Organized Medical Staff Section (OMSS) of the AMA and to the AMA House of Delegates before the 2018 AMA Annual Meeting.

PHYSICIAN PROFILING

(3/22/98, BOT) Supported the following:

- ISMA members recognize that the public, our patients, have a right to be informed of their physicians' qualifications.
- The ISMA should explore the possibility of a voluntary, physician-sponsored program of physician profile data release to the public.
- The ISMA should use as its possible model the voluntary physician-profiling program of the Colorado State Medical Society.

PHYSICIANS – SURGEONS

(7-31-94, BOT) Supported the ISMA recommending to the Medical Licensing Board adoption of the following language:

- General Responsibilities of the Surgeon - The ultimate responsibility for diagnosing medical and surgical problems is that of the licensed doctor of medicine or osteopathy who is to perform the surgery. The operating surgeon is responsible for all surgical decisions and remains responsible for all treatment decisions. Pre-operative evaluation and postoperative management as well as the surgical procedure constitute the practice of medicine.
- Pre-operative Responsibilities – The surgeon is responsible for pre-operative evaluation of the patient. That includes obtaining a review of the patient's history, performing an adequate pre-operative exam and making an independent diagnosis. In addition, it is the responsibility of the operating surgeon or an equivalently licensed doctor of medicine or osteopathy (or a physician practicing within a board-approved post-graduate training program) to explain the procedure to the patient and obtain informed consent. However, it is not necessary that the operating surgeon witness the signature of the patient on the written form evidencing informed consent.
- Postoperative Responsibilities – The postoperative recovery period is defined as the length of time required to assure that the occurrence of complications from the surgery is minimal. Postoperative management is defined as all the treatment decisions made during the postoperative recovery period, as based upon the operating surgeon's personal observations and professional judgment. The postoperative responsibilities of the operating surgeon include, but are not limited to: (1) monitoring of the patient during the recovery process; (2) detecting and diagnosing conditions arising during the recovery process; (3) adjusting of medications; and (4) treating post-surgical complications. The operating surgeon is responsible for the coordination of overall patient care during the postoperative period until the patient has recovered from the surgery.
- Delegation of Postoperative Responsibilities – The surgeon may delegate certain discretionary postoperative management activities to equivalently licensed doctors of medicine or osteopathy (or to a physician practicing within a board-approved post-graduate training program) under the following specific conditions:
    - Postoperative care may not be delegated to any other health care practitioner except under the direct on-premise supervision of the operating surgeon or equivalently licensed doctor of medicine or osteopathy (or a physician practicing within a board-approved post-graduate training program).
    - If the surgeon is unable to personally render postoperative care due to an unusual event, such care must, when possible, be delegated by pre-arranged agreement with the patient. This care should be delegated to another equivalently licensed doctor of medicine or osteopathy (or to a physician practicing within a board-approved post-graduate training program).
- All licensed physicians have an ethical obligation to report instances of surgeons routinely delegating postoperative management to non-physicians.

(9/20/87, BOT) That the postoperative care of surgical patients constitutes the practice of medicine and should be performed only by unlimited practitioners (M.D. or D.O.) or under their direct supervision and control. It is, therefore, the policy of the ISMA to encourage its membership to provide postoperative care in accordance with good medical practice and not to allow inappropriate postoperative care to be provided by limited practitioners without proper supervision by an unlimited practitioner (MD or DO).

PROVIDER, USE OF THE TERM

(READOPTED 19-28, HOD; READOPTED 9-59, HOD; RESOLUTION 99-40) RESOLVED, that ISMA oppose the use of the term "provider" or "health care provider" to refer to a physician.

REPRODUCTIVE HEALTH

(RESOLUTION 24-19) RESOLVED, that the ISMA does not equate any type of contraception (including emergency contraception, hormonal and non-hormonal long-acting reversible contraceptives (LARC), Depo, pills, patches, rings and spermicides) with abortion; and be it further
RESOLVED, that the ISMA actively oppose legislation that restricts access to contraception, including but not limited to emergency contraception, hormonal and nonhormonal long-acting reversible contraceptives (LARCs), Depo, pills, patches, rings, and spermicides. This includes legislation which criminalizes physicians providing contraception, patients seeking contraception, and any who facilitate access to contraception.

(RESOLUTION 23-11) RESOLVED, that the ISMA work with the Indiana state government to design and implement a framework for defining and licensing crisis pregnancy centers that market medical or clinical services, that includes:

- A requirement that CPCs disclose whether or not they have been licensed by the state of Indiana on their advertising and at their physical location, and
- A requirement that CPCs that offer medical and clinical services will not receive state funding until licensed;

and be it further
RESOLVED, that the ISMA support policies and legislation that require crisis pregnancy centers to disclose and display the credentials of the individuals who are on staff or conducting services on site; and be it further
RESOLVED, that the ISMA support policies and legislation that require crisis pregnancy centers to disclose a list of medical and non-medical services offered on their internet websites and at their physical locations prior to those services being offered including, but not limited to, contraception, pregnancy termination, adoption, and referral for any such services.

