

RESOLUTION 10-01

STATEWIDE GUIDELINES FOR THE
ESTABLISHMENT OF PEDIATRIC BRAIN
DEATH

Introduced by:

Emil L. Weber, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, reliable and consistent guidelines are essential for the establishment of brain death and facilitate the best possible end-of-life decisions for treating physicians, next-of-kin and/or legal representatives; and

Whereas, the Indiana Organ Procurement Organization (IOPO) has found inconsistencies within the state for establishing brain death including: hospitals with no policy for the establishment of death, confusion regarding recognized definitions of brain death, inconsistencies in diagnostic protocols among physicians charged with determining death by neurological criteria and inappropriate use of radiologic agents for determining brain death; and

Whereas, new therapeutic interventions, i.e. hypothermia, barbiturate coma and hemicraniectomy, complicate the present day brain death determination process; and

Whereas, most practicing physicians do not confront brain death determination issues in their day-to-day care of patients, reference guidelines serve as a valuable tool to help direct the process to obtain accurate diagnostic information for patient care decision-making; therefore, be it

RESOLVED, that the ISMA adopt brain death guidelines for children for use in Indiana medical facilities. (Proposed guidelines are attached.)

Proposed Guidelines for Brain Death Determination in the State of Indiana

PEDIATRIC DIAGNOSTIC CRITERIA – PATIENTS 36 WEEKS OR MORE GESTATIONAL AGE

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

- A History: Determine cause of coma to eliminate remediable or reversible conditions
- B. Physical examination criteria: Refer to Adult Guidelines for details of examination for this section.
 - 1. Coma and apnea
 - 2. Absence of brainstem function -
 - (a) Midposition or fully dilated pupils that are fixed to light
 - (b) Absence of spontaneous oculocephalic (doll's eye) and caloric-induced eye movements
 - (c) Absence of movement of bulbar musculature, corneal, gag, cough, sucking and rooting reflexes
 - (d) Absence of respiratory effort with standardized testing for apnea
 - 3. Patient must not be hypothermic or hypotensive
 - 4. Flaccid tone and absence of spontaneous or induced movements excluding activity mediated at spinal cord level
 - 5. Examination should remain consistent for brain death throughout the predetermined period of observation
- C. Observation period according to age
 - 1. Reliable criteria have not been established for the determination of brain death in children less than 7 days old.
 - 2. Seven days to two months: Two examinations and electroencephalograms (EEG) should be separated by at least 48 hours.
 - 3. Two months to one year: Two examinations and EEGs should be separated by at least 24 hours. A repeat examination and EEG are not necessary if a concomitant radionuclide or other angiographic study demonstrates no visualization of cerebral arteries.
 - 4. More than one year and less than 18 years of age: Two examinations 12 to 24 hours apart; EEG and isotope angiography are optional.
 - 5. Above age 18 years of age, use Adult Guidelines for determining brain death.

RESOLUTION 10-02

SAME-SEX MARRIAGE: PUBLIC HEALTH
IMPLICATIONS

Introduced by: William C. Buffie, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, legal marriage status confers numerous financial and legal benefits upon married individuals that improve access to health care; and

Whereas, better access to health care results in lower overall mortality; and

Whereas, the lesbian, gay, bisexual, transgender (LGBT) community has diminished access to health care; and

Whereas, the LGBT community suffers from significantly worse mental and physical health outcomes compared to the community at large; and

Whereas, the American Medical Association at the November 2009 convention acknowledged same-sex marriage bans do contribute to health disparities in the U.S.; and

Whereas, evolving medical/social science literature attests to the health benefits conferred by the social and legal recognition of same-sex marriage; and

Whereas, the ISMA is a body that is to be guided in its decision-making by science, reason and public policy standards that promote the health and well-being of all Indiana citizens; and

Whereas, same-sex marriage equality has not been demonstrated to have any deleterious consequences for society in general; therefore, be it

RESOLVED, that the ISMA acknowledge that it is sound public health policy to support the legal and social recognition of same-sex marriage.

[2] www.theglobeandmail.com/news/national/boy-or-girl-take-a-quickie-at-home-test/article1176978/

[3] Drabiak-Syed K. Baby Gender Mentor: Class Action Litigation Calls Attention to a Deficient Federal Regulatory Framework for DTC Genetic Tests, Politicized State Statutory Construction, and a Lack of Informed Consent. *Journal of Law and Medicine*. *Accepted for Publication*.

RESOLUTION 10-04

SUPPORTING LEGISLATION AND/OR
REGULATIONS THAT REQUIRE CLEARLY
LABELING FOOD WITH GENETICALLY
ENGINEERED INGREDIENTS

Introduced by: Caitilin Kelly, M.D.; Monroe/Owen County Medical
Society; and the 2nd District Medical Society

Referred to: REFERENCE COMMITTEE II

Whereas, lack of labeling denies health professionals the ability to trace potential toxic [1] or allergic reactions [2] to, and other potential diseases [3] [4] [5] from, genetically engineered food; and

Whereas, the World Health Organization issued warnings on the use of antibiotic marker genes in genetically engineered food [6]; and

Whereas, in order to make informed decisions, the public needs to be made aware of the contents of their food just as patients need to be aware of the risks, benefits and alternatives to their medical and surgical treatments; and

Whereas, 40 countries require labeling of genetically engineered food, including the European Union, Australia, Japan, Russia, China, New Zealand, Brazil and South Africa [7]; and

Whereas, the American Public Health Association [8], American Nurses Association [9], the British Medical Association [10] and the Irish Medical Organization [11] support the labeling of genetically engineered food products; and

Whereas, Catholic Healthcare West (a network of 41 hospitals and 10,000 physicians) avoids genetically engineered food and advocates for public policies that include the labeling of genetically engineered food [12]; and

Whereas, over 240 U.S. hospitals and medical centers have signed the Healthy Food in Health Care Pledge, encouraging vendors to supply food that is produced without genetic modification [13]; and

Whereas, major U.S. food producers currently label genetically engineered food that they sell in overseas markets [14]; and

Whereas, surveys of the U.S. public consistently show overwhelming support for the labeling of genetically engineered food [15] [16]; therefore, be it

RESOLVED, that the ISMA support legislation and/or federal regulatory action that requires all foods containing genetically engineered ingredients to be clearly labeled.

[1] Ewen S and Pusztai A. Effects of diets containing genetically modified potatoes expressing *Galanthus nivalis* lectin on rat small intestine. *Lancet*. 1999; 354: 1353-4.

[2] Bernstein et al. Immune responses in farm workers after exposure to *Bacillus thuringiensis* pesticides. *Environmental Health Perspectives*. 1999; 107: 575-82.

[3] Finamore, A.; Roselli, M.; Britti, S.; Monastra, G.; Ambra, R.; Turrini, A.; and Mengheri, E. Intestinal and Peripheral Immune Response to MON810 Maize Ingestion in Weaning and Old Mice. *Journal of Agriculture and Food Chemistry*. 2008; 56: 11533-11539.

[4] Velmirov, A.; Binter, C.; and Zentek, J. Biological effects of transgenic maize NK603 x MON810 fed in long term reproduction studies in mice. Federal Ministry for Health, Families and Youth, Government of Austria, October 2008.

http://bmgfj.cms.apa.at/cms/site/attachments/3/2/9/CH0810/CMS1226492832306/forschungsbericht_3-2008_letztfassung.pdf

[5] Séralini GE, de Vendô Séralini GE, de Vendômois JS, Cellier D, Sultan C, Buiatti M, Gallagher L, Antoniou M, Dronamraju KR. How Subchronic and Chronic Health Effects can be Neglected for GMOs, Pesticides or Chemicals. *Int J Biol Sci*. 2009; 5: 438-443. Available from <http://www.biolsci.org/v05p0438.htm>

[6] http://www.chwhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/194274.pdf

[7] Kimbrell A. Your Right to Know: Genetic Engineering and the Secret Changes in Your Food. Earth Aware Editions. 2007: 116-117

[8] <http://www.apha.org/advocacy/policy/policysearch/default.htm?id%0>

[9] <http://www.nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/environmentalhealth/PolicyIssues/HealthyFoodinHealthCare.aspx>

[10] Motion passed in 2002 namely "In view of the absence of any epidemiological studies detailing the effects of genetically engineered foods on human health, this AGM requests the Minister for Health and Children provide funding for the establishment of a group to establish the implications of genetically engineered food." Elizabeth Cullen M.D., Secretary, Irish Doctors Environmental Association

[11] http://www.who.int/foodsafety/publications/biotech/en/ec_june2000_en.pdf

[12] <http://www.noharm.org/us/food/pledge>

[13] <http://www.nationalaglawcenter.org/assets/crs/RS20507.pdf>

[14] May 2008 poll by CBS

<http://www.cbsnews.com/stories/2008/05/11/eveningnews/main4086518.shtml>

[15] *Americans and GM Food: Knowledge, Opinion and Interest in 2004*; Food Policy Institute, Cook College – Rutgers, The State University of New Jersey; Publication number RR-1104-007

