MMA Policies

2022

(reflects policies adopted through November 30, 2022)

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10 Abortion

10.02 Abortion is a Component of Comprehensive Medical Care

The MMA affirms a person's right to an abortion as a medical decision to be made under the advice and guidance of their healthcare professional. The MMA understands that abortion is an essential component of reproductive healthcare and that all healthcare decisions—including whether or not to have an abortion—are deeply personal and should be made between a patient and their healthcare professional

The MMA also adopts the following policy language based on the AMA policy titled “Abortion (H-5.995)”:

(1) Abortion is a medical procedure and should be performed only by a duly licensed healthcare professional with appropriate training and proper credentialing in conformance with standards of good medical practice and the Medical Practice Act of their state; and

(2) No healthcare professional shall be required to perform an act violative of good medical judgment. Healthcare professionals, hospitals, and hospital personnel shall not be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the healthcare professional withdraw from the case, so long as withdrawal is consistent with good medical practice. In the case that a healthcare professional withdraws, they should refer their patient to a provider that has the capability of providing medically appropriate care that fits the needs of the patient. (BT-1/90) (Retained 2004) (Reaffirmed BT 11-19) (Retained BT 08-20) (Retained as edited BT 05-22)

10.03 Physician "Gag Rule"

The MMA supports the AMA position on the physician "gag rule" which states as follows: "The American Medical Association (AMA) does not view abortion as a method of family planning. However, the regulations upheld by the U.S. Supreme Court have impact beyond planning prior to pregnancy. The regulations prohibit a physician from counseling a pregnant woman even in situations where the pregnancy presents health risks, often very serious risks, and termination of the pregnancy is medically indicated. Some of those situations in which pregnancy presents health risks include cancer, diabetes, severe cardiac conditions and AIDS. To this extent, the AMA objects to the regulations, both from an ethical and a liability standpoint." Also, the MMA strongly believes that in the interest of excellent medical care, a physician should be free to provide to the patient all information needed for the patient to receive the most medically appropriate care and therefore urges its members to take action to overturn any rules or legislation that restrict free speech communication between a physician and patient. (HD-R24-1991, BT-7/91) (Retained 2004) (Reaffirmed BT 11-19) (Retained BT 08-21)

10.09 Intact Dilation And Extraction

The Minnesota Medical adopts AMA policy H-5.982 as follows: H-5.982 Late-Term Pregnancy Termination Techniques -

(1) The term ‘partial birth abortion' is not a medical term. The AMA will use the term "intact dilatation and extraction" (or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because ‘partial birth abortion' is not a medical term it will not be used by the AMA.

(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second trimester, when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

(5) The AMA urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

(6) The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment, education, and contraceptive methods. (BOT Rep. 26, A-97). (HD-R403-2003)

10.11 Fatal Fetal Anomaly Exception To The "Women's Right To Know"Act

The Minnesota Medical Association supports legislation that adds an exception to the Woman's Right to Know (WRTK) Act that would exclude pregnancies complicated by fetal anomalies incompatible with extrauterine survival. HD-R400-2005)(Retained BT 07-16)

10.13 Minnesota Definition of Abortion to Exclude Ectopic Pregnancies

The Minnesota Medical Association supports policy that specifically exempts from the legal definition of abortion procedures to treat ectopic pregnancies. (HD-R304-2012) (Retained BT 09-22)

10.14 Aligning MMA Policy on Abortion with AMA Policy

The MMA supports current AMA policy on the right to privacy in termination of pregnancy as follows, “The AMA reaffirms existing policy that (1) 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; and (2) 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. The AMA further 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.” (BT 11-14)

10.15 Barriers to Abortion

The MMA opposes laws or regulatory actions designed to deny or restrict access to safe abortion including, but not limited to, the following:

(1) Statutory definitions of informed consent that impose criminal penalties on physicians who perform induced abortions without first disclosing anesthetic or analgesic options to alleviate pain of the fetus, such as the definition currently imposed in Minnesota Statutes Chapter 145.4242;

(2) Informed consent waiting periods for abortions, such as those currently imposed by Minnesota Statutes Chapter 145.4242;

(3) Data reporting requirements for abortions, such as those currently imposed by Minnesota Statutes Chapters 145.4131-145.4135;

(4) Statutory definitions of “family planning” which preclude organizations that provide abortion counseling, referrals, and procedures from applying to family planning grants, such as the definition currently imposed in Minnesota Statutes Chapter 145.925.

(5) Restrictions on the use of medically appropriate abortion services rendered via telehealth.

(6) State-based laws that restrict access to abortion by minors through mandatory parental notification such as those currently imposed by Minnesota Statutes Chapter 144.343, Sub. 2

(7) Insurance plan designs which limit coverage for reproductive care, including induced abortion.

(8) Non-evidence-based requirements targeted toward facilities providing abortion care.

(9) State-based and institutional restrictions that exclude abortion and abortion-related topics in medical education and training programs. (BT 02-21) (Retained as edited BT 05-22)

20 Access to Health Care

20.02 Medicaid Reimbursement to Ensure Access

The MMA will continue to interact with the Department of Human Services and the state Legislature to provide realistic Medicaid reimbursement at a level that would assure access to health care. (HD-R13-1991) (Retained 2004) (Retained as edited BT 08-21)

20.06 Definition of Terms

The MMA adopts the following broad definitions for "universal coverage" and "universal access" adopted by the Minnesota Health Care Commission:

"Universal coverage" implies every Minnesotan has health coverage and contributes to the costs of coverage based on ability to pay.

"Universal access" implies quality health services are accessible to all Minnesotans. In order to achieve universal access in Minnesota, the Commission believes non-financial barriers, such as limited access to providers due to geography; a shortage of providers in the community; cultural, racial and language barriers; lack of transportation; dependence upon out-of-state providers; age-related needs; and lack of knowledge regarding how the system works must be addressed. (BT-7/94) (Retained 2006)

20.08 Direct Access to Preventive Health, Diagnostic & Treatment Services of Obstetricians/Gynecologists

The MMA supports the preservation of a woman's ability to directly access preventive health, diagnostic, and treatment services provided by obstetricians and gynecologists. (HD-R7-1995) (Retained 2005)(Retained BT 07-16)

20.12 Providing Health Care to Undocumented Residents

The Minnesota Medical Association (MMA) is committed to ensuring that all Minnesota patients, regardless of immigration status, have access to safe, timely, high-quality health care. State and/or

federal policies that seek to target health care facilities as part of immigration enforcement actions have the potential to undermine the public's health if individuals in need of care avoid care due to fear and/or misinformation. The MMA supports designating medical treatment and health care facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities, as sensitive locations, at which there would be limits to enforcement actions made by the U.S. Department of Homeland Security. The MMA encourages clinics and health care systems to create protocols to ensure that patients, regardless of their immigration status, feel safe accessing health care routinely or in an emergency.

To ensure the delivery of safe and confidential health care, the MMA opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and opposes proof of citizenship as a condition of providing health care. (HD-R300-2008) (Retained as edited BT 07-18) (Retained as edited BT 12-19)

20.14 Improving Access to Physicians with Special Skills Required in Geriatric Care

The Minnesota Medical Association supports efforts to improve access to and availability of high-quality geriatric care. (HD-R305-2012) (Retained as edited BT 09-22)

20.15 Transgender Health Access

The MMA supports AMA policy H-185.950, Removing Financial Barriers to Care for Transgender Patients, which reads as follows: Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician. (HD-R307-2012)

30 Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus (AIDS/HIV)

30.09 Physician's Ethical and Legal Obligations to Treat HIV-Infected Patients

The MMA supports the following principles:

a. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services. (AMA Council on Ethical and Judicial Affairs Principle VI)

The freedom to enter into or decline a relationship with patients does not allow physicians to refuse to see patients, if such refusal violates antidiscrimination laws.

b. Physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute illegal discrimination. (AMA Council on Ethical and Judicial Affairs Opinion 9)

c. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are

seropositive should not be subjected to discrimination based on fear and prejudice. When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services. (AMA Council on Ethical and Judicial Affairs Opinion 9.131)

d. Physicians who believe it is necessary to refuse to treat HIV-infected patients must carefully document the facts and underlying reasons for their decisions not to treat, and consult with other medical professionals with regard to questions concerning medical contraindications or risk of transmission of infection. If the physician believes there is adequate reason to refuse treatment, the physician should consult with an institutional ethics committee and legal counsel to ensure that refusal does not violate AMA ethical principles or opinions or the anti-discrimination laws. (BT-3/92) (Retained 2004) (Retained as edited BT 09-22)

30.13 HIV Testing of Pregnant Women

The MMA supports the routine offering of the HIV test by Minnesota physicians to all pregnant women under their care. The MMA will disseminate this information and provide support to all Minnesota physicians. (HD-R50-1995) (Retained 2005)(Retained BT 07-16)

30.14 Regulation of physicians and allied professionals with HIV/HCV/HBV

In light of the advances in HIV, HCV, and HBV management, the MMA supports the repeal of Minnesota Statutes §§214.17-214.25. The MMA supports the use of the Health Professions Service Program (HPSP) to monitor and support physicians and allied professionals with HIV/HCV/HBV. HPSP monitoring of professionals with HIV/HCV/HBV should be individually and narrowly tailored based on the professional's practice and individual risk of transmission to his or her patients. (BT 07-18)

40 Physician/Health Care Advertising

40.01 Advertising of Prescription Drugs

The MMA believes that the AMA should reaffirm its opposition to the advertising of prescription drugs directly to the public. (BT-11/85) (Retained 2004) (Retained as edited BT 07-16)

40.04 Limits on Advertising and Advertising at Government Sponsored Events

The MMA affirms its support of the AMA's call for a total ban on tobacco advertising. If, in the event it should prove impractical for legal or other reasons to enact a total ban on tobacco advertising, such advertising should not portray people or scenery in a false and misleading manner that falsely implies youth, beauty, vitality and virility as attributes associated with smoking. The MMA urges every community and municipality of Minnesota to adopt, as a principle, that they will not accept money, promotional items or other assistance from tobacco companies for the support of sports or other events. (HD-R4-1990). (Retained 2004)

40.07 Public Disclosure of Health Care Advertising

The MMA supports required public disclosure of the health care management and marketing costs of third party payers. (HD-R8-1988) (Retained 2004) (Retained BT 07-18)

40.08 Adoption of AMA Advertising Policy

The MMA adopts the AMA's opinion on physician advertising:

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication including any newspaper, magazine, telephone directory, radio, television, direct mail or other advertising provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity regardless of format or content is true and not materially misleading.

The communication may include: (a) the educational background of the physician; (b) the basis on which fees are determined (including charges for specific services); (c) available credit or other methods of payment; and (d) any other non-deceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of his or her professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Statements relating to the quality of medical services can raise concerns because they are extremely difficult, if not impossible, to verify or measure by objective standards. However, objective claims regarding experience, competence and the quality of the physician's services may be made if they are factually supportable. Similarly generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio or television, should determine in advance that his or her communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (HD-R25-1989) (Retained 2004)

50 Alcohol and Alcoholism/Chemical Dependency

50.07 Alcohol and Chemical Dependency

The MMA encourages efforts to improve undergraduate medical curriculum content regarding the early identification and treatment of alcoholism and other chemical dependency related diseases. (HD-R21-1985) (Retained 2004) (Retained BT 07-16)

50.09 Physician Role in the Minnesota Consolidated Chemical Dependency Fund

The MMA mandates the role of physicians in the Consolidated Chemical Dependency Fund. Physicians should determine medical needs of patients in hospital-based programs, and physician reimbursement should be based on patient need and individual case management separate from hospital payments. (HD-R32-1988) (Retained 2004)

50.13 Driving While Intoxicated Penalties

The MMA requests the Legislature to require that anyone who is convicted of driving while intoxicated or driving under the influence have his/her license suspended until they have undergone evaluation for chemical dependency and, if indicated, treatment. The second conviction would result in his/her drivers license being suspended until the person has demonstrated sobriety for a period of at least one year. (HD-R43-1993) (Retained 2004)

50.14 Alcohol Screening

The MMA will educate Minnesota physicians about the content and value of the CAGE (cutting down, being annoyed, feeling guilty, and using eye openers) questionnaire as a screening tool for detecting alcohol abuse. (HD-R50-1996) (Retained 2006)(Retained BT 07-16)

50.16 Alcohol and Tobacco Promotions

The MMA opposes the promotion of tobacco and alcohol products by a publically-funded state University. (BT-8/97) (Retained as edited 2007)

50.17 Reporting of Impaired Drivers

The MMA will promote legislation in coalition with other appropriate organizations, that will allow physicians, without threat of penalty, to report in good faith to law enforcement agencies a driver of a motor vehicle whose blood alcohol level exceeds the state's legal limit to provide probable cause for a forensic blood alcohol test to be drawn. (HD-LR208-1997)

50.18 Youth Access to Alcohol

The MMA supports efforts to reduce youth access to alcohol by supporting policies that would mandate compliance checks to identify establishments that sell alcohol to underage youth, improve social host laws to hold adults more accountable for supplying alcohol to youth, and maintain local control of alcohol regulatory ordinances. (HD-LR320-1997) (Retained BT 07-17)

50.2 Methadone Maintenance Treatment

The Minnesota Medical Association shall endorse American Medical Association policy H-95.957 regarding use of methadone maintenance therapy in clinics and in the offices of physicians properly trained and administratively monitored.