(RESOLUTION 23-10) RESOLVED, that the ISMA actively oppose any legislation limiting access to gender-affirming care for adults (18 and older) including criminalization of physicians providing that care, or patients seeking that care.

(RESOLUTION 23-09) RESOLVED, that the ISMA actively oppose legislation that restricts access to physician-prescribed or provided contraception including but not limited to emergency contraception, hormonal and nonhormonal LARCS, depo, pills, patches, rings, and spermicides; and be it further
RESOLVED, that the ISMA actively oppose legislation that criminalizes physicians for providing contraception or patients for seeking contraception.

(RESOLUTION 23-08) RESOLVED, that the ISMA encourages the Indiana State Department of Health to promote public education efforts to educate youth on menstrual health and hygiene; and be it further
RESOLVED, that the ISMA supports legislation that includes discussion of menstruation including instruction on the menstrual cycle, premenstrual syndrome and menstrual management, menstrual irregularities, and other relevant topics, as part of developmentally appropriate comprehensive sexuality education.

(RESOLUTION 22-79) RESOLVED, that ISMA seek state legislation that would enable Indiana residents to access an oral contraceptive pill that is FDA-approved for over the counter distribution.

(RESOLUTION 22-73; AMENDED RESOLUTION 19-38) RESOLVED, that the ISMA oppose abortion bans in recognition that restrictive abortion laws do not decrease abortion; rather, they lead to a higher number of unsafe or illegal abortions and forced pregnancy continuation, endangering patients' health and leading to significant maternal morbidity and mortality; and be it further
RESOLVED, that ISMA oppose any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment.

(RESOLUTION 22-62A) RESOLVED, that ISMA strongly oppose the criminalization and associated criminal penalties for actions taken in good faith in regard to the physician-patient relationship, health care decision-making, or the performance of any medical procedure; and be it further
RESOLVED, that ISMA will oppose any attempt to limit any actions required to protect the life or health of our patients; and be it further
RESOLVED, that ISMA facilitate and encourage its member physicians to be actively engaged in the legislative process.

(RESOLUTION 22-57) RESOLVED, that ISMA support increasing access to and funding for Title X resources as well as initiatives regarding easy access to affordable comprehensive birth control; and be it further
RESOLVED, that ISMA support legislation that addresses the contraceptive disparities affecting women of reproductive age be it race, ethnicity, or socioeconomic status; and be it further
RESOLVED, that ISMA encourage counseling patients seeking birth control in a way that respects patient autonomy through patient-centered care and empowering the patient.

(AMENDED 22-07, HOD; RESOLUTION 21-97) RESOLVED that ISMA support the Indiana ban regarding the procedure federally defined as partial birth abortion, and medically defined as dilation and extraction of a viable fetus except in situations where the mother's life is endangered.

(RESOLUTION 22–06) RESOLVED, that ISMA support legislation to protect access to a safe medical abortion in the instance of rape, incest, or a mother's life is in jeopardy; and be it further
RESOLVED, that ISMA continue to support legislation that prevents interference of a legislative body into a doctor-patient relationship, reaffirming Resolution 16-37 point #2; and be it further
RESOLVED, that ISMA support legislation to offer expanded access and remove barriers to effective birth control to any persons requesting or in need; and be it further
RESOLVED, in the case of imposition of a statewide abortion ban, the ISMA support the inclusion of language in such a bill exempting dangers to maternal health or life; rape; incest; and lethal fetal anomaly, a condition that in reasonable medical judgement is incompatible with sustained life outside of the womb.

(RESOLUTION 21-47) RESOLVED, that the ISMA support the removal of medically unnecessary and burdensome restrictions on medication abortion and that the drug Mifepristone be made available in retail pharmacies; and be it further
RESOLVED, that the ISMA support the elimination of the ban on telehealth and telemedicine services for medication abortion.

(RESOLUTION 21-38) RESOLVED, that the ISMA oppose legislation criminalizing gender affirming care of minors.

(READOPTED AND AMENDED 21-31, HOD; RESOLUTION 10-09) RESOLVED, that the ISMA support education about HPV vaccination and testing, as an essential component of comprehensive sex education.

(RESOLUTION 21-28) RESOLVED, that the ISMA endorse the public health goal of substantially reducing the rate of teen pregnancy and unintended pregnancy at any age in Indiana via public education, pre-conception intervention, and professional awareness.

(RESOLUTION 19-37) RESOLVED, that ISMA oppose any government intervention into defining the scope of residency programs in Indiana, particularly with regard to reproductive health training; and be it further
RESOLVED, that ISMA support access to comprehensive reproductive health training.

(RESOLUTION 19-36) RESOLVED, that ISMA support legislation to provide counseling and the opportunity to receive contraception to interested females in Indiana correctional facilities.

(RESOLUTION 19-33) RESOLVED, that ISMA encourage the Indiana State Department of Health to promote and support contraception services for all interested fertile women who are on chronic opioid therapy.

(RESOLUTION 18-57) RESOLVED, that ISMA take legislative action to allow pregnant minors age 16 and older to consent to care related to pregnancy from the prenatal through postpartum stages, including postpartum contraception.