[16] <http://www.cbsnews.com/stories/2008/05/11/eveningnews/main4086518.shtml>

RESOLUTION 10-05

SUPPORT OF CONVENTION ON TOBACCO
CONTROL

Introduced by: Caitilin Kelly, M.D.; Monroe/Owen County Medical
Society; and the 2nd District Medical Society

Referred to: REFERENCE COMMITTEE I

Whereas, tobacco use is the second major cause of death and the fourth most common risk factor for disease worldwide; and

Whereas, if current smoking patterns continue, it will cause 10 million deaths worldwide each year by 2020; and

Whereas, the tobacco industry is aggressively seeing a foothold into the profitable markets of Africa, Asia and Latin America, exploiting the world's most disadvantaged populations; and

Whereas, tobacco and poverty are inextricably linked with many studies showing that in the poorest of households in some low-income countries, as much as 10 percent of the total household expenditure is on tobacco; and

Whereas, 166 nations (95 percent of the global population) have acceded to the World Health Organization's (WHO) Framework Convention on Tobacco Control; and

Whereas, the U.S. refuses to ratify WHO's Convention on Tobacco Control; and

Whereas, the tobacco corporations' objections to the convention include such things as an unwillingness to put package warnings in the language of the country where it is being sold; therefore, be it

RESOLVED, that the ISMA work with the AMA to encourage ratification of the World Health Organization's Framework Convention on Tobacco Control.

RESOLUTION 10-06

SUPPORT OF CONVENTION ON CHILDREN'S
RIGHTS

Introduced by: Caitilin Kelly, M.D.; Monroe/Owen County Medical
Society; and the 2nd District Medical Society

Referred to: REFERENCE COMMITTEE I

Whereas, our children are our nation's most prized and valued asset; and

Whereas, children are a vulnerable population whose physical and mental
immaturity requires special safeguard and care,

Whereas, the United States lacks broad and comprehensive policies that address
the status of children in a consistent manner; and

Whereas, the United Nations Children's Fund's (UNICEF's) Innocenti Report Card,
an analysis of child well-being in wealthy countries, ranks the U.S. 21st of 21
nations for health and safety, and 20th of 21 nations for all composite measures;
and

Whereas, the United Nations Convention on the Rights of the Child includes 54
articles articulating the fundamental rights of children, including special safeguard
and care, freedom from discrimination, and medical and educational rights; and

Whereas, the U.S. helped write these 54 articles but is the only nation that has not
signed the convention (other than Somalia, which recently stated it would sign);
therefore, be it

RESOLVED, that the ISMA work with the AMA to encourage the U.S. to ratify the
United Nations Convention on the Rights of the Child.

RESOLUTION 10-07

INDIANA SAFE HAVEN LAW

Introduced by:

Don Henry, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, albeit infrequent, tragedies occur from abandoned infants; and

Whereas, these cases occur disproportionately in unplanned teen pregnancies; and

Whereas, Indiana has enacted a Safe Haven Law to permit the legal and safe release of a newborn infant; and

Whereas, the ISMA has endorsed comprehensive sex education as a means of reducing teen pregnancy; and

Whereas, implementation of effective sex education has yet to be legally mandated in Indiana, with many schools having "abstinence only" programs or none; and

Whereas, no program will be completely successful in eliminating unplanned teen pregnancy; and

Whereas, the rate of teen pregnancy in Indiana is high and expected to remain high for the foreseeable future; therefore, be it

RESOLVED, that the ISMA 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 10-08

UNINTENDED PREGNANCY

Introduced by:

Don Henry, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Indiana continues to have a high rate of unintended pregnancy, particularly among teens; and

Whereas, the medical and social costs to patients and society as a whole from unintended pregnancy are high; and

Whereas, the ISMA has endorsed a number of measures to reduce unplanned pregnancy, including improved access to and education about contraception; therefore, be it

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, professional awareness and legislation.

RESOLUTION 10-09

HPV EDUCATION AS A COMPONENT OF
COMPREHENSIVE SEX EDUCATION

Introduced by: Don Henry, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, human papilloma virus, or HPV, is recognized as the key etiology of preinvasive and malignant cervical disease; and

Whereas, HPV is highly prevalent among teenagers; and

Whereas, public awareness of the availability of vaccines for protection against HPV is low; and

Whereas, low levels of public awareness are further hampered by widespread misinformation about HPV vaccine and vaccines in general; and

Whereas, vaccines for HPV have been extensively tested and have a record of safety; and

Whereas, HPV vaccination has a potential for dramatically decreasing the incidence and prevalence of HPV among teenagers; and

Whereas, a decreased incidence of HPV will have a long-term beneficial effect in reducing cervical disease; and

Whereas, the ISMA has endorsed comprehensive sex education as a public health measure; therefore, be it

RESOLVED, that the ISMA public policy include support for education about HPV vaccination and testing as an essential component of comprehensive sex education.

RESOLUTION 10-10

REFORMING THE COST OF HEALTH CARE

Introduced by:

Bernard Emkes, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, the Health Care Reform Act of 2010 has over 2,000 pages and enacts MANY changes in health care coverage and health care policy over the next 10 years, yet adds over \$1 trillion to the cost of health care; and

Whereas, there are simpler changes that would actually have an overall impact on reducing health care costs; and

Whereas, physicians should always be advocates for cost-effective health care; and

Whereas, several changes that are intuitive and that could be implemented would impact costs much sooner than the above stated Act, and

Whereas, these changes would reduce red tape, work and rework for physician offices, as well as other health care providers; therefore, be it

RESOLVED, that the ISMA adopt, and encourage the AMA to also adopt, the following three characteristics that advocate for health care reform than the currently enacted Health Care Reform Act of 2010. They include:

- 1. For a specific package of insurance coverage, all payers – including Medicare, Medicaid and commercial payers – must cover the same procedures, techniques and related services equally.**
 - a. A plan may have many coverage options, such as Package A, B, C, D, etc., but once packaged as Package A - UHC, Aetna, Cigna and Wellpoint, as well as Medicare and Medicaid and all other payers must cover services equally. Today, the confusion created by variable plan coverage that varies from federal to commercial payers and between plans makes application of consistent rules almost impossible. This then also leads to extra approval time for tests and services, denial of care, non-payment of fees, appeals and rework, all of which cost “the system” and physician offices huge amounts of money. If “best practice is indeed best practice,” then plans should agree on one standard of care and apply that equally across all plans and coverage. That is simply not the case today.

2. **Society must better define “end-of-life” care and payment for such services.**

What care a patient receives at the end of life should be a decision made by physicians and family members in consultation, but what society pays for should be evidence-based and limited only to care that has some appreciable chance of success. That discernment must be determined by society and relate to the willingness to pay more taxes or other fees, if non-evidence-based care is requested to be paid for by societal programs.

 - a. The rationale for “coding” patients in their 90s or expending ICU resources for incurable conditions must have some basis other than family emotion and the often unrealistic expectations of family members. Society must determine where the lines are drawn based on outcome data and realistic application of health care resources; and beyond that line, costs need to be paid by family for any care society deems as ineffective or futile.

3. **New guidance and processes need to be implemented as related to “malpractice.”** Malpractice reform will not be enough to reduce this “hidden cost” of health care due to the defensive testing ordered daily by physicians all over this country to cover themselves as protection against legal liability.
 - a. The answer is to establish “evidence-based protocols of care.” If a physician can show he/she has followed a nationally developed and peer-reviewed, accepted evidence-based protocol, that in itself should be de facto evidence that “standard of care” was met, unless there was some egregious deviation from the protocol. Allowing some form of health courts to hear these cases, or a health judge to weigh in on the merits of any tort action should also bring some logic to the “jackpot lottery” mentality currently pervasive in this country. Legitimately injured patients should be compensated – perhaps even outside this legal scenario and prior to a case getting to the judicial level.

RESOLUTION 10-11

INCREASED MEDICAID REIMBURSEMENT
RATES

Introduced by: Thomas Barley, M.D.

Referred to: REFERENCE COMMITTEE III

Whereas, Resolution 00-07 is set to expire in 2010; and

Whereas, with the increased enrollment with the Children's Health Insurance Program (CHIP) in Indiana, the number of children requiring medical access has increased; and

Whereas, the enrollment level is now based on 200 percent of the poverty level; and

Whereas, the largest problem with enlisting providers of medical services is in regard to adequate reimbursements to cover costs of providing these services; and

Whereas, it has previously been demonstrated that Indiana lags behind this region of the country when comparing Medicaid reimbursement rates, and the whole region is significantly below when compared to Medicare reimbursement rates; therefore, be it

RESOLVED, that the ISMA reaffirm its policy and continue to support legislation that increases physician Medicaid reimbursement at least to the Medicaid regional average and preferably to a level comparable to Medicare.