H-95.957 Methadone Maintenance in Private Practice:

The AMA:

1. Reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further.

2. Supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed.

3. Encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users.

4. Supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols.

5. Urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and

management. (CSA Rep. 2 - I-94; Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99; Reaffirmation I-00Modified: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20) (HD-R407-2000) (Retained as edited BT 08-20)

50.26 Alcohol Health Impact Tax

The Minnesota Medical Association (MMA) shall advocate for an increase in the excise tax on beer, wine, and spirits by the equivalent of $.10 a drink and that these increased funds be used for prevention, treatment, and public safety services related to alcohol abuse, and to support that future alcohol excise tax increases keep pace with inflation. The MMA shall also consider alcohol abuse, particularly among underage drinkers, one of its public health priority issues. (HD-SR201-2006) (Retained BT 07-16)

50.28 Economic Interventions for Excessive Alcohol Consumption

The Minnesota Medical Association continues to support efforts to reduce excessive use of alcohol by increasing the alcohol excise tax and indexing it to inflation; supporting the imposition of higher fees for retail liquor licensure; and, supporting efforts to prohibit discounts for on-sale alcohol. (HD-R300-2009) (Retained as edited BT 07-19)

50.29 Minimum Drinking Age

The Minnesota Medical Association opposes efforts to lower the legal drinking age from 21 years. (HD-R306-2009) (Retained BT 07-19)

50.3 Supporting Harm Reduction Approaches to Illicit Drug Use and Illicit Use of Prescription Drugs

The Minnesota Medical Association will explore the development of evidence-based policies that would promote harm reduction with respect to illicit drug use and illicit use of prescription drugs. The Minnesota Medical Association will support evidence-based health and treatment services for illicit drug users, such as methadone, buprenorphine and heroin substation programs. (HD-R200-2013)

50.31 Expansion of Naloxone Access and Good Samaritan Laws in Minnesota

The Minnesota Medical Association acknowledges that prescription opioid overdoses are a public health epidemic and supports efforts to expand naloxone access to community-based organizations and to create a Good Samaritan law in Minnesota to support limited immunity for witness reporting of overdoses. (BT 11-13)

50.32 Reduction of Medical and Public Health Consequences of Drug Abuse

The Minnesota Medical Association encourages state policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use. (BT 01-15)

50.33 Harm Reduction for Opioid Dependence through Evidence-Based Approaches to Addiction Treatment

The Minnesota Medical Association will support efforts to ensure the availability of effective and evidence-based addiction treatment options for individuals with opioid dependence, and will provide resources and information regarding these harm reduction options for physicians. (BT 01-15)

50.34 Buprenorphine – Physician & Treatment Program Locator

To assist physicians in finding resources for their patients seeking opioid addiction treatment, the Minnesota Medical Association will provide information on resources such as the Substance Abuse & Mental Health Services Administration's (SAMHSA) "Buprenorphine – Physician & Treatment Program Locator," to assist physicians in locating physicians certified for buprenorphine treatment in their area. (BT 01-15)

50.35 Medication Assisted Treatment

The Minnesota Medical Association will support efforts to encourage physicians to obtain DEA waivers to prescribe buprenorphine for the treatment of opioid addiction. (BT 01-15)

50.36 Prescription Drug Fraud

The MMA will work with the Minnesota Board of Pharmacy, Minnesota Pharmacists Association, and other relevant stakeholders to consider strategies to reduce prescription drug fraud, including consideration of expanded use of e-prescribing for controlled substances, and the use of photo identification for controlled substance pick up. (BT 11-15)

50.37 Next Steps to Address

the Addiction, Abuse and Diversion of Prescription Opioids

(1) Reconvene MMA Prescription Opioid Management Advisory Task Force

The MMA, recognizing that additional strategies to improve physician management of opioid prescribing are needed, will reconvene the MMA Prescription Opioid Management Advisory Task Force. The task force is charged with developing recommendations for consideration by the MMA Board of Trustees on the following topics:

oThe potential circumstances for when mandatory use of the Minnesota Prescription

Monitoring Program may be appropriate.

oThe potential circumstances for when required education/additional training with

respect to opioid prescribing may be appropriate.

oStrategies for expanding the number of buprenorphine providers.

oThe task force is also charged with reviewing the recommendations from the DHS Opioid Prescribing Work Group to help guide MMA response.

(2) Convening Stakeholders

The MMA, in collaboration with relevant stakeholders, including health system leadership, will work to do the following:

oExplore the feasibility of generating clinic and/or physician-specific opioid

prescribing data to support benchmarking and improved prescribing practices; and

oUnderstand current strategies to address opioid prescribing, identify opportunities to share such strategies, and consider other areas for collective action.

(3) Education on Pain and Addiction

The MMA will continue to provide continuing medical education and maintenance of certification credits via the MMA Pain, Opioids, and Addiction lecture series.

(4) Public Education Campaign

The MMA, recognizing the public health epidemic associated with the addiction, abuse, and diversion of prescription opioids, will work with state agen

cies to explore financing for a public education campaign, focused on (a) safe use; (b) safe storage; and (c) safe disposal. (BT 07-16)

50.38 Prescription Opioid Public Health Statement

In recognition of the public health epidemic associated with the addiction, abuse, and diversion

of prescription opioids, and understanding the paradigm shift in the treatment of pain, the MMA supports looking at all options for treatment, including the appropriate use of opioid therapy in patients exhibiting non-cancer, acute or subacute pain, as well as the appropriate use of opioid therapy in the management of patients with active cancer and/or receiving palliative or hospice care. In addition, the MMA

believes that the use of opioid therapy for chronic pain requires a comprehensive evaluation of the benefits and harms associated with its use, given the limited available evidence to support long-term use. (BT 09-16)

50.39 MMA Prescription Opioid Management Advisory Task Force Recommendations

MN Prescription Monitoring Program Use

1. The MMA is committed to appropriate physician use of the Minnesota Prescription Monitoring Program (PMP). To help address current barriers to its use, the MMA will support a legislative appropriation aimed at integrating the PMP into electronic health record and pharmacy operations software across the state. The MMA will also monitor trends in the use of the PMP and reconsider additional actions if rates do not increase.

Improved Access to Treatment

1. The MMA opposes unnecessary financial and administrative barriers to opioid addiction treatment, including the use of prior authorization for buprenorphine and naltrexone.

2. The MMA opposes the application of prior authorization requirements on naloxone. Such policies unnecessarily delay access to a life-saving intervention and threaten efforts to expand its availability.

3. In an effort to increase the number of Drug Addiction Treatment Act (DATA) waived physicians, the MMA will provide information to physicians on (1) the importance of obtaining a DATA waiver, and (2) the waiver application and management process to prescribe or dispense buprenorphine for opioid dependency treatment. In addition, to help address the concerns associated with becoming a DATA-waived physician, the MMA will work to connect physicians with supportive resources.

Education

1. The MMA encourages physicians to obtain education on pain management, opioid prescribing and addiction – education that is specific and relevant to a physician's specialty and practice. This

education is particularly important for physicians that are prescribing long-acting opioids for chronic pain.

2. The MMA reaffirms existing MMA Policy (380.22), opposing any legislation or government regulation that defines the subject matter or content of continuing medical education required for physician relicensure in Minnesota.

3. The MMA will support efforts to incorporate information on pain management, opioid prescribing and addiction into the undergraduate and graduate medical education curricula of the University of Minnesota Medical School and Mayo Medical School.

(BT 11-16)

50.4 Chemical Abuse as a Chronic Condition

The MMA identifies substance use disorders as chronic conditions that are both preventable and treatable.

Greater attention and increased resources are needed for substance use disorder prevention, treatment, and recovery services in Minnesota. (BT 11-16)

60 Allied Health Professionals/Services

60.12 Chiropractic Scope of Practice

The MMA reaffirms its position that performing a comprehensive physical examination, such as a DOT exam, which requires the examiner to diagnose the presence or absence of medical conditions, is outside the scope of chiropractic practice in Minnesota. (HD-R5-1996) (Retained 2006) (Retained as edited BT 07-16)

60.13 Increased Dental Access For All Patients

The MMA recognizes that dental health is an important part of overall health, and the MMA supports improving dental care accessibility for all patients. (HD-R204-2007) (Retained as edited BT 07-17)

60.17 Nurse Midwives

The MMA believes that the practice of midwifery be reserved for those who undergo specific training programs following attainment of a registered nurse license and that nurse midwives be certified by the American College of Nurse Midwives and registered with the Board of Medical Practice. Nurse midwives should function under the direct supervision of a practicing licensed physician who is qualified and competent to manage drug therapy and complications of birth; and training programs preparing nurse midwives should be monitored to assure quality of training. Finally, obstetrical deliveries, whenever feasible, should be in a hospital or other licensed health care facility to assure availability of needed resources and support. (HD-R19-1983) (Retained 2004)

60.2 Regulation of Traditional Midwives

The MMA opposes legislation that will transfer the responsibility of traditional midwives from the Board of Medical Practice to the Department of Health and will support state efforts to conduct a study and collect data regarding planned home births attended by traditional midwives to assess the nature of the practice and the occurrence of adverse outcomes before legislation is enacted and significant amounts of money are expended that would affect only a small number of individuals in the state.

The MMA supports the efforts of the certified nurse midwife community to explore options of incorporating direct entry midwives into a licensed status via a formal education program.

The MMA opposes legislation and regulations that formally recognize home birth by traditional midwives as an acceptable and sanctioned option for childbirth unless such individuals are required to be appropriately educated and licensed to ensure patient health and safety. (HD-R36-1993) (Retained 2004)

60.236 Delegation To LPNs

The MMA approves the 2002-2003 report of the Task Force on Delegation to Licensed Practical Nurses (LPNs) in a clinic, or office setting. (BT-1/03)

60.237 Nursing Administration of Sedation Medications

It is the position of the MMA that with appropriate training, experience, and supervision, registered nurses can administer, and should be allowed to administer, medications for sedation under the direction of a qualified physician. (EC-10/05) (Retained as edited BT 07-16)

60.238 Support for Quality of Care in Supervisory Agreements

The Minnesota Medical Association strongly encourages physicians to utilize written agreements when entering into collaborative management plans with advanced practice registered nurses (APRNs). (BT 07/08) (Retained as edited BT 07-18)

60.239 Resources for Physicians re: APRNs

The MMA will work to educate Minnesota physicians about recent changes to APRN scope of practice. Such education should address the origin and evolution of the legislation, the effect of the law in terms of physician employment of APRNs, and the implications on medical liability. (BT 11-14)

60.24 Occupational Therapy

The MMA supports current Department of Health rules that require a specific referral from a physician prior to initiating occupational therapy and strongly opposes proposed rules that do not require a specific physician referral. (BT-4/95)

60.281 Optometrists Prescribing

The MMA opposes the increased authority of optometrists in the prescribing and administering of oral drugs proposed in current legislation (HF373/SF418, introduced during the 2003 legislative session) and opposes both compromises recommended by the optometrists and ophthalmologists. (BT-3/03)

60.282 Opposition To Optometric Reimbursement For Invasive Medical Procedures

The Minnesota Medical Association is opposed to any reimbursement policy allowing optometrists to perform invasive procedures, (e.g., anterior stromal puncture, corneal foreign body removal, corneal epithelial scraping, and corneal flaps) and, that a formal letter be sent from the MMA to the Medicare Carrier Advisory Committee by October 15, 2003, notifying the committee of the MMA's opposition to the optometric reimbursement of invasive medical procedures. (HD-R217-2003)

60.3 Certified Medical Interpreters

The MMA approves collaboration with the Minnesota Department of Health, Refugee Health Office, and the nonprofit Community Interpreter Service to promote the use of qualified medical interpreters whenever possible to deliver high quality health care by physicians to patients who primarily use a different language. The MMA will make efforts to improve knowledge among physicians and health planners regarding the need for confidential, accurate, neutral, and culturally sensitive medical interpretation similar to the provision of services for hearing impaired patients. (HD-R29-1993)

60.323 Nursing Staff Ratios

The Minnesota Medical Association encourages physicians in hospital practice and hospital leadership positions to work with interested stakeholders to assure a safe practice environment. These efforts should include careful analysis of the application of technology and impact of workflows to develop the best structure and systems for patient care without resorting to legislatively mandated staffing levels. (BT 11-10) (Retained BT 08-20)

60.34 Therapeutic Substitution of Drugs by Pharmacists

The MMA vigorously opposes therapeutic substitution of drugs by pharmacists, and opposes efforts to authorize pharmacists to independently dispense therapeutic substitutes to a physician's prescription. (Retained BT 01-15)

60.362 Pharmaceutical Issues Task Force

The Minnesota Medical Association adopts the report "Minnesota Medical Association Report on Pharmaceutical Issues," issued in 2001.

The Minnesota Medical Association ratifies the following recommendations regarding pharmaceutical issues:

1. The MMA encourages HMO's/insurers to disclose to physicians with whom they contract the rationale for choosing a formulary drug, whether a rebate of discount has been negotiated, and the actual cost of formulary drugs.

2. The MMA encourages pharmaceutical benefit management companies to inform HMO's/insurers with whom they contract about the actual cost of the drugs they obtain on behalf of HMO's/insurers.

3. The MMA encourages HMO's/insurers to develop and provide information to consumers about the true cost of pharmaceuticals and provide ways in which consumers can positively impact the rising cost of drugs.

4. The MMA supports HMO's/insurers offering a multiple-tiered pharmaceutical co-payment system to their enrollees.

5. The MMA urges HMO's/insurers to discontinue the use of physician financial incentives that could influence prescribing choices that may not be in the patients' best interest.

6. The MMA encourages HMO's/insurers to disclose to enrollees and physicians with whom they contract whether they have negotiated a rebate with a drug manufacturer or pharmaceutical benefit management company.

7. The MMA supports physicians' use of electronic, computerized devices, e.g., handheld aids/"palm pilots," as well as non-electronic tracking methods to help them recognize individual HMO/insurer formulary options and, where available, the cost benefit ratios of comparable medications available on formularies.

8. The MMA supports and encourages efforts to develop electronic prescribing technologies.

9. The MMA supports access to prescribing drug coverage for all Americans.

10. The MMA will provide physicians with information about the benefits and consequences of accepting drug samples from pharmaceutical manufacturer representatives.

11. The MMA will work with the Minnesota Department of Human Services and other appropriate organizations to develop and disseminate information about pharmaceutical patient assistance programs available in the state for the uninsured, underinsured, and indigent patients.