(RESOLUTION 18-53) RESOLVED, that ISMA support prosecution to the full extent of the law of groups and persons that threaten providers of reproductive health care and other health care providers.

(RESOLUTION 18-52) RESOLVED, that ISMA oppose state legislation that restricts access to abortion services. This includes legislation that burdens practitioners with unnecessary regulation, as well as legislation that imposes burdens on facilities not based on any medical evidence.

(RESOLUTION 18-21) RESOLVED, that ISMA support state and federal legislation requiring all facilities in Indiana rendering emergency care to provide on-site, comprehensive services to sexual assault patients in accordance with widely accepted standards of care. Such services must include all the following:

- Treatment of trauma.
- Testing and prophylaxis for sexually transmitted disease.
- Collection of forensic evidence.
- Timely availability of emergency contraception for patients capable of pregnancy.
- Information and written materials about a patient's right to emergency contraception. Information shall be scientifically accurate, factual and objective. It shall be clearly written and readily comprehensible in a culturally competent manner. It shall explain the nature of emergency contraception, including its use, safety, efficacy and availability, and shall state that this form of contraception does not cause abortion of an established pregnancy.

(RESOLUTION 17-41) RESOLVED, the ISMA support legislation creating a maternal mortality review program in Indiana. This program will allow confidential collection, investigation and review of maternal mortality in Indiana to develop strategies to prevent future maternal-related mortality.

(RESOLUTION 17-02) RESOLVED, that ISMA petition the secretary of the Indiana Family and Social Services Administration and the commissioner of the Indiana Department of Insurance to require Medicaid and insurance companies to provide and compensate providers' offices for one nurse-education visit in the early second trimester of pregnancy and one nurse-education visit in the early third trimester of pregnancy to discuss signs and symptoms of preterm labor, preterm premature rupture of membranes, incompetent cervix and the dangers to an infant of low or very low birth weight. Reimbursement would be in addition to the global prenatal care reimbursement.

(1/14/90, BOT) Reaffirmed its abortion policy that "Abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state. No physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice." (This policy differs from the AMA's policy that was amended in December 1989 to include a third paragraph that reads: "The American Medical Association supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.")

RESIDENCIES

(RESOLUTION 23-48) RESOLVED, that the ISMA support the creation of residency positions sufficient to accommodate the number of Indiana medical graduates; and be it further
RESOLVED, that the ISMA specifically supports the creation of residency positions addressing specialties of demonstrated physician shortage.

(RESOLUTION 23-45) RESOLVED, that the ISMA support maximal and equitable geographic allocation of physicians within the state of Indiana of J-1 visa waiver recipients; and be it further
RESOLVED, that the ISMA support the preferencing of psychiatric care physicians and primary care physicians in J-1 visa waiver allocation; and be it further
RESOLVED, that the ISMA support the carrying forward of a resolution to AMA lobbying for the reauthorization of Conrad 30 J-1 visa waiver program.

(RESOLUTION 23-31) RESOLVED, that the ISMA support the encouragement of flexibility in scheduling graduate medical students during their training in their third trimester of pregnancy.

(RESOLUTION 22-70) RESOLVED that ISMA support wellness education and the inclusion of wellness activities in residency curriculum in an effort to mitigate burnout and promote work-life balance; and be it further
RESOLVED, that ISMA advocate for more research into how to mitigate resident burnout.

(RESOLUTION 22-10) RESOLVED, that ISMA join the Association of American Medical Colleges (AAMC) and American Medical Association (AMA) in supporting the Resident Physician Shortage Reduction Act of 2021; and be it further,
RESOLVED, that ISMA advocate for support from and co-sponsorship by federal representatives from Indiana for the Resident Physician Shortage Reduction Act of 2021 (S. 843, H.R. 2256).

(RESOLUTION 19-32) RESOLVED, that ISMA encourage the American Medical Association (AMA) to redouble its efforts to promote an increase in residency program positions in the U.S.; and be it further
RESOLVED, that the ISMA HOD (House of Delegates) ask the AMA (American Medical Association) HOD to assign appropriate AMA committee or committees to:

- Study the issue of why the residency positions have not kept pace with the new physician supply and also investigate what novel residency programs have been successfully developed across the country in order to expand positions using both traditional and nontraditional mechanisms.
- Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure to match. The committee(s) would depend upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. If valid statistics are gleaned, then this information would be of value to medical students who seek to improve their chances of success in The Match.
- Report back to the AMA HOD and ISMA HOD with their findings and recommendations; and be it further

RESOLVED, because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, the ISMA HOD asks the AMA House of Delegates to support the suggestion that those individuals would be offered the option of participating in one future match at no charge; and be it further
RESOLVED, in order to understand the cost of The Match and to identify possible savings, the ISMA HOD asks the AMA House of Delegates to request that the Board of the National Residency Matching Program undergo an independent and fully transparent audit with identification of opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians. It is expected that the BNRMP would avail itself of these opportunities; and be it further
RESOLVED, the ISMA HOD ask the AMA HOD to encourage the Board of the National Residency Matching Program to propagate the lessons learned from the AMA committee(s) work, such that it would actively promote success for those participating in The Match by better understanding and identifying those issues that interfere with the successful match and to identify strategies to mitigate those issues. This important knowledge can be disseminated through the program website and through its services, such as its "help" and "Q&A" links, and also through the AMA.