RESOLUTION 10-12

SETTING UP A TASK FORCE TO STUDY BUNDLED
PAYMENTS AND ACCOUNTABLE CARE
ORGANIZATIONS

Introduced by: 13th District Medical Society

Referred to: REFERENCE COMMITTEE I

Whereas, the health reform legislation proposes the creation of new mechanisms of reimbursement for health care services; and

Whereas, in these new mechanisms, bundled payments and accountable care organizations are being created; and

Whereas, most physicians have concerns about bundled payments and accountable care organizations; and

Whereas, knowledge about the impact of bundled payments on physician practices and accountable care organizations on the delivery of health care is limited; therefore, be it

RESOLVED, that the ISMA set up a task force to study the mechanism of how to create an accountable care organization; and be it further

RESOLVED, that the ISMA set up a task force to study the impact of bundled payments on physician practices; and be it further

RESOLVED, that ISMA, working with its AMA delegation, set up a task force at the AMA level to study bundled payments and accountable care organizations.

RESOLUTION 10-13

MEDICARE REIMBURSEMENT TO HOSPITALS
FOR PHARMACEUTICALS ADMINISTERED
DURING 23-HOUR OBSERVATION STAYS

Introduced by: 13th District Medical Society

Referred to: REFERENCE COMMITTEE III

Whereas, many Medicare patients are admitted to 23-hour observation; and

Whereas, these Medicare patients need the medications they take routinely for their chronic conditions; and

Whereas, the current Medicare rules do not pay for these medications during the 23-hour observation stay; and

Whereas, Medicare patients get billed by hospitals separately for these medications; and

Whereas, these bills for the pharmaceuticals administered during the 23-hour observation stay can be substantial; therefore, be it

RESOLVED, that the ISMA, working with its AMA delegation, seek to change the current Medicare policy about coverage for pharmaceuticals during the 23-hour observation stay, either by legislative means or administrative means.

RESOLVED, that the ISMA, working with its AMA delegation, seek to change Medicare policy, either legislatively or administratively, to pay for medications needed by Medicare patients when they are admitted for 23-hour observation stays in hospitals.

RESOLUTION 10-14 PHYSICIANS' ACCESS TO THEIR OWN PRESCRIBING
INFORMATION VIA INSPECT

Introduced by: St. Joseph County Medical Society

Referred to: REFERENCE COMMITTEE II

Whereas, INSPECT was designed to address the problem of prescription drug abuse and diversion in Indiana; and

Whereas, licensing boards can already query the system by licensee number to investigate a licensee; and

Whereas, the only names a physician should discover when a physician queries one's own DEA number in the system are individuals for whom one has written a controlled substance prescription and thus has an established patient-physician relationship, thus no HIPAA violation is involved; therefore, be it

RESOLVED, that the ISMA work with the appropriate state and federal agencies to modify INSPECT so that individual physicians can query their individual DEA numbers and see what prescriptions have been filled by whom under their prescribing authority.

RESOLUTION 10-15

PROPOSITION FOR HEALTH CARE COST
CONTAINMENT

Introduced by:

Bernard Emkes, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, many services provided by physicians and hospitals are later denied for payment based on "failure to get a prior authorization"; and

Whereas, these services are often urgent yet with health plans or other payers requiring 2-14 days to turn around an authorization; and

Whereas, these services are often nonetheless needed whether authorized or not; and

Whereas, if time and effort were sufficient, an authorization would have been requested and granted; and

Whereas, health plans use this lack of authorization by itself to deny payment regardless of medical necessity; and

Whereas, this practice is artificial, put in place to "manage" services provided but more often used as yet another way to deny legitimate health care claims; therefore, be it

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 our delegation to the AMA.

RESOLUTION 10-16

NON-COVERAGE NOTIFICATION

Introduced by:

James Leland, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, a provider submits a claim for services rendered to payers identified by the patient as their primary carrier/network for reimbursement; and

Whereas, patient has Medicaid as secondary; and

Whereas, payer verbally verifies that the patient is covered under primary and services are rendered in good faith; and

Whereas, upon adjudication it is determined that a patient is not covered and cannot be billed as Medicaid, which is secondary; and

Whereas, the provider then has no alternative but to write-off charges; therefore, be it

RESOLVED, that ISMA support federal/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; and be it further

RESOLVED, that ISMA delegates to the AMA forward this resolution to the next AMA annual meeting for action on a national level.

RESOLUTION 10-17 FUNDING FOR INDIANA MEDICAID EXPANSION UNDER
THE PATIENT PROTECTION AND AFFORDABLE HEALTH
CARE ACT

Introduced by: Thomas S. Whiteman, M.D., and the 8th District Medical
Society

Referred to: REFERENCE COMMITTEE III

Whereas, the federal government passed the Patient Protection and Affordable Health Care Act (PPACA), March 23, 2010 (Reconciliation Bill, March 30); and

Whereas, recent actuarial assessment of the costs to Indiana over the first decade due to federally mandated expansion of Medicaid coverage is \$3.5 billion (an increase in Medicaid enrollment from about 16.7 to 24.4 percent of the Indiana population); and

Whereas, current Indiana Medicaid funding is approximately 60-65 percent of the Medicare fee schedule; and

Whereas, for most physicians, even current Medicare funding is significantly insufficient in terms of covering the cost of running a medical practice, thus creating significant issues regarding patient access to care and quality of care; therefore, be it

RESOLVED, that ISMA policy is to increase Medicaid reimbursement to at least 100 percent of current Medicare in order to maintain some semblance of access to care and to prevent significant compromise in quality of care, that the ISMA only support expansion of Medicaid if it is thus funded and oppose any expansion not adequately funded as part of the PPACA-mandated Indiana Medicaid expansion.

RESOLUTION 10-18 PPACA/INSURANCE COMPANY RATE INCREASES –
PUBLIC EDUCATION

Introduced by: Thomas S. Whiteman, M.D., and the 8th District Medical
Society

Referred to: REFERENCE COMMITTEE II

Whereas, the federal government passed the Patient Protection and Affordable Health Care Act (PPACA), March 23, 2010 (Reconciliation Bill March 30); and

Whereas, \$250,000,000 was appropriated for state grants to increase their review and approval process of health insurance carrier premium rate increases; and

Whereas, greater public accountability of health insurance companies has been lacking; therefore, be it

RESOLVED, that ISMA policy support and that the ISMA seek legislation to obtain and utilize as much of the \$250,000,000 appropriated for state grants from the Patient Protection and Affordable Health Care Act for the benefit of full health insurance disclosure and public education in Indiana.

RESOLUTION 10-19 INCENTIVES FOR PHYSICIANS TO PRACTICE
 AT BELOW COSTS

Introduced by: Thomas S. Whiteman, M.D., and the 8th District Medical
 Society

Referred to: REFERENCE COMMITTEE II

Whereas, the federal government passed the Patient Protection and Affordable Health Care Act (PPACA), March 23, 2010 (Reconciliation Bill March 30); and

Whereas, recent actuarial assessment of the costs to Indiana over the first decade due to federally mandated expansion of Medicaid coverage is \$3.5 billion (an increase in Medicaid enrollment from about 16.7 to 24.4 percent of the Indiana population); and

Whereas, current Indiana Medicaid funding is approximately 60-65 percent of the Medicare fee schedule; and

Whereas, for most physicians, even current Medicare funding is significantly insufficient in terms of covering the cost of running a medical practice, thus creating significant issues regarding patient access to care and quality of care; and

Whereas, substantial numbers of practicing physicians in Indiana are approaching a point in their careers where retirement is a better option than continuing patient care under the current circumstances of decreasing reimbursement, increasing red tape, increasing medical liability risk and decreasing respect for the profession; therefore be it

RESOLVED, that the ISMA policy support and seek legislation to encourage physicians, especially those near retirement, to continue to provide care by decreasing liability risks (especially for total charity care but also for significant under-compensated care), and providing some reduced tax liability proportional to the amount of uncompensated, under-compensated care donated.

RESOLUTION 10-20

INDIANA PROFESSIONAL LICENSING
AGENCY

Introduced by:

Douglas Morrell, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, Resolution 00-48 is set to expire in 2010; and

Whereas, the Indiana Professional Licensing Agency has difficulty functioning and meeting deadlines for physician licenses; and

Whereas, support is needed to make the Indiana Professional Licensing Agency more effective; and

Whereas, monies generated from licensing fees go to the general fund as opposed to supporting the budget for the Indiana Professional Licensing Agency; therefore, be it

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.

RESOLUTION 10-21

REDUCING BULLYING THROUGH EDUCATION
PARTNERSHIPS

Introduced by:

Mary McAteer, M.D.; Stacie Wenk, D.O.;
First District Medical Society; and the Indiana
Chapter of the American Academy of Pediatrics

Referred to:

REFERENCE COMMITTEE IV

Whereas, bullying leads to a negative school/social environment; and

Whereas, research shows that 60 percent of boys who were bullies in the 6-9th grades were convicted of at least one crime; and

Whereas, children who are bullied may suffer from variable levels of emotional consequences; and

Whereas, Indiana implemented code 20-33-8-0.2 defining bullying and code 20-33-8-13.5 requiring schools to adopt policies prohibiting bullying during ANY school-related event; therefore, be it

RESOLVED, that the ISMA develop a program or mailing to educate medical providers on identifying at-risk children and the reporting process; 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.