12. The MMA encourages physicians to disclose to patients whether they have negotiated a rebate with a pharmaceutical manufacturer.

13. The MMA supports and will participate in the development of educational materials for consumers on DTCA that physicians can provide to patients in their office settings to assist in balancing information provided to DTCA.

In addition the MMA will carry the following resolutions to the AMA Annual Meeting in 2001:

1. The MMA requests the AMA staff responsible for ongoing communications with PhRMA to forward the recommendations to PhRMA that were made by the MMA Pharmaceutical Issues Task Force that are designed to enhance and improve the Prescribing Drug Patient Assistance Programs. (Please see Appendix E for the specific list of recommendation).

2. The MMA delegation to the AMA will request the AMA to do the following:

a. Work with appropriate organizations to investigate the use of large group purchasing coalitions as a strategy for controlling escalating pharmaceutical costs for all segments of the population;

b. Develop and make available specific informational materials to increase physicians' awareness of drug programs that are available for the uninsured, underinsured, indigent patients;

c. Study the positive and negative affects associated with physicians dispensing drug samples and issue a report describing the impact of this practice on pharmaceutical costs and patient care;

d. Develop policy that specifically limits the gifts pharmaceutical manufactures can offer physicians;

e. Request that the FDA promulgate rules that prohibit pharmaceutical manufactures from engaging in prescription drug marketing strategies such as offering coupons or free drug samples directly to consumers;

f. Study the total affects of discount and rebate arrangements on the health care systems, including how these arrangements affect the drug costs of insured, underinsured, and Medicare beneficiaries;

g. Continue to monitor the relationships between PBMs and the pharmaceutical industry and strongly discourage any arrangements that result in potential conflicts of interest that could cause a negative impact on the cost or availability of essential drugs

h. Work with the Food and Drug Administration (FDA) to assure DTCA guidelines support the provision of patient information that is accurate, backed by scientific evidence, identifies potential side affects, and encourages patients to contract their physician for information about pharmaceuticals;

i. Continue to work with the FDA to investigate the impact of DTCA on the price of drugs and how DTCA impacts consumers' knowledge of drugs; and

j. Develop and disseminate printed materials to educate consumers about the risks, benefits, determents, and potentially misleading information provided in DTCA. (BT-3/01) (Retained BT 08-21)

60.364 Pharmacists Scope Of Practice

The MMA opposes HF692/SF574, introduced during the 2003 legislative session, as written, allowing for the expansion of pharmacists scope of practice to include administering flu and pneumococcal vaccines. (BT-3/03)

60.366 Pharmacists to Administer Vaccines

The Minnesota Medical Association opposes the concept of pharmacists' administration of vaccines to individuals under the age of 18 and remains neutral on pharmacists' administration of vaccines for individuals age 18 and older as long as pharmacists follow prescribed guidelines of medical practice and that the Minnesota Pharmacists Association will agree to work with the Minnesota Department of Health to ensure that all vaccines that are administered by pharmacists are entered into the state immunization registry. (BT 01/08) (Retained BT 07-18)

60.367 Expanding Pharmaceutical Immunization Authority

The Minnesota Medical Association supports efforts to improve immunization rates for Minnesotans while also preserving the physician-patient relationship. The MMA supports expanding pharmacists' authority to provide influenza vaccines for individuals age 6 and older, and supports mandatory reporting of vaccinations to the Minnesota Immunization Information Connection (MIIC), within 10 business days to MIIC for all providers and facilities. (BT 01-15)

60.374 Physician Assistants

The MMA supports SF229/HF279 as amended (introduced during the 2003 legislative session), which amends the scope of practice of physician assistants. (BT-3/03)

60.421 Opposition To Psychologist Prescribing

The Minnesota Medical Association strongly opposes any effort to permit prescribing privileges for psychologists in Minnesota. (HD-R208-2002) (Retained as edited BT 09-22)

60.422 Psychologist Scope Of Practice

The MMA opposes expansion of psychologist scope of practice with regard to hospital staff privileges for psychologists and with regard to psychologists' authority to sign certification for disability benefits related to mental health. (EC-2/03)

60.5 Surgical Assistants Licensure

The MMA opposes legislation to license surgical assistants (SF492/HF1067, introduced during the 2003 legislative session). (BT-3/03)

60.51 Scope Of Practice

The Minnesota Medical Association work with the appropriate regulatory and legislative agencies to establish, secure, and maintain a high level of standards which must be met and maintained before expanding scope of practice privileges beyond those limited to licensed, practicing medical doctors and, that the MMA lead an effort to promote a strong, unified approach by all state medical organizations to support its stand on meeting and maintaining high standards on scope of practice issues and, the MMA work with specialty societies to actively fight legislation that would inappropriately expand the scope of practice of non-physicians through all legal means at its disposal. (HD-SR203-2003)

60.52 Scope of Practice Guidelines

The Minnesota Medical Association (MMA) supports the following guidelines (based on the report from the Federation of State Medical Boards) in considering scope of practice proposals:

1. Review the existing scopes of practice and the effect of requested changes on provision of services and other practitioners providing those services;

2. Review the boundaries of non-physician practice and the advisability of allowing independent practice, or requiring collaboration or physician supervision;

3. Review the formal education and training purported to support scope of practice changes and the existence of formal processes for accreditation;

4. Review the existing or proposed regulatory mechanisms such as licensure, certification and registration;

5. Review the requirements for full and accurate disclosure by all health care practitioners as to their qualifications to perform the proposed health care services;

6. Review the financial incentives related to and affecting the request for scope of practice changes;

7. Review the accountability and liability issues relating to requests for scope of practice changes.

(BT-07/2004)(Retained BT 07-16)

70 Bicycle and Motorcycle Safety

70.02 Motorcycle Helmets

The MMA supports requiring protective head gear for all motorcyclists. (BT-11/88) (Retained 2004) (Retained as edited BT 07-18)

70.04 Bicycle Safety and Helmet Use

The MMA supports supports the mandatory use of approved protective helmets for minors when riding bicycles, snowmobiles, or two-, three-, or four-wheel motorized recreational vehicles in the state of Minnesota. (HD-R7-1992) (Retained 2004) (Retained as edited BT 09-22)

70.06 Motor Vehicle and Bicycle Safety

The MMA supports legislation specifying: that the nonuse of vehicle restraints is a primary offense punishable by a $100 fine; that the nonuse of helmets for motorcycle, snowmobile and all-terrain-vehicles is a misdemeanor punishable by a $25 fine; and that the use of bicycle helmets be required for all minors in the state of Minnesota. (BT-12/94) (BT-12/94) (Retained as Edited 2006)

70.07 Protective Head Devices

The MMA reaffirms its current policy that supports legislation that mandates the use of protective head devices for children under the age of 18 while operating bicycles or off-road vehicles, motorized wheeled vehicles, and snowmobiles in the state of Minnesota. (HD-R33-1995) (Retained 2005) (Retained as edited BT 07-16)

70.09 Protective Headgear for Minors While Riding ATVs, Snowmobiles, Bicycles, and Motorcycles

The MMA supports the use of helmets for bicycles, motorcycles, snowmobiles, and ATVs. (HD-R304-1997) (Retained as edited BT 07-17)

80 Birth Control/Contraception (See also, Pregnancy)

80.01 Funding for Family Planning Activities

The MMA supports funding for family planning activities. (BT-11/89) (Retained 2004) (Retained as edited BT 07-19)

80.03 Emergency Contraception

The MMA reaffirms that physicians have a responsibility to provide comprehensive information to patients as a part of the process of obtaining informed consent to treatment and recognizes that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims. (BT-1/2002) (Retained as edited BT 09-22)

80.04 Emergency Contraception Mandate

The MMA opposes SF270/HF322, introduced during the 2003 legislative session, which would legislate the standard of care for sexual assault victims. (BT-3/03)

80.05 Family Planning Gag Clause

The MMA opposes legislation (HF436/SF431, introduced during the 2003 legislative session) that affects the physician/patient relationship by restricting the information that providers give to patients. Specifically, the legislation prohibits the use of state family planning grants for abortions, for any counseling that promotes abortion, or for referral to a health care provider who performs abortions. These grants include the family planning grant funds distributed through the maternal and child health

block grant program, the family planning special projects grant program, grants to eliminate health disparities, and "any other state grant program whose funds are or may be used to fund family planning services". This policy is based on opposition to the state interfering in the physician/patient relationship regardless of the issue being discussed. (BT-3/03)

80.06 Emergency Contraception

The Minnesota Medical Association adopts as policy that physicians and other health care professionals be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it with men and women as part of contraceptive counseling; and that it is the policy of the Minnesota Medical Association to promote access to emergency contraception, including making emergency contraception pills more readily available through hospitals, clinics, emergency rooms, acute care centers, and physicians' offices. (HD-R300-2003)

80.07 Emergency Contraceptive Pills

The Minnesota Medical Association reaffirms its policy that promotes access to emergency contraceptive pills. (HD-R400-2006) (Retained BT 07-16)

80.08 Pharmacists' Refusal To Fill Prescriptions

The Minnesota Medical Association (MMA) shall support protocols that provide patients with immediate access to emergency contraception in the event of a pharmacist's refusal to fill the prescription or request. (HD-R403-2006) (Retained as edited BT 07-16)

80.09 Payment Policy for Long Act

ing Reversible Contraception (LARC)

The MMA recognizes that long-acting reversible contraceptives (LARCs) are safe and highly effective for decreasing unintended pregnancy. The use of LARCs in the immediate postpartum setting has the potential to provide cost savings and decrease the incidence of adverse maternal and child health outcomes. The MMA urges Minnesota payers, particularly Medical Assistance/MinnesotaCare, to implement or revise those policies that bundle payments for delivery with payment for LARC to optimize the use of LARCs in the inpatient postpartum setting.

(BT 09-16) (Reaffirmed BT 11-19)

80.1 Improved Access to Contraceptives

Consistent with the position of the American College of Obstetricians and Gynecologists, the MMA supports efforts to move oral contraceptives to over-the-counter (OTC) status, noting that the benefits in terms of unintended pregnancy outweigh the risks of OTC access and broader use. (BT 11-16)

100 Board of Medical Practice/Physician

Discipline (See also, Practice of Medicine)

100.03 License Fees

The MMA supports an appropriate increase in the physician licensing fee which is required for practicing medicine in Minnesota if such an increase is needed to produce the additional resources that the Board of Medical Practice may need to implement an improved and more efficient investigatory/disciplinary process. (HD-R13-1985) (Retained 2007)

100.08 Publication of Disciplinary Action for Chemical Dependency

The MMA believes the following grounds for disciplinary action should not be published or classified as public data by the Board of Medical Practice: 1) inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills; 2) becoming addicted or habituated to a drug or intoxicant. The MMA also believes the Board should be allowed greater flexibility to exclude from publication and status as public data disciplinary actions taken for physician activity that is secondary to mental or physical illness or chemical dependency. (HD-R39-1989) (Retained 2004)

100.11 Contested Case Hearing Record as Public Information

The MMA opposes efforts to include as public information a physician's entire contested case hearing record or an administrative law judge's entire unedited report, since the record or report may contain allegations made against the physician for which the physician was not ultimately disciplined. (BT-11/89) (Retained 2004) (Retained BT 07-19)

100.12 Mandatory Reporting Law

The MMA supports efforts to bring groups, clinics, or hospitals that self-insure for malpractice within the terms of the mandatory reporting law which requires reporting physician conduct constituting grounds for discipline to the Board of Medical Practice. (BT-11/89) (Retained 2004) (Retained BT 07-19)

100.13 Medical License Fees

The MMA urges the Board of Medical Practice to offer a prorated fee for physicians obtaining their initial Minnesota license. (HD-R52-1990) (Retained 2004) (Retained 08-20)

100.16 Non Discrimination In Physician Licensure

The MMA urges the Minnesota Board of Medical Practice to deal respectfully and fairly with applicants for licensure and licensees, ensuring that individual rights to be free from discriminatory practices are not violated. (HD-LR412-1997) (Retained as edited 2007) (Retained BT 07-17)

100.18 Super Board

The MMA opposes any efforts designed to establish a move towards one entity that regulates all health professions, sometimes referred to as a "super board." (BT-2/98) (Retained as edited 2008) (Retained BT 07-18)

100.22 Minnesota Board Of Medical Practice Support For Clinical Skills Assessment Exam

The MMA urges the Minnesota Board of Medical Practice to rescind its support of an additional medical student clinical competency examination as these already occur in LCME-accredited medical schools (including Mayo, University of Minnesota). In addition, the MMA reaffirms its support of the AMA's decision not to support this examination. (BT-3/03)

100.24 Health Plan Regulatory Accountability

The Minnesota Medical Association encourages the Board of Medical Practice to hold makers of health and treatment decisions accountable to the same regulatory plan referral review standards as other providers delivering medical services. (HD-R404-2005) (Retained BT 07-16)

100.26 Alternatives to Mandatory Site Visit for Minnesota Physician License Applicants

The Minnesota Medical Association supports and encourages the use of video conferencing and other alternative means of physician identity verification and interview process in lieu of a personal appearance before the Board of Medical Practice in order to obtain a Minnesota license. (HD-R401-2010) (Retained BT 08-20)

110 Children and Youth

110.03 Sleep Deprivation in Adolescents Educational Campaign

The MMA approves development of an educational campaign explaining the need for more sleep in adolescence than during childhood, the biological shift to a later sleep pattern in adolescence, and the impact of inadequate sleep on driving safety and school performance. The MMA urges local school districts to eliminate early starting hours of school for teenagers. (HD-R30-1993) (Retained 2004)

110.044 Adolescent Health Position Statement Endorsement

The MMA adopts the following Adolescent Health Position Statement, developed as a joint project of the Adolescent Health Care Coalition and the Center for Population Health:

ADOLESCENT HEALTH POSITION STATEMENT

Whereas, our goal is to promote and enhance the physical and mental health and well-being of adolescents in Minnesota;

Whereas, we recognize that many factors influence the health of adolescents;

Whereas, we recognize two key phases in child development with the greatest potential to influence health: early childhood and early adolescence;

Whereas, the health care system has a unique and important role in the way it serves adolescents;

Whereas, we understand the health care system includes: health care professionals, public health, managed care, hospitals, community-based health care organizations and other medical care delivery systems;

Be it resolved, our organization is committed to the following:

ACCESS: All adolescents have access to developmentally appropriate health care services that are affordable, accessible, and when necessary, confidential.