RESTRICTIVE COVENANTS

(RESOLUTION 21-75) RESOLVED, that the ISMA and the Commission on Legislation support legislation that prohibits medical noncompete clauses or in the alternative specifies that noncompete agreements are per se invalid except to the extent that the employer clearly demonstrates in the contract a quantified, defensible, protectable interest, other than the typical expenses incurred when a departing employee has to be replaced.

(RESOLUTION 19-17) RESOLVED, that ISMA seek legislation to ensure that existing health systems and practices notify patients when their personal physician changes location or provide patients with adequate information to access their physician upon request; and be it further
RESOLVED, that ISMA seek legislation that includes a requirement for the departing physician's approval on communication sent to patients by their previous health system or practice.

(RESOLUTION 18-33) RESOLVED, that ISMA advocate that physicians leaving a practice be allowed to notify their patients and appropriate entities of their change in practice, practice location and new contact information within a reasonable time; and be it further
RESOLVED, that ISMA advocate that the exiting practice be required to inform any callers of all available contact information related to the practice change.

(RESOLUTION 24-08; AMENDED RESOLUTION 18-12) RESOLVED, that ISMA reaffirm a policy that non-compete agreements for physicians are anti-competitive and such clauses violate the right of the patient to choose a physician, as well as the right of the physician to work; and be it further
RESOLVED, that ISMA actively seek and support legislation that specifies physician non-compete agreements are *per se* invalid unless the employer clearly demonstrates a protectable interest, other than the typical expenses incurred when a departing employee must be replaced; and be it further
RESOLVED, that ISMA actively seek and support legislation, working with Indiana subspecialty organization leaders, to expand the prohibition on physician noncompetes to include subspecialty physicians in Indiana.

SCHOOL NUTRITION, HEALTH AND SAFETY

(RESOLUTION 24-28) RESOLVED, that the ISMA support legislation that incorporates comprehensive evidence-based nutrition education, including but not limited to hands-on instruction and interactive cooking coursework, into K-12 education.

(RESOLUTION 24-16) RESOLVED, that the ISMA support legislation that makes menstrual hygiene products available for free in public schools and incentivizes private schools to offer free menstrual products.

(RESOLUTION 24-05) RESOLVED, that the ISMA support initiatives and/or legislation aimed at establishing or expanding universal free lunch programs in all Indiana K-12 public schools.

(Resolution 23-37) RESOLVED, that the ISMA (1) seek or supports legislation to prohibit corporal punishment in public and private schools; (2) encourage universities that train teachers to emphasize alternative forms of discipline during their training; and (3) encourage physicians to work toward the abolition of corporal punishment in their communities.

(READOPTED 22-87, HOD; RESOLUTION 12-24) RESOLVED, that the ISMA seek legislation to change the Indiana school vision testing requirement to a more inclusive screening process to ensure all students are screened and those needing additional treatment receive it.

(READOPTED 22-83, HOD; RESOLUTION 12-08) RESOLVED, that the ISMA seek and support legislation amending existing law that supports daily physical activity in elementary schools to specify at least 30 minutes of daily structured physical activity, defined as activity directed by an educator, at an intensity to increase students' heart rate appropriate for their age and physical ability that will build endurance and strength.

(RESOLUTION 21-65) RESOLVED, that the ISMA support endeavors aimed at increasing the educational attainment of all Hoosier children in order to maximize the health of our population. These endeavors include but are not limited to:

a) Advocating for all educational public and private stakeholders to explore and propose strategies, regulations, and/or legislation to further the access of all children to a quality public education, including early childhood education

b) Encouraging the Indiana Department of Education to develop policies and initiatives in support of students that decrease the educational opportunity gap and increase the high school graduation rate.

(READOPTED AND AMENDED 21-57; RESOLUTION 10-21) RESOLVED, the ISMA update the program and disseminate information regarding bullying to present the epidemiologically linked factors that increase the risk of bullying, such as, but not limited to, the presence of mental or physical disability, cultural variance, sexual identity, and psychosocial factors; and be it further
RESOLVED, that the ISMA further update medical providers on identifying children at risk for bullying and appropriate responses for dealing with the identification; and be it further
RESOLVED, that the ISMA continue to support legislation addressing bullying; and be it further
RESOLVED, that the ISMA partner with community programs to educate parents and children regarding bullying.

(RESOLUTION 21-35) RESOLVED, that the ISMA support efforts to implement CPR instruction in schools for both students and teachers across the state of Indiana, and be it further
RESOLVED, that ISMA work with relevant stakeholders to understand schools' implementation of the 2015 law requiring CPR instruction in the Indiana school systems; and be it further
RESOLVED, that the ISMA support action, to decrease disparities in CPR implementation among Indiana school districts.

(RESOLUTION 21-27) RESOLVED, that the ISMA continue to endorse, as part of a comprehensive sex education program, instruction regarding the Indiana Safe Haven Law, and encourage both voluntary and legally mandated efforts to educate teens regarding laws for protection of newborns.