Fiscal Note: \$5,000

RESOLUTION 10-22

LASER SURGERY

Introduced by:

William Penland, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, lasers use extremely high-energy light waves to cut, coagulate and remove tissue; and

Whereas, with any surgical procedure the key to a successful outcome is a knowledgeable, experienced and skillful surgeon; and

Whereas, the surgeon who uses lasers should understand the technology being employed, be well trained in its use, be capable of managing potential complications, and be able to meet the high standards of medical peers; and

Whereas, a number of states have faced legislative battles to allow non-physicians to perform laser surgery, and in Oklahoma non-physicians were successful; and

Whereas, the ISMA approved Resolution 00-02, which sunsets this year, resolving that the ISMA support the position that statutes define laser surgery as the practice of medicine that should be performed only by doctors of medicine and osteopathy; therefore, be it

RESOLVED, that the ISMA adopt the policy that laser surgery should be performed only by individuals currently licensed by statute (MD or DO) and properly trained to practice medicine and perform surgical services.

RESOLUTION 10-23

INDIANA HIGH SCHOOL ATHLETIC ASSOCIATION
(IHSAA) PREPARTICIPATION PHYSICAL EXAM

Introduced by: Scott Curnow, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, the IHSAA has allowed coaches earlier access to athletes during the summer months, no change has been made in the mandatory date of May 1 for preparticipation athletic exams; and

Whereas, most junior high schools and many community sports programs have adopted the IHSAA physical form and mandate of May 1, this increase in the volume of patients makes it impossible for a primary care office to schedule all of its athletes prior to the start of their athletic season; and

Whereas, the increased volume of athletes needing pre-participation exams and the difficulty of all these students to be seen in their medical home, more and more student athletes are receiving care from individuals or at facilities unable to give comprehensive care, including vaccinations, drug and alcohol counseling, or obesity screening; and

Whereas, the most recent edition of *Preparticipation Physical Evaluation*, a collaboration by the AAFP, AAP, ACSM and AOSSM, recommends an exam **at least** six weeks prior to the start of preseason practice; and

Whereas, this minimum gap would allow for proper follow-up of athletes with injuries, cardiac or respiratory difficulties identified at their preparticipation physical; and

Whereas, the IHSAA does a tremendous job administering the logistics of high school athletics, it is the responsibility of the medical community to see to the health and well-being of our student athletes; and

Whereas, the majority of states throughout the Midwest and the country have adopted a policy of an exam 365 days prior to the start of athletic participation, a change in Indiana's policy would allow a much smoother transition for those athletes moving from another state; therefore, be it

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.

RESOLUTION 10-24

TRENDING "NON-REGULATED" PROVIDERS

Introduced by:

Stacie Wenk, D.O.; Maria Del Rio Hoover, M.D.;
William Pond, M.D.; and First District Medical
Society

Referred to:

REFERENCE COMMITTEE II

Whereas, safety is paramount for all health care professionals when performing "procedures" on patients/clients; and

Whereas, the state of Indiana has established licensing and certification requirements designed to protect the citizens of Indiana; and

Whereas, most procedures are monitored and held to a rigorous standard (based on scientific outcomes) and permitted under the standard of practice established for each health care profession; and

Whereas, there remain some areas of practice by individuals who are non-licensed or non-certified by the state of Indiana that may not utilize science-based standards of care; and

Whereas, the practice of midwifery and home deliveries by individuals not trained medically or not licensed as a physician or nurse midwife, most often referred to as lay midwives, has been practiced in Indiana without any adverse outcome reporting requirements; and

Whereas, the practice of body modification, or the deliberate altering of the human body for non-medical related reasons by persons not trained in medicine or not licensed by the state of Indiana, has been practiced in Indiana without any adverse outcome reporting requirements; and

Whereas, studies and research are currently limited or unavailable to determine best practices in these areas; and

Whereas, Indiana's local county health departments are typically charged with the task of preserving, protecting and promoting the health of the public in Indiana's counties, collection of information and investigations regarding public health are critical to the county health department's success with preserving, protecting and promoting health; and

Whereas, it is common for licensed hospitals and facilities to report to the Indiana State Department of Health regarding various health measures; therefore, be it

RESOLVED, that the ISMA seek legislation to establish "trends" for non-regulated areas such as the practice of midwifery and home deliveries by individuals not trained medically or not licensed as a physician or nurse midwife who perform procedures on patients/clients; and be it further

RESOLVED, the ISMA seek legislation that requires immediate reporting to the local county health officer (or its representative) adverse reactions resulting in hospital admission and/or death for the specific purpose of gathering data when a non-regulated person is performing midwifery or body modification.

RESOLUTION 10-25

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

Introduced by:

Don J. Wagoner, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Congress gave Medicare leeway to give health care providers who curb Medicare spending a share of the savings as long as they reach quality and cost control targets; and

Whereas, Medicare has plans to pilot test and implement accountable care organizations in which networks of providers must be created; and

Whereas, it appears hospitals will have the major advantage by having the administrative organization that will be required by these accountable care organizations; therefore, they will have a conflict of interest when it comes to negotiating with independently practicing physicians; and

Whereas, a significant number of physicians, on the order of 70 percent, are still in solo or small groups in this country; and

Whereas, the governance of accountable care organizations are just now being created; therefore, be it

RESOLVED, that the ISMA request the AMA support legislation that mandates the boards of directors of each accountable care organization consist of at least 50 percent physicians who own their own practice, and not physicians who are employed either directly or indirectly by any hospital system.

RESOLUTION 10-26

SPICE

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, spice (brand names such as K2, Pep and Kind) is an imported herbal blend with or without added synthetic chemicals, intended to be used as an incense, not for human consumption; and

Whereas, spice is usually used for smoking and referred to as synthetic marijuana; and whereas

Whereas, spice can cause hallucinations, tachycardia, headaches and other reactions; and

Whereas, spice is legal and unregulated in Indiana; and

Whereas, spice is banned in Kansas, Britain, France, Germany, Poland, Russia and South Korea; therefore, be it

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; and be it further

RESOLVED, that the ISMA urge the AMA to support efforts for Federal Drug Administration regulation of herbal products, also known as 'spice,' as well as other similar products, and support efforts to ban the sale and use of such products in the USA.

RESOLUTION 10-27

ACCEPTABLE ALTERNATIVE MEDICATIONS
THAT DO NOT REQUIRE PRIOR
AUTHORIZATION

Introduced by: Marc Willage, M.D.

Referred to: REFERENCE COMMITTEE III

Whereas, frequently a treating physician is denied a specific prescribed medication, indicating that a prior authorization is necessary; and

Whereas, it would be most useful to have a list of alternative medications that do not require a prior authorization; therefore, be it

RESOLVED, that the ISMA support regulatory or statutory change requiring insurers to provide a list to physicians via facsimile transmission of alternative FDA-approved medications that do not require prior authorization

RESOLUTION 10-28

TOBACCO DISPLAYS IN PHARMACIES

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, many pharmacies display tobacco products next to candy in areas easily accessible to minors; and

Whereas, it is irrational in 2010 to sell tobacco, the major killer of Americans, in a store that promotes health, health aids and pharmaceuticals; and

Whereas, the ISMA approved this issue through Resolution 00-13 that sunsets this year; therefore, be it

RESOLVED, that the ISMA work with the Indiana Pharmacists Alliance to explore strategy to request that no licensed pharmacy in Indiana sell tobacco products.

RESOLUTION 10-29

OLDER AT-RISK DRIVERS

Submitted by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, older drivers are increasing in number, usually are good drivers, and mostly at risk of injuring themselves; and

Whereas, cognitive impairment can make it difficult for an individual to assess his/her driving abilities; and

Whereas, physicians want to protect the safety of patients and other highway users but are often reluctant to report and are unaware of the ethical and legal obligations to report at-risk drivers; and

Whereas, 12 states require physicians to report at-risk drivers and 22 states encourage reporting, Indiana does neither; and

Whereas, 25 states provide immunity from lawsuits for reporting and 19 states protect the identity of those reporting, Indiana does both; and

Whereas, the AMA and the National Highway Traffic Safety Administration have published the "Physician Guidelines for Assessing and Counseling Older Drivers"; and

Whereas, the AMA's Code of Medical Ethics on impaired drivers and their physicians states, "in situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the (BMV)"; therefore, be it

RESOLVED, that ISMA form a coalition/alliance/partnership with other agencies and organizations concerned with older at-risk drivers to study and evaluate the methods of reporting medically unfit drivers; and be it further

RESOLVED, that the findings/recommendations/resolutions of this said group be submitted to the 2011 ISMA House of Delegates for possible action.

RESOLUTION 10-30

SMOKING PROHIBITED IN DAY CARE CENTERS

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, the ISMA supported the prohibition of smoking in day care centers through Resolution 00-12, which sunsets this year; therefore, be it

RESOLVED, that the ISMA continue to support efforts that would prohibit smoking in all day care centers.