QUALITY: Guidelines for best practice in delivery of health care services to adolescents are implemented throughout the health care system.

FINANCING: The payment system is modified to provide adequate financing and reimbursement for services unique to the delivery of adolescent-focused health care.

EDUCATION: Education for health care professionals includes an adolescent-focused component and assures adequate numbers of practitioners educated in adolescent health and development. (BT-3/99) (Retained 2009)

110.049 Parental Consent For Medical Treatment Of Minors

The MMA opposes legislation that would require a minor to obtain parental consent to receive treatment for pregnancy, abortion, sexually transmitted diseases, mental health, chemical dependency, and hepatitis B vaccination. (BT-3/03) (Retained as edited, HOD 2013)

110.08 Religious Exemptions in Child Abuse Statutes

The MMA supports the removal of all spiritual healing exemptions in child neglect statutes and supports appropriate child abuse laws providing needed medical care for children involved in abuse or neglect situations. The MMA also believes that laws enacted to protect and provide for the medical needs of children should be fashioned so as to protect the constitutional rights of both parents and children. The MMA encourages compliance by health care personnel and others with the reporting provisions of state child abuse and neglect care. (BT-3/91) (Retained 2004) (Retained BT 08-21)

110.09 Prohibition Against Tuberculosis in Schools

The MMA supports prohibiting the presence of persons with active tuberculosis from remaining in or near school buildings, unless they have physician's certificate stating that their presence will not endanger the health of others. (BT-3/80) (Retained 2004) (Retained as edited BT 08-20)

110.1 Physical Exams for Children Attending Summer Camp

The MMA urges the Legislature and Minnesota Department of Health to require the same vaccination panel as that required for school attendance as a condition for children attending a summer camp. The MMA further urges the Minnesota Department of Health to require a health history for children attending summer camps, and a physical exam if indicated by the health history. (BT- 8/80) (Retained 2004) (Retained as edited BT 08-20)

110.16 Health Aspects of Child Care

The MMA supports efforts to ensure the availability of child care at a reasonable cost. (HD-R34-1989) (Retained 2004) (Retained as edited 07-19)

110.17 Sale of Tobacco from Vending Machines

The MMA supports a total ban on cigarette sales from vending machines. (BT-1/90) (Retained 2004) (Retained as edited BT 11-17) (Retained as edited BT 08-20)

110.2 Conflict Resolution Training

The MMA supports the expansion of conflict resolution and reconciliation training in educational settings (K through 12) and parenting classes, as appropriate. (HD-R44-1994) (Retained 2006)

110.212 Preparticipation Athletic and Camp Physical Exams

The MMA supports the inclusion of prevention, assessment, and screening for high-risk behaviors in preparticipation athletic and camp physical exams. (HD-R414-1998) (Retained 2008) (Retained as edited BT 07-18)

110.2192 Protecting Children's Health Care Access Via Support of Partner Co-Adoption

The Minnesota Medical Association (MMA) supports efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (BT-07/2005) (Retained BT 07-16)

110.22 Immunization of Children Against Disease

The MMA believes that all children should be vaccinated. Exemptions for vaccines should be limited to medical contraindications only. The MMA supports legislation requiring all children enrolled in public, private, and parochial schools and day care facilities to be immunized per the Advisory Committee on Immunization Practices' (ACIP) guidelines. Schools, day care facilities, and summer camps should be required to maintain immunization records and make annual reports. (BT-3/80) (Retained as edited BT 05-20)

110.26 Immunizations Coverage

The MMA will support the coverage of childhood immunizations and specifically encourage self-insured companies to also provide coverage for childhood immunizations.

(HD-R17-1995) (Retained 2005) (Retained as edited BT 07-16)

110.275 Vaccine Safety

The MMA opposes HF887, as introduced during the 2003 legislative session, requiring a Vaccine Safety Checklist. (BT-3/03)

110.2791 Role of Physicians and Clinics in Encouraging Reading in Young Children

The Minnesota Medical Association encourages physicians to speak to their patients who are parents regarding the importance of reading to their children and encourages clinics to develop programs to foster reading to children. (HD-R101-2008) (Retained as edited BT 07-18)

110.2792 Lead Education Policy

To enhance public and clinical education regarding lead in the environment, the Minnesota Medical Association will: (1) continue to endorse and assist in promoting the Childhood Blood Lead Screening Guidelines, Childhood Blood Lead Case Management Guidelines, and Childhood Blood Lead Clinical

Treatment Guidelines developed by the Minnesota Department of Health (MDH); and (2) investigate ways to advocate for primary prevention of lead exposure including distribution of lead education materials not just at the point of detection, but as early as prenatal care and at other critical stages thereafter. (BT 07-10) (Retained as edited BT 08-20)

110.2794 Minnesota Department of Health Blood Lead Screening Guidelines for Pregnant and Breastfeeding Women

The Minnesota Medical Association endorses and supports the updated Blood Lead Screening Guidelines for Pregnant and Breastfeeding Women in Minnesota, issued by the Minnesota Department of Health in 2015. (BT 09-15)

110.2795 Vaccine Exemptions

The MMA supports repeal of the "conscientiously held beliefs" exemption currently available in Minnesota's school and childcare facility immunization law, and for purposes of postsecondary educational institutions. Exemptions from vaccines should be limited to medical contraindications only. (BT 11-15) (Retained as edited BT 11-18)

110.2796 Adult ATV Use by Children Younger Than 16

The Minnesota Medical Association recommends that no child under the age of 16 should ride or operate an adult-size all-terrain vehicle (ATV). (BT 02-16)

110.2797 Minor Consent for HPV Vaccination

The MMA supports legislation that would add HPV vaccination to the list of health services to which minors can consent. (BT 11-16)

110.2798 MDH Childhood Blood Lead Case Management Guidelines for Minnesota

The Minnesota Medical Association endorses and supports the updated Childhood Blood Lead Case Management Guidelines for Minnesota, issued by the Minnesota Department of Health in 2017. (BT 11-17)

110.28 Fair Payment for Vaccine Administration under the Minnesota Vaccines for Children Program

The MMA supports efforts to take full advantage of the federal dollars available to our state for vaccine administration. (HD-R315-2007) (Retained as edited BT 07-17)

110.3 Infant Circumcision

The MMA's position on infant circumcision is: (1) Newborn circumcision has potential medical benefits and advantages as well as disadvantages and risks. (2) Physicians should discuss the benefits and risks of circumcision with parents on a case by case basis and medical consent should be obtained. (3) The MMA also encourages third party payers and insurers to consider the medical benefits of circumcision and to reconsider their policies regarding coverage for the procedure. (HD-R18-1989) (BT-1/90) (Retained BT 08-20)

110.34 Birth Defects Information System

The MMA supports the Birth Defects Information System as outlined in MN Stat 144.2215. (HD-R302-1997) (Retained as edited 2007) (Retained BT 07-17)

110.35 American Academy of Pediatrics (AAP) Guidelines for Circumcision

The MMA shall encourage physicians to become knowledgeable of the American Academy of Pediatrics policy regarding circumcision and to follow its recommendations.

American Academy of Pediatrics – Task Force on Circumcision – Recommendations and AAP Policy Statement (2012)

- Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
- Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
- Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks and by ensuring that they understand the elective nature of the procedure.
- Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.
- Parents of newborn boys should be instructed in the care of the penis, regardless of whether the newborn has been circumcised or not.
- Elective circumcision should be performed only if the infant’s condition is stable and healthy.
- Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.
- Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.

o Nonpharmacologic techniques (e.g., positioning, sucrose pacifiers) alone are insufficient to prevent procedural and postprocedural pain and are not recommended as the sole method of analgesia. They should be used only as analgesic adjuncts to improve infant comfort during circumcision.

o If used, topical creams may cause a higher incidence of skin irritation in low birth weight infants, compared with infants of normal weight; penile nerve block techniques should therefore be chosen for this group of newborns.

• Key professional organizations (AAP, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Society of Anesthesiologists, the American College of Nurse Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:

o Develop standards of trainee proficiency in the performance of anesthetic and procedure techniques, including suturing;

o Teach the procedure and analgesic techniques during postgraduate training programs;

o Develop educational materials for clinicians to enhance their own competency in discussing the benefits and risks of circumcision with parents;

o Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.

• The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

(HD-R302-1999) (Retained 2009) (Retained as edited 07-19)

110.38 Updating Minnesota School and Daycare Requirements for Vaccination

The Minnesota Medical Association strongly encourages the Minnesota Department of Health to update in a timely fashion Minnesota school and daycare requirements for vaccination consistent with current and future recommendations by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). (HD-R208-2012) (Retained BT 09-22)

110.4 Minnesota Newborn Screening-Preserve Bloodspots and "Opt Out" Provisions

The Minnesota Medical Association endorses the following: 1) Maintain the Minnesota Newborn Screening program, as administered by the Minnesota Department of Health, as an "opt out" public health program to save newborn lives; 2) Increase the length of newborn bloodspot retention from 71 days (for negative test results) and two years (for positive test results) to eighteen years for all newborn bloodspots collected; 3) Support the efforts of the Minnesota Department of Health to implement parental consent for use of stored bloodspots for future public health test development. (HD-R210-2012) (Retained BT 09-22)

110.5 Minnesota Department of Health - Childhood Blood Lead Treatment Guidelines for Minnesota:

The Minnesota Medical Association endorses and supports the updated Childhood Blood Lead Treatment Guidelines for Minnesota, issued by the Minnesota Department of Health in 2019. (BT 10-19)

110.51 Consent for Vaccination by Mature Minors

The MMA will support legislation allowing certain older minors who have the capacity to give informed consent, called mature minors, to self-consent for any vaccination recommended by Advisory Committee on Immunization Practices guidelines. (BT 11-20)

110.52 Comprehensive Eye Exams

The Minnesota Medical Association will support the Minnesota Academy of Ophthalmology and oppose legislation that would mandate comprehensive eye exams for all children, given the lack of scientific evidence to support such a requirement. (BT 03-15)

110.53 Advocacy for Investment in Early Childhood

The MMA acknowledges the critical importance of birth through age 3 in brain development and in establishing a foundation for long-term health, and will advocate for investments to support every Minnesota child's "Three Key Years" with particular attention to investments in early childhood care, early childhood education, parent education, and paid parental leave. (BT 11-21)

130 Civil and Human Rights

130.03 Treatment Center for International Victims of Torture

The MMA supports the treatment center for international victims of torture. (BT-5/85) (Retained 2004) (Retained as edited BT 07-16)

130.04 Patient-Physician Relationship/Free Speech Communication

The MMA strongly believes that in the interest of excellent medical care, a physician should be free to provide to the patient all information needed for the patient to receive the most medically appropriate care and therefore urges its members to take action to overturn any rules or legislation that restricts free speech communication between the physician and patient. (BT-7/91) (Retained 2004) (Retained BT 08-21)

130.05 Support of Human Rights and Freedom

The MMA supports American Medical Association policy number H-65.992, which states, "Continued Support of Human Rights and Freedom: The American Medical Association continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any

discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies."

The MMA encourages the physicians of the state of Minnesota to take a leadership role within their community in efforts to eradicate any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin or age and any other such reprehensible policies. (HD-R107-1997) (Retained 2007) (Retained BT 07-17)

130.06 Remembering Persons with Developmental Disabilities who were Involuntarily Committed to State Institutions

The MMA supports the efforts of the Remembering with Dignity project. (HD-R404-1999) (Retained 2009) (Retained as edited 07-19)

130.07 Education of Physicians regarding Tortured and Traumatized Refugees

The Minnesota Medical Association encourages physicians who treat refugees to assess the refugee for the possibility of post-traumatic stress, depression, or medical injury due to torture or trauma. (HD-R404-2000) (Retained as edited 2010) (Retained as edited 08-20)

130.1 Human Rights Act

The MMA opposes legislation (HF341/SF545, introduced during the 2003 legislative session) that would remove sexual orientation as a protected class under the Human Rights Act. (BT-3/03)

130.11 Torture And Human Rights

The MMA endorses the AMA's policy on human rights (H-65.997) and its policy against the participation of physicians in torture, including the definition of torture contained in that policy (E-2.067).

AMA Policy H-65.997: Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04)

AMA Policy E-2.067: Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened. Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. Physicians who treat torture victims should not be persecuted. Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great. (I, III) Issued December 1999. (HD-R400-2007) (Edited BT 1/09) (Retained BT 07-17)

130.12 Equality in Marriage and its Health Benefits

The MMA (1) recognizes that denying marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) 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. (BT 03-12) (Retained as edited BT 09-22)

140 Coding, Nomenclature and Administrative Simplification

140.08 E & M Documentation Guidelines

The MMA opposes the 1997 version of the Evaluation & Management (E & M) Documentation Guidelines.