(RESOLUTION 21-01) RESOLVED, that ISMA support efforts and/or legislation that would mandate educating school-aged children about addictive behaviors and substances, such as tobacco use, vaping, alcohol abuse, opioids, high-calorie junk food intake, caffeinated beverages, use of electronics and others.

(READOPTED, 18-20, RESOLUTION 08-33) RESOLVED, that ISMA re-adopt Resolution 08-33 and continue to urge legislation providing for developmentally appropriate comprehensive sexuality education for all high school and middle school students; and be it further
RESOLVED, that ISMA advocate with state and local school boards for developmentally appropriate comprehensive sexuality education in public and private schools that meet these standards. Approved programs should:

- Be based on rigorous, peer-reviewed science.
- Show benefit for delaying the onset of sexual activity and reduction of sexual behaviors that put adolescents at risk for contracting STDs.
- Teach responsible sexual behavior.
- Show benefit for reducing rates of unintended pregnancy.
- Teach that abstinence used consistently is the only sure way to have no risk of pregnancy and STDs, but also teach contraceptive and condom use; and be it further

RESOLVED, that ISMA promote physician education opportunities and offer CME credits for courses including:

- Reproductive medical care of teens.
- Logistics and medico-legal issues of teen medicine.
- Sexual behavior and public health.
- Physicians' role in life-span comprehensive sexuality education;

and be it further

RESOLVED, that ISMA report on the progress of each Resolved statement of Resolution 18-20 to the 2019 House of Delegates.

(RESOLUTION 18-11) RESOLVED, that ISMA seek legislation to place a wall-mounted bleeding control station, which includes a poster showing step-by-step bleeding control techniques for the injured, and eight (8) personal bleeding control kits in every school in Indiana and recommend that such stations be positioned near AEDs; and be it further;
RESOLVED, that ISMA seek legislation to support bleeding control training for bystanders in all 92 counties in Indiana.

(READOPTED 15-19, HOD; RESOLUTION 05-06) RESOLVED, that the ISMA work with schools to encourage programs to educate and promote a more active and healthy lifestyle, with special attention given to children, and be it further,
RESOLVED, that the ISMA discourage active promotion of unhealthy food, drinks and lifestyle in schools.

(READOPTED 15-11, HOD; RESOLUTION 05-27) RESOLVED, that the ISMA encourage county medical societies to collaborate with their local medical Alliance and other organizations to create and implement focused educational activities to prevent steroid and other potentially harmful supplement use in school and community environments; and be it further,
RESOLVED, that the ISMA encourage physicians to discuss this topic with their adolescent patients.

(READOPTED 15-06, HOD; RESOLUTION 05-28) RESOLVED, that the ISMA support legislation providing for the availability for all high school and middle school students of a comprehensive program of sexuality education. Approved programs should:

- Be based on rigorous, peer-reviewed science
- Show potential for delaying the onset of sexual activity and reduction of high-risk behavior for contraction of STDs
- Teach responsible sexual behavior
- Show potential for reducing rates of unintended pregnancy
- Encourage parental involvement in school sexual education

SCOPE OF PRACTICE – ALLIED PROVIDERS

(RESOLUTION 23-62) RESOLVED, that the ISMA assist the Indiana Academy of Dermatology (IAD) and other interested specialty societies in researching the laws of other states related to medical spas and support IAD and other specialty societies' efforts in seeking legislation to regulate medical spas; and be it further
RESOLVED, that ISMA support legislation regulating medical spas that includes, at a minimum: (1) prohibiting cosmetic procedures from occurring outside of a medical office or clinical setting (such as bars, restaurants, or the home of the practitioner or patient); (2) maintaining a transfer agreement between a medical spa owned and operated by a non-physician practitioner with an appropriate physician office or facility to timely address adverse outcomes; (3) requiring a mechanism for public disclosure of the services provided and—for non-physician practitioners—the name, credentials, and primary practice location of the physician the services are being provided under.

(RESOLUTION 23-59) RESOLVED, that ISMA adopt the following language in formal written and verbal communication: "nonphysician practitioner" (NPP) to collectively describe physician assistants (PAs), advanced practice registered nurses (APRNs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs); further that ISMA refrain from the use of "advanced practice practitioner/provider" (APP), or "advanced practice clinician" (APC) as a collective description; and be it further
RESOLVED, that ISMA adopt the following language in formal written and verbal communication: "unsupervised practice of medicine" (UPM) rather than "independent practice," "full practice authority," or "optimal team practice" when referring to the proposed or actual clinical activities of nonphysician practitioners including advanced practice registered nurses (APRNs), certified registered nurse anesthetists (CRNAs) and

physician assistants (PAs) when performed in the absence of physician collaboration or supervision; and be it further
RESOLVED, that ISMA adopt the following language in formal written and verbal communication: "medical residency," "medical resident," "medical internship," "medical fellowship," "medical fellow," "medical school" in discussions regarding physicians only, and not in relation to nonphysician practitioner (NPP) training programs; and be it further
RESOLVED, that the ISMA adopt the following language in formal written and verbal communication in acknowledgment that the profession and practice of medicine are distinct from the business of health care: reserve the use of the word "medical" as a descriptor when referring to only physicians such as in "medical staff," "medical clinic," "medical ethics," and use more generalizable terminology when collectively referring to multiple types of professionals such as "hospital staff," "clinic staff," "health care system," and "health care practitioners;" and be it further
RESOLVED, that the ISMA encourage the use of the aforementioned standardized terminology by all physician organizations in Indiana including all medical student and physician training programs; and be it further
RESOLVED, that the ISMA advocate at the national level within the AMA to adopt similar standardized terminology at the national level if such policies have not previously been adopted.