RESOLUTION 10-31

TOBACCO SETTLEMENT

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, the ISMA supported tobacco funding control efforts of the CDC guidelines and for monies to be used for health-related issues through Resolution 00-29, which is due to sunset; therefore, be it

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 10-32

UNDERAGE DRINKING

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, the ISMA supports efforts to reduce underage drinking through Resolution 98-29 and Resolution 00-25, which sunset this year; therefore, be it

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.

RESOLUTION 10-33

SMOKING ON SCHOOL PROPERTIES

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, the ISMA supported smoking bans on school properties through Resolution 00-28, which sunsets this year; therefore, be it

RESOLVED, that the ISMA continue to support banning smoking and the use of all tobacco products 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 10-34

SMOKE-FREE ENVIRONMENT IN ALL WORKPLACES

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, the U.S. Surgeon General states: "The debate is over, the science is clear, secondhand smoke is a serious health hazard that causes premature death and diseases"; and

Whereas, secondhand smoke is a workplace hazard and no employee should have to choose between a job and their health in order to earn a living; and

Whereas, all credible economic studies show communities with comprehensive smoke-free workplace laws have not seen a negative impact on the hospitality industry or any other sector; and

Whereas, smoke-free policies decrease absenteeism among non-smoking employees, reduce housekeeping and maintenance costs, lower insurance rates and reduce smoking-related fires; and

Whereas, according to the U.S. Surgeon General, the only way to effectively protect individuals from the hazards of secondhand smoke is to completely eliminate indoor smoking; therefore, be it

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

RESOLUTION 10-35

UNFAIR COMPETITION FROM CLINICS

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, the federally funded clinic in Porter County is funded to primarily serve the poor and indigent; and

Whereas, the funding is being abused and wasted through billboard advertising, television ads, electronic boards along highways, extravagant fees for board members, and treatment for worker compensation cases; and

Whereas, it is an affront to have tax dollars used to compete against physicians in private practice; therefore, be it

RESOLVED, that the ISMA ask the federal agency to investigate and bring about changes to prohibit the federally funded clinic in Porter County to compete with physicians in independent practice.

RESOLUTION 10-36

COUNTY EMPLOYEE CLINIC

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, in Porter County, the county commissioners have made arrangements with a local entrepreneur for county employees to seek medical care at clinics in which deductibles and co-pays are waived; therefore, be it

RESOLVED, that the ISMA direct its legal department to investigate the legality of county governments arranging for county employees to seek medical care at clinics in which deductibles and co-pays are waived, and then advise the ISMA leadership of the findings and recommendations to either counter county government actions or find mechanisms to participate in it if the county is "subsidizing" without obvious announcement.

RESOLUTION 10-37

HIRED PHYSICIANS AND STARKE RULE
VIOLATION

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, more physicians are being employed by non-physician entities; and

Whereas, the reimbursement and thus the income of "private" physicians is stagnating or decreasing; and

Whereas, the non-physician employer entities are employing physicians by paying these physicians "more than what they would earn on their own" by subsidizing from "general hospital revenues"; and

Whereas, these acts of "subsidies" may be tantamount to inducement and thus violate Starke rules; therefore, be it

RESOLVED, that the ISMA direct the legal department to review hospital subsidization of employed physicians from general hospital revenues for any violation of Starke rules, and if so, direct the legal department to lodge complaints with the Attorney General of the United States of America.

RESOLUTION 10-38

BAN ON HIRING OF PHYSICIANS

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, the new health care bill (OBAMACARE) has been passed and the government has seen fit to not allow physicians to own hospitals, presumably to protect the public from "conflict of interest" on the part of physicians; and

Whereas, hospitals and other corporations (non medical) are allowed to own or hire physicians and practitioners; and

Whereas, there is a far greater danger that the employer will have a 'coercive' influence on the hired hand to do the employers bidding over the optimal care the practitioner otherwise is likely to deliver; and

Whereas, this is also true of pharmacies and Wal-Mart, etc., that hire practitioners; therefore, be it

RESOLVED, that the ISMA ask the government in the interest of public safety that hospitals, pharmacies and other entities not be allowed to own or hire physicians.

RESOLUTION 10-39

MALPRACTICE REFORM

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, physicians in Indiana enjoy a better "malpractice" protection, and the citizens of Indiana benefit from this provision; and

Whereas, it is now becoming evident that as more physicians become employees of hospitals and other such corporations; and

Whereas, these physicians can and will be coerced tacitly or openly into advocating care to patients that may turn out to be in the best interest of the physician's employer; and

Whereas, to protect the people of the state of Indiana from these corporations from committing such acts and by lifting the said protection of these corporations due to "deep pockets" will refrain from imposing physicians from committing acts under coercion; therefore be it

RESOLVED, that the ISMA seek to remove the "malpractice cap" from the physicians who are "hired" by hospitals and corporations.

RESOLUTION 10-40

STATEWIDE MEDICAL SERVICE ORGANIZATION

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, private practice is a good alternative to corporate medicine; and

Whereas, with health reform and the changing medical environment, there will likely be an increase in the number of physicians who become employed; therefore, be it

RESOLVED, that the ISMA create a medical service organization to provide economies of scale for purchasing supplies, negotiating better contracts and pooling to buy retiring physicians practices and recruiting individual private physicians to maintain the viability of the private practice of medicine.

RESOLUTION 10-41

BUNDLING

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, health insurance companies have complained about “unbundling” of charges; and

Whereas, the same insurance companies are guilty of unfairly “bundling”; and

Whereas, physicians are not allowed certain charges in the office while hospitals and patient surgery centers are allowed separate charges, such as for “tray and facility use”; therefore, be it

RESOLVED, that the ISMA request that physicians be reimbursed at a reasonable rate for in-office services similar to those provided in a surgery center or hospital.

RESOLUTION 10-42

REIMBURSEMENT FOR PRIOR AUTHORIZATIONS
AND PRE-CERTIFICATIONS, ETC.

Introduced by:

Bharat Pithadia, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, the insurance industry has been implementing "prior authorization" and "pre-certification" for approval of medications, procedures and imaging; and

Whereas, this practice has led to increased workload, personnel expense and increased aggravation, as well as increased malpractice risk; therefore, be it

RESOLVED, that the ISMA formally take measures to (a) have the insurance industry reimburse physicians for services rendered or, (b) have the insurance industry hire its own employees and physicians to tell patients that the medications or services advised are being denied.

RESOLUTION 10-43

ISMA WOMEN IN MEDICINE COMMITTEE

Submitted by:

Maria Del Rio Hoover, M.D., and Heidi
Dunniway, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, the number of female physicians has steadily increased from 7.6 percent in 1970 to 27.8 percent by 2006; and

Whereas, the percentage of medical school graduates who are female was 47.1 percent by 2005; and

Whereas, the ISMA Women in Medicine Ad Hoc Committee has evolved over the past three years with increasing participation and a well-defined long-term mission; therefore, be it

RESOLVED, that the ISMA establish a Women in Medicine Committee with the purposes of:

- Increasing membership and participation of female medical students, residents and physicians in the ISMA
- Providing a forum for mentoring, leadership development and collegiality among Indiana women in medicine.

RESOLUTION 10-44

MEDICAL STUDENT SCHOLARSHIPS

Introduced by:

Fred Ridge, M.D.; David Welsh, M.D.; Ed Probst, M.D.; ISMA Medical Student Society; the ISMA Young Physician Society; the Resident Fellow Society

Referred to:

REFERENCE COMMITTEE I

Whereas, the future of medical care in Indiana will, in great part, be dependent on encouraging gifted and committed students to pursue a medical education and career in Indiana; and

Whereas, nearly half of IU School of Medicine (IUSM) graduates accept instate residencies; and

Whereas, quality medical education is expensive and the IU School of Medicine's annual tuition for 2010-11 is \$29,653 for Indiana residents and \$42,981 for non-residents; and

Whereas, only 7.3 percent of financial assistance received by students at the IU School of Medicine is in the form of a scholarship; and

Whereas, more than 86 percent of the IUSM graduates in the class of 2010 borrowed an average of \$168,000 to finance their medical education; and

Whereas, the majority of IUSM graduates will not have the means to repay education loans while on a resident's salary and will incur additional interest debt, bringing their total indebtedness to over \$220,000 when repayment begins; and

Whereas, a typical resident will pay an average of \$330,000 in loans and interest before their entire student loan debt is paid off, with monthly payments of more than \$3,800 (based on 7 percent interest) over 10 years; and

Whereas, the current efforts of the ISMA and the ISMA Alliance are appreciated and they are in a unique position to further assist in reducing medical student debt; and

Whereas, the current economic uncertainty may preclude a physician from considering a multi-year financial commitment to medical student scholarships; and

Whereas, Indiana physicians may be able to contribute annually at different dollar levels; and

Whereas, the Dean's Council Board of Directors at the IU School of Medicine is providing an opportunity for a one-time contribution of \$5,000 (this donor may name the scholarship) that will be matched with five gifts of \$1,000 to provide \$10,000 medical student scholarships; therefore, be it

RESOLVED, that the ISMA endorse the IU School of Medicine Dean's Council scholarship fundraising efforts and assist the school by informing the ISMA membership of opportunities for individual support and participation as a means for easing part of the student debt load facing our medical students.