The MMA supports the development of a new set of documentation guidelines that, at a minimum, incorporates the following principles:

- reflects clinical practice
- recognizes the need for flexibility
- acknowledges a physician's medical decision making and assessment skills
- serves to improve patient care

The MMA recommends that the July 1, 1998 implementation date for the E & M documentation guidelines be extended for at least two years to allow the development of a new set of guidelines and to allow adequate time for physician education. The MMA strongly encourages the AMA to continue its dialogue with the Office of Inspector General (OIG) to ensure that its investigations of physicians related to allegations of billing fraud and abuse be conducted according to the levels of proof currently required by law (e.g., patterns of abuse, knowing and willful conduct), and that no iteration of the E & M Documentation Guidelines be used as a means to lower that

standard. The MMA strongly opposes the use of the E & M Documentation Guidelines to establish a prima facie case of Medicare billing fraud and abuse. (BT-4/98)

140.1 Administrative Simplification

The Minnesota Medical Association will continue to advocate for further modernization, standardization, and simplification of health care administrative processes and transactions, including the use of electronic data transfers instead of paper or fax technology. (HD-R209-2009) (Retained BT 07-19)

140.12 Prior Authorization Task Force Recommendations

The Minnesota Medical Association will advocate for efforts to address the challenges and administrative burdens present in the prior authorization process for prescription medications. The Minnesota Medical Association adopts the following recommendations from the MMA Prior Authorization Task
Force:

1. Streamline administrative processes
2. Treat all authorizations the same in state law
3. Standardize disclosure of Rx coverage and formulary design
4. Limit changes during enrollment year
5. Improve state oversight/transparency
6. Transform authorization to retrospective Q1 function

(BT 01-15)

150 Credentialing (See also, Ethics)

150.02 Physician Credentialing

The MMA supports the concept of central verification of credentials, provided the process is controlled by physicians or medical societies and that the information on individual physicians not be released without their permission, other than as mandated by law. Hospitals and their medical staffs should control the granting of privileges. (HD-R41-1988) (Retained 2004) (Retained BT 07-18)

150.03 Information Regarding a Colleague

The MMA believes that it is the ethical duty of a physician to share truthful quality of care information regarding a colleague when requested by an authorized credentialing body so long as the requested information is not protected by statute or regulation as confidential peer review information. Also, legal immunity for submitting or sharing truthful and accurate quality care information should be provided to physicians by appropriate legislation. (HD-R10-1988) (Retained 2004) (Retained as edited BT 07-18)

150.04 Economic Credentialing

The MMA will monitor the use of economic criteria as factors which do not apply to quality in hospital medical staff credentialing and actively oppose any attempts to introduce such economic credentialing in the medical staff credentialing process. (HD-LR49-1991) (Retained 2004) (Retained BT 08-21)

150.05 Public Access to National Practitioner Data Bank

The MMA strongly opposes Congressional action to allow the general public access to information contained in the National Practitioner Data Bank, since such access will lead to unwarranted concern,

confusion, and misinterpretation thereby damaging the health care industry and creating a low confidence environment. (HD-R28-1993) (Retained 2004)

150.16 Mandatory Accurate Disclosure of Provider Credentials to Current and Potential Patients and the Public

The Minnesota Medical Association supports precise and accurate disclosure of specific academic credentials in all patient interactions and advertising/media; precise verbal disclosure to patients and/or the public in a professional capacity, and visible title accurate provider ID shall be required by statute to identify fully and transparently provider's degree. (HD-R203-2011) (Retained as edited BT 08-21)

150.17 National Practitioner Database Reporting Requirements

The MMA supports AMA policy H-355.976 regarding the National Practitioner Data Bank as follows, "1. Our AMA believes that (A) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than $30,000 are not reported or recorded; (B) reports, other than licensure revocation, in the Data Bank should be purged after five years; (C) proctoring of physicians for the purpose of investigation should not be reportable; (D) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (E) any physician's statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank. 2. Our AMA will (a) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; and (b) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners. 3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee. 4. Our AMA supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested, and supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification. 5. Our AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician's record reported decisions which have been overruled. 6. Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further

clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians." (BT 11-14)

150.18 Hospital Privileges for Procedures

The MMA opposes legislation that requires physicians to have hospital admitting privileges as a condition of performing specific procedures in an outpatient setting. (BT 11-14)

150.19 Network Transparency

Consistent with the goal of promoting a patient-centered health care system, the MMA will advocate for transparency in network design and benefits in order to allow patients to make fully informed decisions about their choice of physician. Physicians should not be penalized or otherwise constrained from referring patients to the physicians or practices they believe would provide the best care to their patients. (BT 09-15)

150.20 Limit Mental Health Disclosure Questions on Licensing and Credentialing

The Minnesota Medical Association encourages the Minnesota Board of Medical Practice to replace the current licensing application question, "Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?" with the language recommended by the Federation of State Medical Boards that 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)." The Minnesota Medical Association also encourages specialty boards, hospitals, and other organizations involved in credentialing to adopt this language. (BT 11-19)

160 Data & Quality

160.04 Role of Physicians in Developing Diagnosis and Treatment Plans

The MMA endorses the role of physician leadership, accountability and more active involvement in the assessment of patient needs and in determining treatment plans. (HD-R6-1987) (Retained 2004)

160.16 Accountability of Certifying or Accrediting Organizations and Data Collection Services

The MMA supports policy that all certifying or accrediting agencies, government or private, include in its standards justification based on improved patient care, cost savings or proven patient outcomes. (HD-R1-1994) (HD-R1-1994) (Retained as Edited 2006)

160.22 Reporting Hospital Bed Capacity to the Minnesota Department of Health

The MMA continues to support the Minnesota Department of Health's efforts to require the reporting of hospital bed capacity and nursing home capacity data. (HD-R408-1999) (Retained as edited 2009) (Retained BT 07-19)

160.24 National Practitioner Data Bank Protection

The Minnesota Medical Association opposes any attempts to open the National Practitioner Data Bank to public level of query.

The MMA delegation to the American Medical Association shall continue to support the AMA's position of opposing any attempt to open the National Practitioner Data Bank to public query. (HD-R402-2000 (Retained 2010) (Retained BT 08-20)

160.25 Encounter Level Data Collection

The MMA supports the Minnesota Department of Health in its collection of claims-level data as part of the state's legitimate interest in promoting and protecting public health. The MMA supports appropriate public health research provided that stringent safeguards exist so as to protect patient identifying data. (EC-10/02) (Retained BT 09-22)

160.3 A Strategy For Obtaining Better Patient Adherence

The Minnesota Medical Association notes that patient adherence to medical treatment programs is necessary in order to achieve high quality and cost-effective health care. The MMA will colaborate with health insurance companies, government entities, and consumer advocacy organizations to educate the public about the adverse consequences of non-adherence to evidence-based treatment guidelines and personalized physician recommendations, which are likely to enhance a patient's quality of life and increase life expectancy. The MMA shall submit a resolution to the American Medical Association asking the AMA to study what factors lead to patient non-adherence and identify techniques to assist physicians in optimizing patient adherence. (HD-R206-2005) (Reaffirmed: HD-R204-2008)

160.31 Medical Chart Survey

The Minnesota Medical Association shall recommend that third-party payers that review charts for quality indicators provide a list of charts reviewed identifiable by patient, the criteria used for each assessment, and the results of each assessment identified by patient with the option for physicians to contest any discrepancies. (HD-R209-2006) (Retained BT 07-16)

160.32 Fairness in Assigning Tiers and Peer Groups

The Minnesota Medical Association supports the use of transparent risk-adjustment mechanisms when placing physicians or practices in tiers, in peer groups, or when publicly reporting performance and will work to assure that such risk adjustments consider nonclinical factors such as psychosocial, financial, and other personal factors that impact patient compliance and influence clinical quality performance

reports. The MMA will encourage and monitor local and national efforts to advance risk adjustment methods and partner with other Minnesota organizations to study the burdens on physician practices associated with collecting and submitting data to improve risk adjustment. (HD-R200-2010) (Retained BT 08-20)

160.36 Community Measurement Waiver for Quality Research

The Minnesota Medical Association will work with Minnesota Community Measurement, through its role on the Minnesota Community Measurement Board of Directors and its work groups and committees, to develop policies that allow for waivers from public reporting of quality data for Minnesota researchers and physicians who are participating in clinical research studies. These policies should consider criteria including but not limited to funding source, topic of research, study registration status, and the degree to which there is conflict with current measure specifications. (HD-R210-2011) (Retained 08-21)

160.38 Data Privacy

The Minnesota Medical Association supports legislation to ease the sharing of clinically appropriate data across systems and practices, while maintaining proper privacy of patient data, in furtherance of the care-coordination and cost-management goals articulated in the Affordable Care Act. (EC 02-13) and (BT 03-13)

160.39 Provider Peer Grouping

The Minnesota Medical Association supports the retention of Minnesota's all-payers claims database (APCD) and will work to repurpose it for uses other than provider peer grouping (PPG), such as analyses of population health, utilization of care, practice patterns, access to care, and results of care. (BT- 01/14)

160.4 Financial Impact of Statutory Requirement on Primary Care Clinics

The Minnesota Medical Association will continue to pursue efforts to quantify and assess, including possible self-reporting by clinics, the administrative and financial burden associated with quality measurement reporting on medical practices, especially Family Medicine and other primary care clinics. The Minnesota Medical Association will continue to advocate for adequate payment to clinics for costs associated with Minnesota's statewide quality reporting and measurement system reporting. (HD-R201-2013)

160.41 Limiting the Number of Measures Required of Clinics by MN Community Measurement

The Minnesota Medical Association will urge Minnesota Community Measurement to improve its transparency and documentation for the evidence base associated with its measures. The Minnesota Medical Association will also advocate that Minnesota Community Measurement develop criteria and a process to limit the number of measures that a clinic is required to report in a given year, based on factors such as strength of evidence and value for clinical improvement. (HD-R202-2013)

160.42 Limiting the Number of Measures Required of Clinics by Minnesota Community Measurement

The Minnesota Medical Association opposes the addition of health care quality measures for primary care physicians beyond the number being collected in 2014. If new measures are added an equal number of existing measures must be removed. All measures will be evaluated using the National Quality Forum criteria on importance; evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority aspect of healthcare. All measures will have pre-determined criteria to evaluate effectiveness.

(EC-06/14)

160.43 Moving Minnesota Quality Measurement toward a Core Measurement Set

1) MMA work to move measurement in Minnesota to a parsimonious, core set of measures as recommended by the Institute of Medicine; 2) MMA seek to establish a moratorium on the introduction of any new state measures until a core measure set for use in Minnesota is defined;

and, 3) MMA pursue changes to Minnesota's statewide quality reporting and measurement sys

tem (SQRMS) to exempt from SQRMS requirements those practices that participate in Medicare's quality payment program, either through MIPS performance measurement or measurement under alternative payment models.

(BT 07-16)

170 Death (See also, Ethics)

170.01 Mandatory Autopsy Study of Trauma Deaths

The MMA supports efforts to study the cause of deaths from trauma in Minnesota. (HD-LR73-1990) (Retained as edited 2007) (Retained BT 08-20)

170.02 Religious Exemption for Autopsies

The MMA opposes legislation providing for religious exemptions for autopsies. (BT-3/99) (Retained 2009) (Reained BT 07-19)

180 Disability

180.02 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

The MMA supports the efforts of the National Alliance for the Mentally Ill, the American Psychiatric Association, and other organizations working toward parity in coverage and reimbursement for medical problems which are currently discriminated against as "mental health disorders." The MMA approves the pursuit, with appropriate state regulatory agencies and the legislature, a requirement that all third party payors provide coverage and reimbursement for the evaluation and medical treatment of learning disabilities and of Attention Deficit Hyperactivity Disorder (ADHD) at the same level as provided for other neurodevelopmental conditions. (HD-R12-1993) (Retained 2004)

180.04 Improving Access to Care for Homebound Minnesotans

The MMA supports adequate access to health care for the homebound and/or disabled; will advocate that third-party payers ensure access for medical home visits, including covering and providing adequate physician reimbursement for the medical home visit; encourages medical schools and residency programs in the state to include training in home care; and, will educate state legislators and state agencies on the issue of health care access for the homebound and disabled, as part of our work toward universal health care access, including pursuing different strategies for ensuring access for our homebound and/or disabled population. (HD-R408-2007) (Retained BT 07-17)

190 Domestic Violence and Abuse

190.01 Domestic Violence and Abuse Campaign

The MMA will continue to work with the Minnesota Coalition for Battered Women, Womankind, Inc., the Minnesota Department of Health, the Consumer Incentive Subcommittee of the Minnesota Health Care Commission, members of the media, and other coalitions interested in achieving a violence-free society by the year 2010 and continue its campaign against violence in Minnesota and assist physicians in being as effective as possible in helping patients achieve both a healthy and safe environment. The MMA urges all physicians in Minnesota to join the National Coalition of Physicians Against Family Violence. (HD-R45-1993) (Retained 2004)

190.05 Legislation for Increasing the Severity of Charges for Domestic

Violence in the Presence of a Child

The MMA supports an enhanced penalty for domestic violence when perpetrated in the presence of a minor. (HD-R400-1998) (Retained as edited BT 07-18)

200 Driving While Intoxicated/Driving While Impaired

200.03 Blood Alcohol Standard

The MMA supports reducing the blood alcohol standard for legal intoxication to .05. (BT-1/89) (Retained as edited 2007) (Retain 07-19)

200.04 Driving While Intoxicated Penalties

The MMA requests the Legislature to require that anyone who is convicted of driving while intoxicated or driving under the influence have his/her license suspended until they have undergone evaluation for chemical dependency and, if indicated, treatment. The second conviction would result in his/her drivers

license being suspended until the person has demonstrated sobriety for a period of at least one year. (HD-R43-1993) (Retained 2004)

200.05 Reporting of Impaired Drivers

The MMA will promote legislation in coalition with other appropriate organizations, that will allow physicians, without threat of penalty, to report in good faith to law enforcement agencies a driver of a motor vehicle whose blood alcohol level exceeds the state's legal limit to provide probable cause for a forensic blood alcohol test to be drawn. (HD-LR208-1997)

200.08 Impaired Driving

The Minnesota Medical Association will research and make information available to physicians regarding existing resources and processes to assist physicians in identifying and potentially detecting and removing from Minnesota roads individuals whose ability to operate a motor vehicle may be impaired. (HD-R405-2004)

200.09 Cell Phone Use Prohibited/Illegal While Driving a Vehicle

The Minnesota Medical Association will request that the Minnesota State Legislature pass a law forbidding the use of cell phones, handheld or otherwise, while driving a vehicle, but allowing use while parked and out of traffic. (BT-11/2004) (Retained BT 01-15)

200.1 Impaired Drivers

The MMA supports legislation to require the Minnesota Department of Public Safety to develop a screening mechanism to identify at-risk drivers. (HD-R311-2007)

210 Elderly Persons

210.04 The Diagnosis and Management of Dementia as a Chronic Disease

The Minnesota Medical Association will encourage appropriate organizations to explore how best to diagnose and treat dementia and to further study the financial and health impacts of early diagnosis. The MMA recognizes the critical need to ensure that physicians who care for older adults are capable of recognizing the signs of cognitive impairment and will promote resources that include essential tools, referral options, and other information that could be used by physicians in the diagnosis and treatment of dementia as a chronic disease. (HD-R207-2010) (Retained BT 08-20)

220 Emergency Medical Care/Services

220.02 Control of Pre-Hospital Care at the Scene of Emergencies

The MMA adopts the following policy on control of pre-hospital care at the scene of emergencies:

In situations where a physician is present at an emergency, several guidelines should apply in determining who should be in charge of managing the patient's care:

1. If the patient's personal physician is present and wishes to assume responsibility for the patient's care, the paramedic should defer to the orders of the personal physician, and so inform the radio control physician.