(RESOLUTION 23-52) RESOLVED, that ISMA study the feasibility of a public education campaign and an information campaign to all physicians, including resident physicians, and medical students in the state of Indiana on recent legislation including:

- The patient's right to clear and true information about the differences in the "profession, skills, training, expertise, educational degree, board certification or license" between physicians and non-physician practitioners, and
- The patient's right to truth and transparency in the type of licensure of the health care professional caring for them, and
- The patient's right to ask and to be informed in good faith by the former employer of a physician of the location and contact information of the physician who has left that practice and whom they had been cared for within two years of the physician's last employment.

(RESOLUTION 23-50) RESOLVED, that the ISMA recognize that physician collaboration with nonphysician practitioners and delegation of authority to practice medicine is not a usual nor customary duty of a physician and, as such, the decision to collaborate must be made voluntarily, not as a condition of employment, and with a formal collaborative practice agreement; and be it further
RESOLVED, that the ISMA support legislation or regulation to ensure that the employers of nonphysician practitioners have the financial and administrative responsibility in providing work and staffing conditions to provide (1) a safe level of collaboration in the independent medical judgment of the collaborative physician and (2) timely and safe level of oversight in the independent medical judgment of on-site physicians who may be asked to verify with or without attestation to medical acts of the nonphysician practitioner; and be it further
RESOLVED, that the ISMA seek and support legislation regarding physicians with no active collaborative agreement(s), regardless of employment arrangement that:

- An on-site physician shall not delegate medical authority to a nonphysician practitioner; and
- An on-site physician may verify a medical task performed by a nonphysician practitioner provided that the verifying physician is present for key portions of any patient care task or procedure verified (similar to the standards for the verification of resident physician care); and
- An on-site physician may only attest, through signature or other written documentation, to tasks, procedures, and elements of patient care that they have verified; and
- Attestation of tasks, procedures, and patient care notes for patients whom the physician has not seen is not within the usual and customary duty of a physician in the course of employment and a request from the employer that a physician attest to care that the physician has not participated in may constitute a breach of ethics or contract on the part of the employer; and
- To ensure a safe level of patient care provided by nonphysician practitioners, the on-site physician who has formally agreed to be available for verification or attestation of medical acts by the nonphysician practitioners must (1) have adequate time set aside from other professional responsibilities and duties to perform the verification and attestation function as determined by the on-site physician's

independent medical judgment and (2) receive adequate compensation to account for the loss of individual productivity and lost revenue due to the verification and attestation functions;
and be it further
RESOLVED, that the ISMA seek and support legislation on behalf of physicians with an (or multiple) active collaborative agreement(s), regardless of employment arrangement, that:

- A physician must be allowed to fully participate in the recruitment, selection, hiring, performance evaluation and firing decisions regarding the nonphysician practitioner; and
- To ensure a safe level of patient care provided by nonphysician practitioners, the collaborative physician must (1) have adequate time set aside from other professional responsibilities and duties to perform the collaborative function as determined by the collaborative physician's independent medical judgment and (2) receive adequate compensation to account for the loss of individual productivity and lost revenue due to the collaborative function.

(RESOLUTION 23-18) RESOLVED, that the ISMA seek legislation that requires nonphysician practitioners to have on-site, in-person supervision by their collaborating physician or other designated physician no less than 25% of total clinical time worked (1) during their first two years of clinical practice, and (2) in their first two years of after transitioning into a different specialty.

(AMENDED 22-41, HOD; RESOLUTION 18-16) RESOLVED, that ISMA support legislation limiting the collaborative agreement and active supervision between a physician and any nonphysician practitioner (PA, NP, CRNA, etc.) to four providers total, regardless of licensure, under one physician license.

(AMENDED 22-40, HOD; RESOLUTION 18-31) RESOLVED, that ISMA seek and support legislation that would require any nonphysician practitioner to work in a setting and perform tasks and procedures that are within the collaborating physician's scope of practice, and include those tasks and procedures within a particular field of medicine that the supervising physician is qualified by residency training and/or board certification to perform.

(RESOLUTION 22-35) RESOLVED, that the ISMA House of Delegates reaffirm the urgency of addressing Resolutions 18-16 and 18-31, which address physician supervision of nurse practitioners and physician assistants, at the next session of the Indiana General Assembly; and be it further
RESOLVED, that ISMA seek and support legislation in Indiana indicating that physicians who pro-vide supervising and/or collaborating duties from a location outside of Indiana for APRN's and/or PA's who are practicing in Indiana, must be available to answer questions and directly collaborate with the nonphysician practitioners, or to examine the patient, during a majority of the hours of activity of the APRN and/or PA via teleconferencing.