RESOLUTION 10-45

MEDICAL MISSIONS SPONSORSHIP

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, the ISMA exists to promote the practice of medicine by Indiana physicians; and

Whereas, the essence of the practice of medicine is caring for the sick and disadvantaged; and

Whereas, one of the greatest gifts a physician can give another human being is relief from the pain and suffering of disease; and

Whereas, the commitment of a physician to his or her patients is not limited by geographic or political boundaries; and

Whereas, the ISMA House of Delegates adopted Resolution 00-03 supporting a mission sponsorship, which sunsets this year; therefore, be it

RESOLVED, that the ISMA each year sponsor a physician 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 10-46

ASSISTANCE FOR ALLIANCE

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, the alliance is a component part of the ISMA and should be supported;
and

Whereas, the projects and programs in which the alliances are involved are for the
betterment for the communities where they reside; and

Whereas, Resolution 00-5A, which was adopted by the ISMA House of Delegates,
is set to expire this year; therefore, be it

RESOLVED, that the ISMA retain the current funding to the ISMA Alliance of \$4
per ISMA member as adopted in 2000.

RESOLUTION: 10-47

ACTIVE MEDICAL STAFF PHYSICIAN
REPRESENTATION ON COUNTY HOSPITAL
GOVERNING BOARDS

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, a licensed active medical staff physician member of a county hospital benefits that hospital and the community economically, as well as by the credibility they represent; and

Whereas, a county hospital governing body/active medical staff physician relationship should be "mutually beneficial" to each party and the citizens they serve; and

Whereas, a true partnership for problem solving and effective leadership cannot occur without adequate, active medical staff physician representation on the respective county hospital governing board; and

Whereas, many, if not most, county hospital governing boards are underrepresented by licensed, active medical staff physicians of that hospital; and

Whereas, under Indiana law, one member of the four-member county hospital governing board may be a physician who is a member of the medical staff, but county hospital governing boards are not required to request appointment of any licensed medical staff physician of that hospital to representation on the board; and

Whereas, Resolution 00-15 is set to expire; therefore, be it

RESOLVED, that the ISMA introduce legislation to amend Indiana Code 16-22-2-2 to mandate or require active medical staff physician representation on the respective county hospital governing board; and be it further

RESOLVED, that the ISMA also introduce legislation to amend Indiana Code 16-22-2-2 prohibiting active medical staff physician members of county hospital governing boards from being employees of their respective county hospitals, its governing board, or any of its public or privately developed corporations.

RESOLUTION 10-48

LAW ENFORCEMENT DATA

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, law enforcement entities in Indiana do not have sufficient systems in place to share information regarding citations or arrests across geographic or institutional lines in real time; and

Whereas, this lack of coordination hinders law enforcement personnel's ability to identify the complete criminal history of individuals with whom they are interacting; and

Whereas, this situation decreases the safety of Indiana communities as well as the working environment of Indiana law enforcement personnel; and

Whereas, the Traffic Records Steering Committee has been established, in part, to identify methods of improving information sharing among Indiana's law enforcement community; and

Whereas, this issue was adopted as Resolution 00-27, which is set to expire this year; therefore, be it

RESOLVED, that the ISMA seek a legislative study to determine the current and desired status of police and court records being filed in a timely manner and the accessibility of such information to governmental agencies, especially of arrests and convictions for driving under the influence of alcohol; and be it further

RESOLVED, that blood alcohol testing be mandated for all drivers involved in all motor vehicle accidents with fatalities.

RESOLUTION 10-49

SUPPORT OF EXISTING GUN LAWS

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, "Saturday night special" is a slang term generally used to refer disparagingly to relatively compact, less expensive, small caliber handguns including expensive ones; and

Whereas, compact handguns popular through American history are useful for self defense; and

Whereas, "Robbery and assault victims who used a gun to resist were less likely to be attacked or to suffer an injury than those who used other methods of self-protection or those who did not resist at all" (Klect, Targeting Guns, 1977); and

Whereas, "Evidence clearly indicates that the belief that so-called 'Saturday night specials' are used to commit the great majority of felonies is misleading and counter-productive" (Police Foundation, Firearm Abuse, 1977); and

Whereas, a law against "Saturday night specials" would be discriminatory by having a "disproportionate impact on poor people," prohibited by the Constitution's Equal Protection Clause; and

Whereas, the ISMA House of Delegates adopted Resolution 00-30 that supports responsible firearm ownership and education, and is set to expire; therefore, be it

RESOLVED, that the ISMA advocate educational programs for the responsible use and storage of firearms; advocate comprehensive health education as a means of addressing social issues such as violence and urge incorporation of such health education into our societal framework; support scientific research and objective discussion aimed at identifying causes and finding solutions to 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 10-50

PHYSICAL THERAPY DIRECT ACCESS

Introduced by:

Young Physician Society

Referred to:

REFERENCE COMMITTEE II

Whereas, rehabilitation is a team process that functions to improve the quality of life and improve self-care for patients; and

Whereas, the physician is uniquely qualified to diagnose and prescribe rehabilitation care to patients; and

Whereas, the physical therapists in Indiana would like to have direct access to all patients without having a prescription from a physician; and

Whereas, direct access is not allowed in Indiana under IC 25-27-2-1 and should continue as ISMA policy as established in Resolution 00-38, which expires this year; therefore, be it

RESOLVED, that the ISMA oppose the concept of direct access to physical therapists without a prescription for therapy from a physician.

RESOLUTION 10-51 MAINTAINING THE INDIANA TOBACCO PREVENTION
AND CESSATION AGENCY AS AN INDEPENDENT
AGENCY OF STATE GOVERNMENT

Introduced by: Dick Huber, M.D., and Richard Feldman, M.D.

Referred to: REFERENCE COMMITTEE II

WHEREAS, tobacco use is Indiana's greatest public health problem causing 10,000 deaths per year; and,

WHEREAS, tobacco use annually costs Indiana \$3.4 billion including \$2.1 billion in health-care costs, and \$486 million yearly to the Indiana Medicaid program; and,

WHEREAS, it has been documented in states like California that each tobacco prevention dollar reduces health care costs and costs to business and industry by up to \$7; and,

WHEREAS, Indiana remains one of the states with the highest adult smoking rates in the nation; and,

WHEREAS, Indiana's greatest health achievement was its historic 1999 Tobacco Settlement legislation that created the Indiana Tobacco Prevention and Cessation Agency; and,

WHEREAS, the Indiana Tobacco Prevention and Cessation Agency, a nationally acclaimed state tobacco control program, administers a comprehensive program consistent with the CDC's best practice guidelines for tobacco control; and,

WHEREAS, Senate Bill 108 purposely created the Indiana Tobacco Prevention and Cessation Agency as an independent agency with its own governing executive board to preserve its focus and dedicated funding, as well as to maintain separation from gubernatorial control and to insulate it from politics and tobacco industry influence; and,

WHEREAS, there have been recent legislative efforts to abolish the Indiana Tobacco Prevention and Cessation Agency and move the program to the Indiana State Department of Health (ISDH), terminate its 14 staff positions and dissolve its 22-member volunteer executive board; and,

WHEREAS, the ISDH's staffing is already marginal and the program will likely be given to a few individuals with other full-time responsibilities and little or no expertise in tobacco prevention; and,

WHEREAS, the ISDH not only lacks the personnel necessary, but also the essential capacity and infrastructure to work intensively with local communities and their tobacco control efforts; and

WHEREAS, if the tobacco prevention and cessation program is moved to the ISDH, its dedicated funding will eventually be raided for other purposes and diminish over time; and

WHEREAS, if the tobacco control program resides at the ISDH it will be subject to the priorities of future state health commissioners and governors; and

WHEREAS, over the past 10 years, the Indiana Tobacco Prevention and Cessation Agency, despite insufficient funding, has produced impressive results in the smoking rates of both adults and especially high school and middle school children (between 2000-2008 smoking declined 42 percent among high school students and 58 percent among middle school students); and

WHEREAS, it is well documented that states with the most impressive reductions in tobacco use are those that have functional and adequately funded statewide tobacco control programs; therefore, be it

RESOLVED that the ISMA strongly oppose any legislative efforts that would abolish the Indiana Tobacco Prevention and Cessation Agency with its governing Executive Board or move it to the Indiana State Department of Health or other state agency.