The personal physician should verify orders by signing the EMS form as soon as time permits. The radio control physician should be contacted enroute if indicated according to local operating procedures. The radio control physician may be contacted from the scene if indicated and the personal physician wishes. The paramedic's responsibility reverts back to the radio control physician (or standing orders per local protocol) at any time when the personal physician is no longer in attendance. However, regardless of whether the personal physician is present enroute, the radio control physician should honor the wishes of the personal physician during the enroute care of the patient, in a manner consistent with standards of patient care.

2. An intervening physician not wishing to assume complete responsibility may elect to assist the paramedics and act as a medical consultant to them and to the radio control physician.

3. When no radio control exists and an intervening physician wishes to assume responsibility for the patient, the paramedics should relinquish responsibility for patient management. The intervening physician must accompany the patient to the hospital. Physicians intervening at an emergency scene should avoid involvement in resuscitation measures that exceed their prior training and experience.

The intervening physician should present identification that includes name, address, degrees, and state license number. He or she should sign appropriate forms assuming responsibility and verifying orders.

The paramedics should present the physician with a statement regarding area policies and authority of paramedics and the medical control physician. This should include the role of the physician on the scene as developed by local participating physicians and medical societies.

When these conditions exist, the paramedics should defer to the wishes of the physician on the scene. If the treatment by that physician differs from that outlined by local protocol, the physician should agree in advance to accompany the patient to the hospital. (In the event of a mass casualty incident, patient care needs may require the intervening physician to remain at the scene.)

4. In the case of multiple intervening physicians at the scene (as at an athletic event), the paramedics should request that the physicians designate one physician to direct the patient care. If the

medical director of the paramedics or his or her designee is present at the scene, that physician should direct the patient care.

5. Except as noted in #1 (where the patient's personal physician is present), the radio control physician is ultimately responsible. If an intervening physician wishes to assume responsibility for the patient and radio control exists, the intervening physician must accompany the patient to the hospital. The paramedics shall contact the radio control center as they normally would, and allow communication between the two physicians. The exchange of credentials should proceed as noted in #3 above.

If there is any disagreement between the intervening physician and the local protocols or the radio control physician, the paramedics should follow the orders of the radio control physician and place the intervening physician in radio contact with the radio control physician.

The radio control physician has the option of managing the case entirely, working with the intervening physician, or allowing the intervening physician to assume responsibility. In the event that the intervening physician assumes responsibility, all orders to the paramedics should be recorded on the ambulance form and signed by the physician, or repeated over the radio for purposes of recording. (BT-9/85) (Retained 2004)

220.07 Standard DNR Form for Use by Emergency Medical Services Personnel

The MMA approves the amended DNR form developed by the Metro Emergency Physicians Committee as revised by the MMA Committee on Ethics and Medical-Legal Affairs, which is entitled, "Minnesota Medical Association Emergency Resuscitation Guidelines." The MMA adopts the technical amendments to the MMA policy entitled, "Recommended 'Do Not Resuscitate' (DNR) Guidelines for Minnesota Emergency Medical Services Agencies" (see HD-R30-1990) and incorporates these amendments by reference. (HD-R35-1993)

220.08 Recommended "Do Not Resuscitate" (DNR) Guidelines for Minnesota Emergency Medical Service Agencies

I. Authorized Definition

Do Not Resuscitate

Do-Not-Resuscitate (DNR, No Code, No CPR): In the event of an acute cardiopulmonary arrest, no cardiopulmonary resuscitation will be initiated.

This order means that prehospital personnel will not initiate or continue cardiopulmonary resuscitation on a patient in cardiac arrest once a valid DNR order is identified. DNR does not mean that the medical care of any other medical condition will be changed.

II. Establishment of a System for Communicating DNR Orders in the Prehospital Setting at the Time of a Medical Emergency

A. Minnesota Medical Association (MMA) Responsibilities

The Minnesota Medical Association will be asked to publish a standard DNR form for distribution to the component medical societies. The MMA will assume no responsibility for the use of the form.

B. Local Medical Society Responsibility

Officers of the component medical societies may request the forms for distribution to physicians in their communities. The local medical society should establish an agreement with the medical directors of ambulance services providing emergency medical care in their communities regarding the use of the form. (A recommended set of guidelines follow.) The component medical society assumes no responsibility for the consent involved in the writing of the DNR order or its implementation at the time of an emergency.

C. Physician Responsibilities

The physician is responsible for obtaining DNR forms from the component medical society. The physician is responsible for discussing with the patient and/or family or others acting on behalf of the patient the indications for withholding CPR and explaining the meaning of the DNR order to the individuals involved. The physician should document this discussion in the medical record and insure that the DNR form is properly completed with the necessary signatures.

The physician should keep one copy in the permanent medical record and give the original to the patient. The physician is responsible for obtaining consent for the DNR order in a manner that conforms with the legal, medical, and ethical standards of care. The physician must ensure that others, signing request forms on the patient's behalf, do so in a manner that conforms to legal and ethical principles.

The physician is responsible for ensuring that the permanent medical record describes the indications, rationale, and involvement of patients (or others) in these decisions in a manner that conforms with legal, ethical, and medical standards of care.

D. Ambulance Service Responsibilities

The ambulance service and the local medical society should reach an agreement on the policies governing the implementation of a system to allow pre-hospital personnel to honor DNR orders.

Once an agreement has been made with the medical society, ambulance providers have the obligation to inform appropriate personnel of the procedural guidelines when presented with a DNR form, or order written in the medical record. Recommended standard operating procedures are as follows:

EMERGENCY MEDICAL TECHNICIANS STANDARD OPERATING PROCEDURES

REGARDING DNR DIRECTIVES:

Do-Not-Resuscitate (DNR) orders are orders issued by a patient's physician to refrain from initiating cardiopulmonary resuscitative measures in the event of an acute cardiopulmonary arrest. DNR orders are compatible with maximal therapeutic care and the patient may receive vigorous support (IV, drugs, anti-shock trousers) up until the point of cardiac or respiratory arrest. DNR orders are valid in long-term care facilities, in the home and any other setting when the DNR form is properly completed and validated. DNR orders must be signed by the patient/proxy/agent/court appointed guardian or conservator/next of kin or loved one, the witness and the physician. [DNR orders written in the order section of the medical record may be signed by only the physician to be valid.] The DNR order should be reviewed periodically. In the event of uncertainty, resuscitative measures should be initiated.

E. Patient Responsibilities and Rights

A patient has the right to refuse cardiopulmonary resuscitation. The patient should be involved to the greatest degree possible in the decision making process. Patients are encouraged to discuss these decisions with family members, if appropriate.

When the decision for a DNR order is reached, a DNR form should be completed, signed and dated by the patient/proxy/agent/court appointed guardian or conservator/next of kin or loved one, physician and witness, or the order should be written in the order section of the medical chart (if one is available), signed by the physician.

The patient, family members, or supervising health care agency should keep the form in a readily accessible location or make its presence known during the provision of emergency medical services.

The patient may revoke the decision at any time by destroying the form with the intent to revoke it or informing prehospital providers or family members of his or her wish for

cardiopulmonary resuscitation (CPR).

F. Responsibilities of Licensed Health Care Providers Involved in Caring for Patients with DNR Orders (Nursing Homes, Home Hospice, Home Health Care)

1. Nursing Homes/Long Term Care Facilities

Nursing facilities should develop policies and guidelines regarding the writing, implementation, and transmission of the DNR order during emergency care. Such guidelines should include consideration of the DNR orders being written in the medical record, signed by the physician and dated. The use of the standard form should be determined by local protocol/agreement with the nursing facility, physicians in the community and ambulance service. A written order in the medical record may be sufficient to transmit the DNR order to emergency medical technicians responding to a long term care facility.

2. Private Homes: Licensed home health care providers.

Procedural Standards for Home DNR Orders

DNR orders become effective on the day when the DNR request form is signed by the patient or acceptable proxy/agent/court appointed guardian or conservator/next of kin or loved one, the physician and the witness.

Licensed home health care providers supervising the care of patients with DNR orders in private homes are strongly urged to develop policies or guidelines to encourage the proper and safe implementation of these directives by medical personnel. Such guidelines may include:

a. accountability to proper decision-making principles (including the principle of patient involvement in these decisions);

b. implementation of these directives as a medical order in the patient's medical record signed by the patient's physicians;

c. documentation of the rationale for these directives in the medical record by the patient's physician;

d. procedural requirements for these orders, including regular home surveillance to ensure that these directives are readily accessible to prehospital personnel;

e. periodic review of these directives. Licensed health care providers should attempt to ensure that patients, families, and others acting on behalf of the patients understand the implementation and decision of DNR orders.

III. Implementation of DNR Orders During Emergency Medical Care

When prehospital emergency medical personnel arrive, the family, patient, or staff should immediately present the DNR request form. Until properly completed orders are presented, prehospital personnel will assume that no valid DNR orders exist and proceed with standing orders for resuscitation as medically indicated under medical control.

The DNR order may not be implemented when prehospital personnel have substantive reason to believe the order is invalid or in cases of unusual, suspicious or unnatural causes of cardiac arrest. In the event a patient changes his or her mind regarding the DNR order prior to cardiac arrest, or family members request resuscitation or disagreement occurs at the time of cardiac arrest, resuscitative measures should be initiated by prehospital personnel and treatment decisions should be made by the physician responsible for subsequent care.

Prehospital personnel will not honor DNR orders if:

a. not legibly or properly signed and dated;

b. using alternative wordings to limit medical care (e.g., living wills, health care durable power of attorney documents, supportive care plans) because the implications of these terms for emergency care have not been defined;

c. given orally by non-physician staff members;

d. given over the telephone by family, nursing staff or physicians.

Physicians present at the scene who are willing to take responsibility for the emergency medical care may verbally give orders to the prehospital personnel to withhold or discontinue resuscitation.

DNR orders may be revoked at any time by the patient who, by destroying the request form with the intent to revoke it, or through verbal or written expression to prehospital providers or family members, will prevent implementation of the DNR directive. The patient is responsible for informing his or her physician of this decision, and the agency, if any, supervising his or her care.

Patients with DNR orders remain appropriate candidates for emergency evaluation, assistance, treatment, and transport. The "911" emergency number may still appropriately be used to summon emergency assistance for such patients who are suffering medical emergencies.

The medical urgency of cardiac arrest precludes prehospital emergency medical personnel from evaluating the propriety of the decision-making processes or administrative procedures used to develop the DNR order. These personnel will not assume any responsibility for such an evaluation. This responsibility rests with the attending physician, and the licensed health care provider supervising care.