(RESOLUTION 21-59) RESOLVED, that the ISMA encourage and/or support legislation to require that physicians who are collaborating with non-physician practitioners working in retail health clinics have a regular practice located within 20 miles of the retail health clinic and be available to answer questions and directly collaborate with the non-physician practitioners, or to directly examine the patient, during a majority of the hours of operation of the retail clinic, either in person or via video conferencing, and be it further
RESOLVED, that the ISMA encourage and/or support state legislation to require that physicians who are collaborating with non-physician practitioners who work in retail health clinics have a professional relationship with a facility providing emergency services within 30 miles of the retail health clinic.

(RESOLUTION 21-58) RESOLVED, that the ISMA seek legislation that would standardize rules governing the scope of practice for all non-physician practitioners; and be it further
RESOLVED, that the ISMA seek legislation that would place all non-physician practitioners under one statutory framework that standardizes the rules for collaborative agreements between physicians and non-physician practitioners, regardless of license type.

(READOPTED AND AMENDED 19-29, BOT, RESOLUTION 9-50) RESOLVED, that ISMA oppose legislation that would authorize non-physicians to engage in the medical diagnosis or treatment of disease or injury

without physician collaboration or supervision and unequivocally oppose and seek to defeat any legislation that would extend the scope of any allied health profession into the areas of the practice of medicine.

(READOPTED AND AMENDED 18-16, HOD; RESOLUTION 08-35) RESOLVED, that the ISMA actively seek legislation in the Indiana General Assembly to limit to four the number of full-time equivalent advanced practice registered nurses that any one physician could legally collaborate with at any one time, the purpose of which is to maintain high quality medical care in Indiana.

(RESOLUTION 18-06) RESOLVED, that ISMA applauds efforts to bring uniform, consistent high quality to medical assistant training, certification and continuing education; and be it further
RESOLVED, that ISMA urge its members, Indiana physicians, and health care organizations to give preference in hiring to medical assistants who have demonstrated training, qualifications and continuing education such as those provided by Certified Medical Assistant (CMA) American Association of Medical Assistants certification.

(7/8/87, EC) Endorsed the concept for the necessity of PA rules with emphasis toward improving supervision of PAs and that the diagnosis or the prescription for drugs, etc., should originate with the physician.

SPORTS MEDICINE (including IHSAA issues)

(RESOLUTION 22-14) RESOLVED, that ISMA work with the Indiana High School Athletic Association (IHSAA) to find a way to incorporate a preparticipation physical into the annual Well Child Checks. This will prevent additional costs to the patients, additional time away from other activities, and reinforce the importance of Well Child Checks.

(RESOLUTION 21-103) RESOLVED, that the ISMA oppose mandatory preparticipation EKGs for all Indiana high school athletes.

(RESOLUTION 21-90) RESOLVED, that the ISMA urge the IHSAA to change the required date for preparticipation physical exams to no more than 365 days prior to the start of athletic participation to allow student athletes an opportunity to receive a comprehensive exam by their primary care provider and to provide ample time for appropriate follow-up.

(8/2/92, BOT; 10/19/84, BOT) Endorsed the recommendation of the ISMA Commission on Sports Medicine that Indiana High School Athletic Association (IHSAA) physical examinations be performed by physicians who have an unlimited license to practice medicine.

(6/7/87, BOT) Endorsed the recommendation from the Commission on Sports Medicine to promote equestrian safety by the use of protective headgear at all equestrian events.

STROKES

(RESOLUTION 16-49) RESOLVED, that the ISMA Commission on Legislation work with the interested legislator to develop the appropriate language for a bill that will facilitate acute stroke care for Indiana residents.

TOBACCO

(RESOLUTION 22-71) RESOLVED, that ISMA support legislation to ban the sale or distribution of all flavored recreational nicotine and tobacco products.

(RESOLUTION 21-19) RESOLVED, that the ISMA continue to support comprehensive legislation calling for smoke-free air in all workplaces, including restaurants, bars, and casinos, to protect all employees; and be it further

RESOLVED, that the ISMA continue as a supporting member of the Indiana Campaign for Smoke-Free Air.

(RESOLUTION 21-18) RESOLVED, that the ISMA continue to support banning smoking, vaping, e-cigarettes, and the use of all tobacco products and vaping devices at all Indiana elementary and secondary schools, on school properties, in all vehicles used for school-sponsored events, and at all school-sponsored events.

(RESOLUTION 21-16) RESOLVED, that the ISMA continue to support funding for tobacco control efforts, as outlined by the CDC guidelines, from the monies Indiana received via the Master Settlement Agreement (i.e., tobacco settlement) and that monies from the Master Settlement Agreement be used for health-related issues.

(RESOLUTION 21-15) RESOLVED, that the ISMA oppose the selling of any tobacco product by any pharmacies or other health-related businesses, institutions, organizations or associations.