RESOLUTION 10-52

INSURANCE DENIALS OF PAYMENT

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, optimum patient care frequently requires a very technical, complex, multidisciplinary approach; and

Whereas, insurance companies frequently practice medicine believing that multiple physicians treating a patient unnecessary and, therefore, deny payment of claims when two or more physicians serve a patient on the same day; and

Whereas, altering diagnoses for reimbursement is considered illegal and current expectation is for the attending physician to see the patient daily regardless of payment; and

Whereas, Resolution 00-46 was adopted by the ISMA House of Delegates and is set to expire; therefore, be it

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 10-53

DESIGNATING LABS ON INSURANCE CARDS

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, various health insurance plans mandate use of lab, radiology and pathology services foreign to normal physician referral patterns; and

Whereas, there is much confusion regarding which labs should receive blood work, pap smears or X-ray requests; and

Whereas, patients do not understand the rules and regulations of their insurance products; and

Whereas, this results in frustration for patients, physician offices and the insurance plans; and

Whereas, the Indiana Department of Insurance has indicated it is not going to address this issue; and

Whereas, the ISMA House of Delegates adopted Resolution 00-52, which expires this year; therefore, be it

RESOLVED, that the ISMA continue to support legislative action mandating that network providers for laboratory testing, pathology services and radiology testing be specifically designated on the insurance card of the enrollee.

RESOLUTION 10-54

BUNDLE CODING FOR NEWBORN HOSPITAL CARE

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, a provider submits claims for newborn hospital services to payers for reimbursement that contains HCFA-coded elements that represent the actual services rendered to the newborn; and

Whereas, payers are then bundling the services for subsequent hospital care into the first-day care code; and

Whereas, the American Academy of Pediatrics and hospitals require that all hospitalized patients be seen on a daily basis, and it is unacceptable that payers bundle added hospital days into the first-day code when these visits are medically sound and required; and

Whereas, ISMA's House of Delegates adopted Resolution 00-59, which addresses this issue and is set to expire this year; therefore, be it

RESOLVED, that the ISMA support legislation that prohibits a payer or PPO from adjusting coding that results in unfair compensation for physicians' services.

RESOLUTION 10-55 EXCLUDE RETROBULBAR AND PERIBULBAR
ANESTHESIA FROM THE MEDICAL LICENSING
BOARD'S OFFICE-BASED SURGERY RULE

Introduced By: Ramana S. Moorthy, M.D.

Referred to: REFERENCE COMMITTEE III

Whereas, the Office-Based Surgery Rule promulgated by the Indiana Medical Licensing Board became effective on Jan. 1, 2010; and

Whereas, this rule does not allow the performing of regional anesthetic procedures (including retrobulbar and peribulbar) as office-based procedures, unless the office in which the procedure is performed is periodically certified by a national certifying body or organization at significant cost and time; and

Whereas, these regional ophthalmic anesthetic procedures have been performed in an office setting often with only heart and BP monitoring by thousands of ophthalmologists for over 40 years with an exceedingly low risk of life-threatening or sight-threatening complications; the rate of cardiovascular complications and neurologic life-threatening complications from rostral spread of local anesthetic agent is 0.6-1.5 per 10,000 cases; the risk of ophthalmic complications is similarly low at 0 to 4.5 per 10,000 cases (Eke T, Thompson JR. Br J Ophthalmol. 2007;91:470-475); and

Whereas, in the last 21 years the Ophthalmic Mutual Insurance Company (OMIC) has had only one office cardiovascular event and only two cardiovascular events in the hospital/ASC relating to the use of retrobulbar or peribulbar injection; and

Whereas, requiring these procedures to be performed in a hospital/ASC setting unless the office is accredited will increase the costs of procedures to patients by increasing their deductibles and co-payments and adding additional costs associated with a facility; and

Whereas, ophthalmologists use these procedures in the office setting for the comfort and convenience of their patients when performing painful laser eye procedures; and

Whereas, in February 2010, the Oregon State Medical Licensing Board while promulgating a similar rule to the Indiana rule specifically excluded peribulbar and retrobulbar anesthetic injections after opposition from the American Academy of Ophthalmology (AAO) and the Oregon Academy of Ophthalmology; therefore, be it

RESOLVED, that the ISMA seek, with the assistance of the American Academy of Ophthalmology and the Indiana Academy of Ophthalmology, a change in the Medical Licensing Board Rule to exclude retrobulbar and peribulbar anesthetic procedures when performed appropriately by board certified ophthalmologists.

RESOLUTION 10-56

MANDATED HEALTH INSURANCE FOR AUTISM

Introduced by:

Sean Trivedi, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 00-22 is set to expire in 2010; and

Whereas, autism as "classically" defined is a devastating pervasive developmental disorder, characterized by age of onset before 36 months (DSM-IV) and a constellation of symptoms affecting an individual's ability to communicate and interact with others including primary alterations in social interactions, receptive/expressive language delay, lack of imaginative play, in addition to a vestibular (sensory) craving; and

Whereas, clinical research and scientific evidence now have verified the emergence of "acquired" autism, a condition in which the child develops normally for the first 12 to 18 months, then regresses to the increasingly wide spectrum of autistic disorders; and

Whereas, autism is a complex developmental disability that is the result of a neurologic disorder that affects the function of the brain, impacting development in the areas of social interaction and communication skills. Both children and adults on the autism spectrum typically show difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities; and

Whereas, no single cause has been identified as the etiology for autism. Research has shown it to be caused by abnormalities in brain structure and function. While multiple etiologies have been and continue to be studied, a genetic vulnerability and environmental factors appear to contribute to autism's presence; and

Whereas, the current epidemic of autism has migrated from a rare disease 20 years ago, occurring in 1-3/10,000 births, to the current prevalence of 90/10,000 births in the United States, growing at a startling rate of 10-17 percent per year. In fact, more children are diagnosed with autism each year than with AIDS, diabetes and cancer combined; and

Whereas, autism is treatable with research demonstrating significantly improved outcomes with early diagnosis and intervention thereby often reducing the need for intensive, ongoing support; and

Whereas, access to this much needed treatment for as many as 1.5 million Americans is impossible due to the stranglehold of the health insurance industry and their labeling of these children as psychologically and behaviorally "retarded;"

and

Whereas, state mandated insurance coverage does not affect federally regulated health plans or self-insured companies, and whereas up to 70 percent of Indiana's insured are under federally regulated health insurance programs; therefore, be it

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

RESOLUTION 10-57 REPORTING OF ADVERSE EVENTS

Introduced by: William W. Pond, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, quality care assessment requires the tracking, trending and analysis of adverse events that occur after any medical procedure, and

Whereas, the majority of post-procedural adverse events are treated at the facility at which the original procedure was performed; and

Whereas, some post-procedure adverse events are not treated at the location at which the original medical procedure was done; therefore, be it

RESOLVED, that the ISMA encourage the Indiana State Department of Health to promulgate regulations that require the reporting of post-procedure adverse events that occur within 30 days of any procedure; and be it further

RESOLVED, that post-procedure adverse events shall be reported to the state licensed facility at which the original procedure occurred and at which facility adverse events shall be tracked, trended and analyzed; and be it further

RESOLVED, if a procedure did not occur at a state licensed facility, then the post-procedure adverse event shall be reported to the county health department.

RESOLUTION 10-58 ISMA DUES STATEMENT CHECK-OFF

Introduced by: William W. Pond, M.D.

Referred to: REFERENCE COMMITTEE I

Whereas, the ISMA distributes dues statements to members and those statements include county, state and national dues; and

Whereas, the ISMA dues statement also allows payment for other statewide projects such as IMPAC; and

Whereas, ISMA dues statements also allow an opportunity for only one "check off" for a county-approved project, such as economic development; and

Whereas, a county may wish to allow members to support by "check off" more than one local initiative; therefore, be it

RESOLVED, that the ISMA formulate dues statements that allow for more than one "check off" for county-approved initiatives; and be it further

RESOLVED, that ISMA dues statements allow a one sentence explanation of the "check off" for county approved initiatives.

Fiscal Note: \$19,850 estimated staff cost to implement and maintain, plus indeterminable costs for additional bank fees for credit card payments and checks issued.

RESOLUTION 10-59 ASSURING FEDERAL HEALTH CARE DOLLARS GO
TO HEALTH CARE RATHER THAN MULTIMILLION
DOLLAR CEO SALARIES

Introduced by: William W. Pond, M.D.

Referred to: REFERENCE COMMITTEE III

Whereas, the federal government's economic stimulus package transferred massive amounts of money from the taxpaying citizens to nongovernmental organizations; and

Whereas, the public perceived that billions went to fund multimillion dollar executive salaries, inflated board member compensation and lavish business expenditures at taxpayer expense; and

Whereas, the current federal health care legislation may also mandate that citizens pay monies to an organization or to the government, which would then distribute health care money to other organizations, businesses, corporations, etc; and

Whereas, capitalistic principles should reward excellence and risk-taking that will advance economic productivity; and

Whereas, the governmental transfer of money from the citizens to other organizations such as insurance companies, ACO (accountable care organizations), individuals, etc accomplishes neither; and

Whereas, every dollar spent on multimillion dollar executive salaries, lavish corporate parties or inflated board member compensation is a dollar not available for the care of those same taxpayers and patients from whom the money was taken; therefore, be it

RESOLVED, that the ISMA support policy that assures that public health care monies be used for providing patient health care; and be it further

RESOLVED, that if companies receive funding from the government or through governmentally mandated programs, then such funding shall have attached stipulations that require the following:

- All officer salaries shall be no more than the salary of the president of the United States.
- Board member salaries shall be limited to the daily rate for U.S. senators.
- Reimbursement for travel shall be no greater than that amount allowed for government employees.
- Corporate yearly dividends shall be limited to no more than the one-year T-bill rate.