IV. Intent with Regard to DNR Directives

The local medical society and ambulance service will make every effort to permit patients accessing emergency medical care and transportation to decline unwanted CPR in a manner consistent with the standard of medical care. The local medical society and ambulance service continue under the presumption that patients are eligible for and desire emergency medical services. This system is established to permit patients the right to refuse unwanted CPR with the realization that this presumption and the urgency of resuscitation may mean that questionable directives may not be honored. (HD-R30-1990) (Amended by HD-R35-1993) (Retained 2004)

220.12 Support for the Emergency Medical Services for Children (EMSC) Program

The MMA endorses and supports the mission and work of the Emergency Medical Services for Children Resource Center of Minnesota. (HD-R411-1998) (Retained as edited BT 07-18)

220.14 Comprehensive Advanced Life Support (CALS)

The MMA shall support efforts to ensure ongoing funding from state and professional sources to offset the costs of the Comprehensive Advanced Life Support (CALS) program. Additionally, the MMA shall encourage medical centers to consider accepting successful completion of Comprehensive Advanced Life Support (CALS) as a substitute for recertification for staff privilege purposes in the following programs: Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), Advanced Life Support-Obstetrics (ALSO), and Neonatal Resuscitation Program (NRP). (HD-R200-1999) (Retained 2009) (Retained 07-19)

220.16 Disaster Preparedness

The MMA shall continue to collaborate with hospitals and appropriate community and government agencies, and provide a leadership role to ensure a coordinated medical community response to disaster. In addition, the MMA will provide information through their publications and website to encourage local physicians to be knowledgeable of and participate in emergency preparedness plans in their area. (HD-LR106-2001) (Retained as edited BT 08-21)

230 Environmental Health

230.04 Underground Storage of Hazardous Waste Materials

The MMA opposes the underground storage of hazardous or toxic waste materials unless all other options for disposal are thoroughly explored and unless it can be assured that there will be no risk of adverse environmental contamination. (HD-SR20-1984)(Retained 2004) (Retained BT 01-15)

230.07 Hazardous Waste Disposal

The MMA supports efforts to enhance the technology to prevent, reduce, recapture and incinerate hazardous wastes, and supports the efforts of the Minnesota Waste Management Board in voluntary site selection and in the stabilization and containment of hazardous wastes. (HD-R11-1986) (Retained 2004) (Retained BT 07-16)

230.09 Lead Poisoning

The MMA encourages education of the public and physicians on lead poisoning and how to keep children safe from lead exposure. The MMA also encourages and supports provision of safe, lead-free, low-cost housing, improvement of water and other systems to limit children's exposure to lead, in addition to other modifications which decrease exposure to lead in the environment in order to improve the health of children. (HD-R3-1991) (Retained 2004) (Retained as edited BT 08-21)

230.11 Air Quality

The MMA will support the development, implementation, and enforcement of legislation that is protective of human health while controlling air pollution. Air Quality standards should be established using the best available scientific data. (HD-R49-1995) (Retained 2005) (Retained BT 07-16)

230.14 Dioxins

The MMA acknowledges the role that polyvinyl chloride (PVC) plays in the production of dioxins, acknowledges the environmental and physical threats associated with dioxins, acknowledges the need to reduce the use of PVC products, and supports efforts to address dioxins as a pollutant through strategies including, but not limited to, material substitution of PVC products. (HD-R310-1998) (Retained 2008) (Retained BT 07-18)

230.16 Disposal of Mercury-Containing Equipment

The Minnesota Medical Association recommends environmentally proper disposal of mercury-containing equipment. (HD-R301-2000) (Retained as edited 2010) (Retained BT 08-20)

230.18 Preventing Human Exposure to Polybrominated Diphenyl Ether (PBDE) Fire Retardants to Protect Public Health

The Minnesota Medical Association urges the state and federal governments to require labeling of halogenated flame retardants used in products as to their persistence, bioaccumulation, and chemical similarity to polychlorinated biphenyls, where applicable. The MMA urges state government to require that use of polybrominated diphenyl ethers flame retardants be phased out in all products manufactured and sold in Minnesota by a date certain. The MMA also urges state, federal, and local governments to regulate the safe disposal of products containing brominated flame retardants and to prohibit land application of sewage sludge until testing can assure that such material does not contain measurable levels of polybrominated diphenyl ethers.

(HD-R304-2004) (Retain as edited BT 01-15)

230.19 Mercury in Foods as a Human Health Hazard

The Minnesota Medical Association (MMA) supports as policy, that the results of any mercury testing of fish, and advisories based upon them, be readily available where fish are sold, including labeling of packaged/canned fish. The MMA encourages physicians to educate their patients about the dangers of mercury toxicity from ingestion of food items, especially fish, and especially to advise pregnant women, parents, and children to review and revise fish consumption habits to maximize the nutritional benefits while avoiding fish higher in mercury and other contaminants.

Furthermore, the Minnesota Medical Association urges that food sources that contain significant levels of methyl mercury be excluded from federally funded programs such as the Women Infant and Children program and free school lunch programs for children.

(BT-11/2004) (Retain as edited BT 01-15)

230.2 Mercury Pollution And Other Power Plant Emissions

The Minnesota Medical Association endorses the phase-out of intentional uses of mercury-containing devices and the use of mercury in manufacturing, as feasible. The MMA endorses AMA policy H-135.949, which supports federal legislation to meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide. (HD-R303-2005) (Retained BT 07-16)

230.22 Pesticide Safety

The Minnesota Medical Association supports efforts to educate physicians (and others) about best practices in the handling of pesticides. (BT-5/06) (Retained as edited BT 07-16)

230.24 Pharmaceutical Source Reduction Policy

The Minnesota Medical Association recognizes that medication excesses and waste are a major problem and that it is important to encourage the proper disposal of pharmaceutical waste in patient care settings and in the broader community as a step toward preventing environmental health hazards (including hormone disruption and antibiotic resistance), and the potential for diversion and abuse. Therefore, the MMA supports the following mechanisms to reduce the health consequences associated with pharmaceutical waste: 1. The use of trial or small initial prescriptions for medications identified as having high side effect profiles, high discontinuation rates, or frequent dose adjustments, so long as reasonable steps are taken to limit barriers to access (e.g., changes to copayment and reimbursement policies); 2. Consideration of non-drug treatment options – if evidence-based and appropriate – such as physical therapy, proper nutrition, and cognitive/behavioral therapy; 3. Use of existing drug "recycling," "repository," or "redistribution" programs that allow for safe and effective use of unwanted pharmaceuticals; 4. "Take back" or other pharmaceutical waste collection programs that provide for safe disposal of unwanted medications. (BT 07-10) (Retained as edited BT 08-20)

230.25 Impacts of the Polymet Mine Project

The Minnesota Medical Association urges the state of Minnesota to conduct a comprehensive analysis of the health risks and public health impacts of the PolyMet NorthMet Sulfide Mine Project. (BT 09-14)

230.26 Climate Change as a Health Concern

The MMA concurs with the scientific consensus that climate change is causing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. The MMA recognizes the importance of physician involvement in public policymaking to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and notes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. The MMA supports the work of Minnesota's state and local health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently. The MMA will work to inform and educate Minnesota physicians and communities at large regarding the health consequences of climate change. (BT 11-14)

230.27 Radon Disclosure to Renters

The MMA supports the extension of Minnesota's current radon disclosure requirements for real estate transactions to also apply to rental agreements. (BT 11-15)

240 Ethics

240.01 Medical Ethics in a Competitive Environment

The MMA approves the following policies on medical ethics in a competitive environment as presented by the Committee on Ethics and Medical-Legal Affairs and the Ad Hoc Committee on Ethics and Competition:

With a rapidly changing structure of medical and health care payment mechanisms, there is an increased potential for erosion of the physician's primary responsibility to the patient. Since every organizational and payment arrangement has some potential for posing ethical challenges for the physician, the extent to which physicians are confronted with those challenges is increased by the number and variety of payment and delivery systems with which that physician interacts. Conflicts of interest are not the exclusive domain of any particular practice setting, but are rather inherent in nearly every situation in which the physician finds him- or herself on a daily basis. Three types of payment mechanisms and the types of conflicts of interest which they pose are noted below.

It should be emphasized that just because a particular situation poses the potential of a conflict of interest, that does not mean that the physician is unable to act ethically in relation to his or her patient. Rather, it is a "red flag" area which suggests that the physician should carefully monitor his or her own behavior in relationship to the patient.

The committee identified four principles which should guide the physician's economic relationship with the patient and his or her understanding of the public's expectations with regard to the practice of medicine. They are:

· The physician should not allow personal economic motives to compromise his or her decision-making process as it relates to the needs of the patient.

· The individual and the public can and should place the relative value of medicine and health care in comparison with other goods and services.

· A physician's actions should ultimately be guided by his or her primary responsibility to his or her patient.

· Cost-effective medical decision-making should be encouraged when it does not compromise quality health care.

The committee recognized that there are differing perceptions among physicians of what constitutes quality medical care. The committee also recognized that all payment systems have the potential for exposing the physician to conflicts of interest. Given those parameters, the physician must determine for him- or herself when a specific behavior is inappropriate. In this section, some potential problem areas are identified and conditions noted under which particular behavior is inappropriate and/or

unethical. In the fee-for-service setting, the committee has identified the following factors to which physicians practicing in this modality should be alert:

A. If the physician receives more money either directly or indirectly for providing more services per patient, there is an incentive to provide more care than may be necessary.

B. If the physician stands to gain directly or indirectly from the ordering of services for a patient from others (tests, drugs, referrals) the physician has an incentive to order care consistent with his or her own economic interests rather than the needs of the patient.

Services ordered from others should be consistent with clinical need. Examples of abuses in this area include:

- Inappropriate mark-ups for lab work subcontracted with an independent provider.
- Failure to pass on volume related discounts to the patient.

C. Physicians who charge fees which are excessive in relation to prevailing community standards are not acting in the best interests of the public (patients).

Significantly higher fees relating to unique factors should be explained in advance to the patient.

The committee identified the following as potential conflict of interest areas for physicians practicing in a capitation setting:

D. If the physician or health plan receives more money directly or indirectly for providing services per patient, there is an incentive to provide less care than may be necessary.

E. Health care plans which direct the provider of service to also function as the limiter of services provided by others ("gatekeeper" role) may undermine the physician's primary responsibility to the patient.

F. Physicians who choose a less costly treatment regimen for their patients without primary consideration for the patient's needs are not acting in the best interests of the patient.

Less costly treatment approaches may be entirely appropriate and consistent with the patient's needs, in which case, in the interests of cost containment, this approach should be pursued. In other cases, the less costly treatment regimen would not be the preferred modality based on the patient's condition and medical indications. The patient's needs must be primary in the clinical decision-making process.

G. The personal or financial involvement of a physician with a health maintenance organization, or a supplier of goods or services to an HMO has the potential of creating conflicts between the duty to maximize profits and the physician's primary role as patient advocate.

One example is a small physician corporation which has contracted with a health maintenance organization to provide all services, including services from referral specialists, for a capitation fee. The physician must carefully scrutinize his or her patterns of referral to ensure that he or she utilizes specialists capable of providing high quality care consistent with the patient's needs.

The committee identified the following as areas which have the potential for conflict of interest under the Prospective Payment System:

H. When insufficient funds are available to adequately pay for the care required by the patient under the Prospective Payment System, the physician is placed in a position of conflict of interest between the needs of the patient and the need to maintain the financial solvency of the corporation (e.g., hospital or other provider).

This conflict posed by the Prospective Payment System is of significant proportions. The linkage between the expenditure patterns of individual physicians and the ability of the hospital to keep its doors open is most obvious in very small facilities with a small medical staff. This problem is further exacerbated in rural areas by the lower payment rate from Medicare to rural institutions. Physicians may be faced with the dilemmas of providing expensive care close to home for a dying patient which may be such a financial hardship on the institution that it jeopardizes the hospital's very existence, or, the physician may make the decision that for the good of the community which needs the hospital as a resource, the patient will have to be transferred to a facility farther from home. These are most difficult decisions.

I. Public policy which dictates that the provider of services is also to be the one who rations those services, and which allows the provider to benefit financially from rationing decisions, may undermine the physician's primary responsibility to the patient.

Examples of this are health maintenance organizations and other capitation arrangements and the Prospective Payment System.

J. Attempts to manipulate diagnoses and chart notations to maximize payment in the absence of clearly supportable clinical evidence, undermine the integrity of the physicians.

Since medicine is not an exact science, there is some room for interpretation regarding which of the patient's charted maladies is the principle diagnosis, and which are the complications and co-morbid factors. Factors which may be clearly supported by clinical evidence may go unrecorded by the physician on the face sheet. Medical records personnel act appropriately in pointing out possible omissions by physicians which could potentially result in maximizing payment to the hospital. However, physicians should not approve changes to the "face sheet" submitted to the Medicare fiscal intermediary which he or she feels are not justified by the clinical evidence.

All Payment Systems

A number of factors identified by the committee as posing areas of potential conflict of interest are not associated with any given payment system, practice arrangement or setting. Rather, they are situations in which any physician may find him- or herself on a daily basis. These areas are noted below:

K. Referrals to other physicians which are made on factors which are unrelated to the patient's best interests undermine the physician's responsibility to his or her patient.

The patient's medical needs shall be the primary consideration in referrals made. Pre-existing referral arrangements should be scrutinized in relation to each patient's specific medical needs prior to the referral.

L. A physician who recognizes poor quality medical care which jeopardizes the health and safety of patients, or unethical conduct engaged in by a colleague, who does not act to bring that behavior to the attention of appropriate peer review committees for sanction and/or correction, is not acting in the best interests of the public (patients).

Physicians have the responsibility to look beyond their personal best interests in such matters to the protection of the public. There are many avenues for expressing concern over a physician's behavior, including personal consultation, peer review at the department or hospital level, external community-wide peer review, medical society grievance committees, and the Board of Medical Practice.

M. Physicians who inappropriately impugn the treatment regimens received by a patient from other physicians are not acting in the best interests of the patient.

Unlike the business person who can cast aspersions on the quality of a competitor's product or service in an effort to create a loyal customer, this would be inappropriate behavior on the part of a physician if his or her colleague's treatment methods were actually medically appropriate.

N. Physicians or health care plans which overschedule or allow insufficient time with the patient to ensure patient understanding of their medical problem, treatment instructions, and rationale are not acting in the best interests of their patients.

There is clearly a difference between efficient handling of patients by physicians, their allied health personnel, and office staff and "assembly-line medicine." Patients have the right to expect dignified treatment and to clearly comprehend treatment instructions.

O. Physicians who are employed by a business or corporation to oversee the health and safety of other employees have a commitment to both the employer and to the employee/patient. The commitment to the employer may undermine the physician's primary responsibility to the patient.

Physicians responsible for overseeing the health and safety of other corporate employees must recognize that their primary responsibility is to act on behalf of the employees' health interests.

P. It is possible for patients to request services based on their own perception of needs which may be in excess of services judged to be appropriate by physicians. (HD-RPT30-1984)

240.05 Ethical Principles for Financial Arrangements

The MMA adopts the following ethical principles:

1. Conflict between the physician's financial interest and the patient's medical interest must always be resolved for the benefit of the patient.

2. Referrals must be made only to providers who have, in the referring physician's opinion, the ability to provide the service needed by the patient in a timely and competent manner.

3. A physician shall provide only medically necessary services, and must not exploit the patient in any way.

4. Physician ownership in a health-related commercial venture is not itself unethical. Physicians are free to enter into lawful contractual relationships, including the acquisition of ownership interests in health facilities, services equipment or pharmaceuticals. However, the potential conflicts of interest must be addressed by the following:

a. the physician has an affirmative ethical obligation to disclose to the patient and referring colleagues his or her financial interest in the facility or therapy prior to utilization;

b. the physician's activities must be in strict conformance with the laws;

c. the patient must have free choice either to use the facility or therapy in which the physician has a financial interest or to seek medical services elsewhere; and

d. when a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must withdraw and offer to make alternative arrangements for the care of the patient.