(RESOLUTION 19-40) RESOLVED, that ISMA lend the association's full support to the state's initiatives to further reduce vaping; and be it further
RESOLVED, that ISMA support parity in state taxation between traditional cigarettes and e-cigarettes; and be it further
RESOLVED, that ISMA support the Alliance for a Healthier Indiana's efforts to enact policies to reduce vaping rates, particularly among Indiana's youth.

(READOPTED 19-25, HOD; READOPTED 09-13, HOD; RESOLUTION 99-31A) RESOLVED, that the ISMA readopt Resolution 09-13 as amended, as follows:
RESOLVED, that ISMA declare as policy that all monies derived from the Master Tobacco Settlement Agreement and deposited into the Indiana Tobacco Master Settlement Fund be used for health care and the promotion of community health; and be it further
RESOLVED, that ISMA continue to take a leadership role with all other health care entities to ensure that monies in the Indiana Tobacco Master Settlement Fund remain completely and totally within the health care arena.

(RESOLUTION 19-15) RESOLVED, that ISMA align support for future legislative action to protect physicians for the prescribing of off-label use of nicotine cessation products until they become approved for minors; and be it further
RESOLVED, that ISMA work with the AMA to seek immediate and thorough study of the use of all forms of nicotine delivery, as well as all nicotine addiction treatment options in populations under the age of 18; and be it further
RESOLVED, that ISMA seek AMA policy for federal regulation that encourages manufacturers of current nicotine addiction treatment therapy approved for adults, to study their products for use in populations under the age of 18.

(RESOLUTION 18-62) RESOLVED, that ISMA support the position of the FDA and AMA opposing the sale and marketing of e-cigarettes to children; and be it further
RESOLVED, that ISMA support legislation and health care policy to curb the sale, marketing and delivery of nicotine, e-cigarettes and nicotine delivery devices to children, including nicotine delivery systems designed to hide such use in schools.

(RESOLUTION 18-32) RESOLVED, that the Indiana State Medical Association support a tax increase on all non-medical nicotine-containing substances and delivery devices and distribute that tax revenue to county health departments in proportion to the county population.

(READOPTED 17-11, RESOLUTION 07-28) RESOLVED, that the ISMA establish policy and support legislation, rules and regulations that would ban smoking in public places in Indiana.

(READOPTED 17-10) RESOLUTION 07-27) RESOLVED, that the ISMA support legislation, policy, rules and regulations that would ban smoking in a vehicle with children; and be it further,

RESOLVED, that the ISMA seek and support legislation, policy, rules and regulations that would protect children in foster or guardianship care from second-hand smoke in enclosed areas.

(READOPTED 16-48, HOD; RESOLUTION 06-41) RESOLVED, that the ISMA actively support efforts to educate owners and managers of apartment complexes on the risks of secondhand smoke and methods to create smoke free buildings and common areas in their complexes; and be it further,
RESOLVED, that the ISMA actively support legislation to require that multi-building complexes provide an adequate number of smoke-free buildings to accommodate non-smoking residents, and be it further,
RESOLVED, that the ISMA also actively support methods and legislation to protect non-smokers in single building complexes (e.g. high rises) in as complete and cost-effective way as possible with the eventual goal of making such buildings entirely smoke-free.

(READOPTED 16-47, HOD; RESOLUTION 06-32) RESOLVED, that the ISMA support and encourage rules or regulations through the Department of Child Services and other agencies that all children placed in foster or guardianship care within the near future be protected from second-hand smoke within enclosed areas.

(RESOLUTION 16-45) RESOLVED, that the ISMA reaffirm its position that tobacco settlement funds should be used only for health-related programs.

(RESOLUTION 16-23) RESOLVED, that the ISMA reaffirm existing policy and support legislation to increase the tobacco tax by at least $1; and be it further
RESOLVED, that the ISMA reaffirm existing policy and support the prioritized and dedicated use of additional funds raised through an increased tobacco tax for health-related purposes, including tobacco cessation and addiction treatment; and be it further
RESOLVED, that the ISMA reaffirm existing policy and support legislation to raise the smoking age to 21; and be it further
RESOLVED, that the ISMA support legislation to repeal the Smokers' Bill of Rights.

(RESOLUTION 16-16) RESOLVED, that the ISMA support and seek rules/regulations/legislation to raise the minimum legal sale age to 21 for tobacco products and other nicotine delivery devices.

(RESOLUTION 15-42) RESOLVED, that the ISMA support public/physician education and appropriate public policy (using AMA policy as a framework) for Electronic Nicotine Delivery Systems/E-Cigs as more peer-reviewed research becomes available; and be it further
RESOLVED, that the ISMA support legislation that the use of any Electronic Nicotine Delivery Systems/E-Cig product should be restricted to citizens greater or equal to 21 years of age; and be it further
RESOLVED, that all existing ISMA policies addressing tobacco and tobacco products be construed to include Electronic Nicotine Delivery Systems/E-Cigs where applicable.

(READOPTED 15-20, HOD; RESOLUTION 05-07A) RESOLVED, that the ISMA continue its current efforts to support smoking cessation.