RESOLUTION10-60 GRADUATED LICENSING FOR 16-& 17-YEAR-OLD
DRIVERS

Introduced by: Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to: REFERENCE COMMITTEE II

Whereas, the ISMA House of Delegates adopted Resolution 00-01 addressing graduated licensing for teen drivers, which expires this year; and

Whereas, the Fatality Analysis Reporting System and General Estimates System, as well as the Nationwide Personal Transportation Survey, collect data on all fatal traffic crashes within the United States that involve a motor vehicle traveling on a public road and that result in a death within 30 days of the crash; and

Whereas, data from this comprehensive database clearly show that the risk of a fatal injury for a 16- or 17-year old driver dramatically increases with the number of passengers; and

Whereas, analysis of the data also shows a substantial increase in the accident rate after 10 p.m. for young drivers; and

Whereas, graduated licensing systems (initial license restrictions diminishing with increased experience) are recommended by the National Highway Traffic Safety Administration; and

Whereas, as of January 2000, 24 states have adopted fully graduated licensing systems with all three stages; therefore, be it

RESOLVED, that the ISMA support legislation requiring Indiana to adopt graduated licensing requirements for young drivers consistent with recommendations from the National Highway Traffic Safety Administration; and be it further,

RESOLVED, that restrictions on carrying passengers shall be included in graduated licensing systems for young drivers.

RESOLUTION 10-61

VACCINATIONS FOR CHILDREN

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) all recognize the public health benefits of childhood immunization, and childhood immunization is our society's greatest health care achievement; and

Whereas, the CDC, the Advisory Committee on Immunization Practices (ACIP), the AAP and the AAFP have published recommendations on appropriate childhood vaccines; and

Whereas, implementation of these guidelines would result in a decrease in illness, mortality and morbidity in Indiana due to diseases that are vaccine preventable; and

Whereas, Resolution 00-24, which was adopted by the House of Delegates, is set to expire; therefore, be it

RESOLVED, that the ISMA support efforts, legislative, administrative and educational, that seek to ensure Indiana children receive all CDC-recommended vaccinations.

RESOLUTION 10-62

PARTIAL BIRTH ABORTIONS

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, many physicians on both sides of the abortion issue agree that partial birth abortion is not a desirable procedure; and

Whereas, Resolution 00-42 that addressed partial birth abortions was adopted by the House of Delegates and expires this year; therefore, be it

RESOLVED, that the ISMA support the present Indiana ban or any future ban regarding partial birth abortion except in situations where the mother's life is endangered.

RESOLUTION 10-63

REQUIRED CPT/ICD9 CODES ON PAYERS AND
INSURANCE COMPANY SYSTEMS

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, a provider submits a claim for covered services to a payer at the beginning of a new year and that the covered service, being a new CPT or ICD9 code is required by Centers for Medicare & Medicaid Services; and

Whereas, the CPT or ICD9 has not been loaded to payers systems, therefore denying payment to the provider; and

Whereas, this practice continues throughout the year without resolution from the payer; and

Whereas, the ISMA House of Delegates adopted Resolution 00-60, which will expire this year; therefore, be it

RESOLVED, that the ISMA support legislation that requires all payers and insurance companies to have all new CPT and ICD9 information loaded to their systems as of January 1 of each year.

RESOLUTION 10-64

UNUSED MEDICATIONS AND MEDICAL SUPPLIES

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, medications from nursing homes are frequently changed and therefore unused, or medications from discharged extended care facility patients are returned to pharmacies and destroyed; and

Whereas, packaged supplies from home care companies or IV supplies and medications that are unused and returned are also destroyed; and

Whereas, there may be legal liability on the part of those issuing and/or distributing the medications and materials; and

Whereas, the ISMA House of Delegates adopted Resolution 00-37, which is set to expire; therefore, be it

RESOLVED, that the ISMA support the concept of having pharmacies supply unused packaged medications and medical supplies from nursing homes and extended care facilities to free clinics for use by their patients; and be it further,

RESOLVED, that the ISMA seek legislative support to provide legal protection to companies, clinics, providers and physicians that supply these medications and materials.

RESOLUTION 10-65 VOTE FOR YOUR HEALTH CAMPAIGN

Introduced by: Deepak Azad, M.D., Kevin Burke, M.D., and
Third District Medical Society

Referred to: REFERENCE COMMITTEE I

Whereas, Congress has passed legislation that will cause major health systems reform in the United States; and

Whereas, in spite of the Obama administration's best efforts, a majority of Americans are opposed to the current health systems reform legislation; and

Whereas, many physicians are not happy with the current health systems reform legislation, especially since it failed to address the flawed Medicare reimbursement formula or produce meaningful tort reform; and

Whereas, the November 2010 national elections may change the majority party in the House and the Senate with the opportunity, therefore, to improve the health systems reform legislation through new legislation or the control of funding of health care; and

Whereas, in these great United States, voting is both a right and a responsibility; and

Whereas, on a typical weekday, Indiana physicians see more than 50,000 patients and, therefore, have a unique opportunity to address the importance of this election and health systems reform with their patients; therefore, be it

RESOLVED, that the ISMA initiate a VOTE FOR YOUR HEALTH campaign. This campaign would begin one month before the November elections. It would consist of: 1) press releases, 2) links on the association website to Indiana House and Senate candidates' websites, 3) a variety of messages physicians can distribute in their offices with the goal of encouraging patients to be informed and to vote, 4) discussion of the candidates and their positions on health systems reform on the ISMA president's blog, and at the discretion of the Board of Trustees, and 5) paid advertisements.

Fiscal Note:

- \$5 million for print, broadcast and Internet advertising
- \$66,000 for print and online collaterals for members
- \$11,000-\$15,000 for media visits including air transportation, mileage, expenses, message development and speaker training

Resolution 10-66

REDUCING INTERPRETATION ERRORS

Introduced by:

Kevin Burke, M.D., and the Clark County Medical Society

Referred to:

REFERENCE COMMITTEE IV

WHEREAS, there are thousands of hospital clinical laboratories and thousands of free-standing laboratories across the United States; and

WHEREAS, there are thousands of hospital radiology departments and free-standing radiology centers in the United States; and

WHEREAS, clinical laboratories can use a variety of formats to present test results and normal ranges on a computer screen or on printed paper; and

WHEREAS, clinical laboratory reports often contain multiple results on each page of a report; and

WHEREAS, radiologists can use a variety of descriptive and diagnostic terminology to produce a radiology report, and these results can be displayed in a variety of formats on a computer screen or on printed paper; and

WHEREAS, a larger variety of formats used to present clinical laboratory or radiology test results produces a larger risk of interpretation errors due to a physician being unfamiliar or less familiar with the layout of the report; and

WHEREAS, the use of vague terms in the descriptive section and the impression section of a radiology report can also produce misinterpretation or confusion about the results of a radiologic study or procedure; and

WHEREAS, reduction of interpretation errors will improve the quality of care and promote patient safety; therefore, be it

RESOLVED, that the AMA will work with the College of American Pathologists, the American Osteopathic College of Pathologist, the American Clinical Laboratory Association, the American a Society for Clinical Laboratory Science and other appropriate entities to produce a single standardized format for presentation of laboratory results. The standard should not only define where test results and normal values will appear on the screen or the printed page, but also specify a consistent sequence for chemistry, hematology and other results; and be it further

RESOLVED, the AMA will work with the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities to standardize the terminology in both the descriptive section and impression section of a radiology report, as well as to produce a standardized format for the presentation of these radiologic results; and be it further

RESOLVED, that this resolution, if approved by the House of Delegates of the ISMA, will be presented at the next appropriate meeting of the AMA for further consideration and adoption.

RESOLUTION 10-67

BLOOD ALCOHOL CONTENT (BAC)

Introduced by:

Fred Ridge, M.D., and Brent Mohr, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Indiana's blood alcohol content (BAC) level was established before there was strong scientific evidence concerning the level at which impairment occurs; and

Whereas, at .10, the current BAC level under Indiana law, the risk of a fatal crash is 32 times greater than for drivers who have no alcohol in their blood; and

Whereas, the 15,935 fatalities that occurred in alcohol-related crashes in 1998 nationwide represent an average of one fatality every 33 minutes; and

Whereas, the National Highway Traffic Safety Administration has determined that while 7 percent of all vehicular crashes involve alcohol, 39 percent of all fatal crashes do; and

Whereas, the National Highway Traffic Safety Administration contends that lowering the acceptable BAC for driving will save thousands of lives and millions of dollars in property damage; and

Whereas, Resolution 00-26, which supports a lower blood alcohol level for intoxication, will expire this year; therefore, be it

RESOLVED, that the ISMA introduce legislation or support legislation that would lower the acceptable BAC level in Indiana so that .08 percent BAC level constitutes prima facie evidence of intoxication and seek harsher penalties for driving while intoxicated.