5. Prospective arrangements which affect practice patterns by providing payments to a physician (in the form of cash or payments in kind) based upon volume of referrals is unethical. (HD-R20-1988) (Retained 2004) (Retained as edited BT 07-18)

240.06 Conflicts of Interest

The MMA approves the following:

1. Support state legislative and rulemaking efforts pertaining to the issue of conflicts of interest that are not more restrictive than the federal Medicare anti-kickback statute and safe harbor regulations.

2. Support state legislative and rulemaking efforts pertaining to the issue of conflicts of interest that provide adequate safeguards for preventing abuse by physicians who refer to entities in which they have a financial interest. (HD-R32-1992) (Retained 2004) (Reaffirmed: BT-03/08)

240.08 Ethics of Physicians' Influence of Their Patients in Legislative Matters

The MMA adopts as policy the following guidelines regarding interpersonal communications about legislative matters:

1. In the clinical situation, office or hospital, dialogue about legislative matters should occur only when initiated by the patient.

2. The time taken for discussion about legislative matters must be clearly separated from time and charges involving the clinical-professional relationship.

3. Dialogue about legislative matters must be separated from clinical consideration in such a way as to avoid abuse of the physician's authority or power by inappropriate persuasion or coercion. Communications that might interfere with the patient's voluntariness by threat of abandonment, through erroneous communication, or other forms of manipulation are unethical.

(HD-R21-1993) (Retained 2007)

240.09 AMA Council on Ethical and Judicial Affairs

The MMA interprets the intent of the Bylaws of the MMA, Section 1.1, as binding members to the AMA Principles of Medical Ethics only, and not the opinions published by the AMA Council on Ethical and Judicial Affairs. The MMA should continue to evaluate, as appropriate, the opinions published by the AMA Council on Ethical and Judicial Affairs and take action as necessary. (BT-5/94) (Retained 2006)

240.1 Self-Treatment or Treatment of Family Members

The MMA adopts the AMA Council on Ethics and Judicial Affairs' Opinion 8.19, Self-Treatment or Treatment of Immediate Family Members, and emphasizes the importance of appropriate documentation in the treatment of self or family members. (HD-R4-1995) (Retained 2005) (Retained BT 07-16)

240.122 Improving Health Literacy

The Minnesota Medical Association (MMA)supports use of informed consent forms that are readable and understandable at a 6th grade reading level throughout Minnesota health care facilities so as to improve patient safety and understandability of decisions. (HD-R406-2006) (Retained as edited BT 07-16)

240.1234 Physician and Industry Relationships

1. In the interest of professional ethics, good medical practice, and responsible stewardship, physicians should not accept any gift from pharmaceutical, medical device, or medical equipment manufacturers and distributors. 2. The MMA will support efforts to make public all payments from industry—pharmaceutical, medical device, or medical equipment manufacturers and distributors—to health care providers (e.g., physicians, nurses, pharmacists, physician assistants, etc.), researchers, health care institutions, professional societies, patient advocacy and disease groups, and providers of continuing medical education.

3. The MMA will work to be directly involved in the development of the requirements and standards for industry payment disclosure and in the development of uniform standards for the public reporting of information. 4. The MMA will support the establishment of a single, statewide resource for physicians to access timely, accurate, and unbiased information about pharmaceuticals (i.e., academic detailing-

type program). Ideally, this service would be financed by fees on drug manufacturers and would not levy fees on physicians who access the resource.

5. MMA Policy 240.123 Physician & Pharmaceutical Industry Relationships is archived (BT 01/10) (Retained BT 08-20)

240.1235 Telemedicine and Reproductive Health Informed Consent

There is no ethical basis to require that a physician be physically present with the patient when telehealth is agreed upon by both parties. It would be unethical to hold any area of medicine to a different standard not based on medically sound evidence. (BT 01/15)

240.1236 Telehealth Task Force Reccomendations

Principle 1: Telehealth is a rapidly-evolving aspect of medical practice, and physicians need to be prepared to understand and, as appropriate, adapt to the changing landscape.

Policy:

a) The MMA encourages and will participate in the creation of educational resources to support telehealth education for physicians at all stages of their career.

b) The MMA will advocate for the inclusion of more comprehensive and embedded

telehealth education in medical school and residency curricula.

c) The MMA urges physicians to consider it an ongoing duty and opportunity to educate patients on the options, uses, and possible benefits that telehealth may provide.

Principle 2: Patient safety must be the paramount consideration for a physician who practices telehealth. Physicians should adhere to specialty-specific guidelines regarding the use of telehealth to ensure adherence to accepted standards of care.

Policy:

a) The MMA encourages physicians to utilize specialty-specific telehealth guidelines and to work with their specialty societies to encourage the development of guidelines where there are none.

b) The MMA will work to establish a Telehealth Resource Site, which will include links to specialty specific telehealth practice guidelines as they are developed.

c) The MMA will explore, with Minnesota Community Measurement, whether or not there is value in developing telehealth quality measures.

d) The MMA encourages physician practices that are utilizing telehealth to adopt internal quality measures.

Principle 3: Telehealth should be used to support patient-centered care that promotes coordinated care and continuity of care. This includes appropriate informed consent, clarity regarding the technology being utilized, understanding of the limitations of telehealth services, and the role of telehealth in the physician-patient relationship.

Policy:

a) The MMA will work to establish a Telehealth Resource Site, which will include access to education about physician ethics and telehealth, especially as regards the physician-patient relationship and informed consent.

b) The MMA will continue to support and encourage improved health information exchange capabilities that fully consider and address evolving role of telehealth in health care.

c) The MMA will continue to advocate for legislation that would align Minnesota's Health Record Act with HIPAA.

d) The MMA will oppose the use of waivers of insurance network adequacy standards that seek to recognize telehealth services over existing and locally available in-person services.

Principle 4: A telehealth visit may establish a physician-patient relationship. An in-person encounter is not always a prerequisite for the establishment of a physician-patient relationship using telehealth.

Policy: N/A

Principle 5: Telehealth must be held to the same standards as face-to-face medical encounters with respect to patient privacy, security and legal rights.

Policy:

a) The MMA will work to establish a Telehealth Resource Site, which will include links to general information regarding telehealth security and privacy.

b) Physicians practicing telehealth must use appropriate technology to ensure health data privacy and security in accordance with state and federal regulations.

Principle 6: Telehealth is not a different type of medicine. Telehealth includes many different modalities for the delivery of medicine. Physicians practicing telehealth should be held to the same licensure, credentialing, and liability standards as other physicians.

Policy:

a) The MMA will support legislation to eliminate the telemedicine license from the Medical Practice Act, which is no longer relevant given Minnesota's adoption of the interstate physician licensure compact.

Principle 7: Telehealth should be compensated fairly.

Policy:

a) The MMA will work with the Minnesota Hospital Association (MHA) and other stakeholders to advocate for Medicare payment reform to expand coverage of telehealth services to include more services and broader eligible service sites.

b) The MMA will monitor the implementation of Minnesota's 2015 Telehealth Parity law. (BT 11-15)

240.125 Electronic Recording of Physician-Patient Encounters

In recognition that the physician-patient relationship is unique and requires openness and trust, the MMA supports an all-party consent law for electronic audio and visual recordings of physician-patient encounters. (BT 01-18)

240.126 Physician Use of Medical Cannabis

Physicians have an ethical obligation to not be impaired in their practice. Many substances, including medical cannabis, have the potential to impair a physician's practice. Therefore, a physician that consumes a potentially-impairing substance has an ethical duty to refrain from practice while impaired by the substance. A physician that practices while impaired demonstrates a lack of good judgment and should be referred to the Board of Medical Practice. (BT 04-18)

240.14 Guidelines for the Determination of Death

The MMA supports the Uniform Determination of Death Act - An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

The MMA also recommends the adoption of this statute in all jurisdictions in the United States. Criteria for Determination of Death:

An individual presenting the findings in either section A (cardiopulmonary) or section B (neurological) is dead. In either section, a diagnosis of death requires that both cessation of functions, as set forth in subsection 1, and irreversibility, as set forth in subsection 2, be demonstrated.

A. An individual with irreversible cessation of circulatory and respiratory functions is dead.

1. Cessation is recognized by an appropriate clinical examination.

2. Irreversibility is recognized by persistent cessation of functions during an appropriate period of observation and/or trial of therapy.

B. An individual with irreversible cessation of all functions of the entire brain, including the brain stem, is dead.

1. Cessation is recognized when evaluation discloses findings of a and b:

a. cerebral functions are absent; and

b. brain stem functions are absent.

2. Irreversibility is recognized when evaluation discloses findings of a and b and c:

a. the cause of coma is established and is sufficient to account for the loss of brain functions; and

b. the possibility of recovery of any brain functions is excluded; and

c. the cessation of all brain functions persists for an appropriate period of observation and/or trial of therapy. (BT-2/82) (Retained 2004) (Retained as edited BT 09-22)

240.15 Implementation and Transfer of Limited Treatment Orders from Long Term Care Facilities to Emergency Service Providers

The following was adopted as a position of the MMA:

I. OVERVIEW

It is widely recognized that in some situations, life-prolonging treatment may not be appropriate. Further, patients have the right to refuse medical therapies.

In the implementation of a POLST, DNR and/or DNI orders, one of the concerns that has emerged relates to how emergency personnel called to a nursing home can know that POLST, DNR and/or DNI orders, or other orders limiting treatment, have been issued. .

II. APPROVED DEFINITIONS

The MMA recognizes the following limited treatment orders:

DNR - Do Not Resuscitate - In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

DNI - Do Not Intubate - In the event of acute or impending respiratory failure, endotracheal intubation to provide sustained assisted ventilation should not be performed. (DNI does not prohibit emergency management to prevent or reverse acute airway obstruction with oral, nasal, or esophageal obturator airways or treatment of transient respiratory insufficiency with oxygen or short trials of assisted ventilation with positive pressure ventilation equipment or Ambu Bags.)

POLST – Provider Orders for Life Sustaining Treatment – In the event of an acute cardiac or respiratory arrest, all treatment will proceed as outlined in the POLST form.

III. IMPLEMENTATION OF LIMITED-TREATMENT ORDERS

A. The writing of the Order

1. The writing of a limited treatment order (POLST, DNR and/orDNI) should not be undertaken without full discussion of the diagnosis, prognosis, treatment options and implications. The attending physician should determine the appropriateness of considering limited-treatment orders for any given medical condition.

2. POLST, DNR and/or DNI orders are compatible with maximal therapeutic care. Persons may appropriately receive evaluation, assistance, treatment and hospital transport by the Emergency Care System, in accordance with the wishes expressed in the orders.

3. If the necessary parties agree to a POLST, DNR and/or DNI decision, the attending physician shall write this directive as a formal order in the patient's medical record. The patient's medical condition, other facts and considerations pertinent to the decision, and the related discussions with the patient and relevant others, should also be recorded by the attending physician in the progress notes.

4. The order should be signed and dated within the previous 12 months to be considered to be in effect. The limited treatment order should be subject to review on a regular basis and may be rescinded at any time by those originally involved in the discussion.

B. Implementation by Long-Term Care Facilities

5. Long-term care facilities are encouraged to adopt institutional guidelines to facilitate the appropriate implementation of POLST, DNR and/or DNI orders. This should include:

· Accountability for proper decision-making principles and practices (including the principle of patient involvement in these decisions).

· Documentation of the rationale for these directives in the medical record by the patient's physician.

· Periodic review of these directives.

· Adoption of readily identifiable transfer forms with POLST, DNR and/or DNI orders signed and dated by the attending physician.

C. Implementation by Emergency Medical Providers

6. Ambulance providers are encouraged to develop standard operating procedures that enable paramedics and emergency medical technicians to honor properly signed and dated POLST, DNR and DNI orders in the medical record.

7. Emergency department and hospital staff are encouraged to honor a valid written POLST, DNR and/or DNI order. The order should accompany the patient during medical transport, and one of the following forms of documentation is recommended:

· An original or copy of the medical order signed and dated by the patient's physician; or

· A patient transfer form signed and dated by the patient's physician; or

· An electronic copy of the medical order

8. POLST, DNR, DNI and all limited treatment orders may be rescinded at any time. If, at the time of an emergency, the patient or a member of the family expresses a desire for treatment, the paramedics should initiate treatment regardless of the notations in the medical record. These orders can be re-evaluated with the patient and family when the physician is present.

(BT-1/86) (Retained 2004) (Retained as edited BT 01/17)

240.16 Physicians Contemplating

Artificially Administered Nutrition and Hydration

The MMA adopts the following policy for physicians contemplating artificially administered nutrition and hydration:

1. Because it is invasive and administered by physicians or under physicians' guidance, the artificial administration of nutrition and hydration qualifies in every respect as a medical treatment. By considering it as such, patients, their family members, and physicians involved in their care can evaluate this treatment in the context of their own value systems and the other medical care provided. The process for deciding to limit, withhold or withdraw any medical treatment, including the artificial administration of nutrition and hydration should include a full discussion with the patient or appropriate family members. The following may provide useful guidance:

a. Medical orders to limit (withhold or withdraw) treatment should not be undertaken without full discussion of the diagnosis, prognosis, benefits, risks and consequences of various treatment alternatives with the patient and appropriate family members.

b. With the concurrence of the patient and/or appropriate family members, the physician should seek to involve the nursing staff or other caregivers in the discussion.

c. If the patient is competent, the decision to limit treatment will be reached consensually between the patient and the physician.

d. For patients who are not competent, the decision to limit treatment will be reached consensually by the appropriate family members and/or the patient's designated proxy or legal guardian and the physician.

e. If the necessary parties agree that treatment should be limited, the physician shall write formal orders consistent with the limited treatment plan in the patient's medical record and note the patient's medical condition, other facts and considerations pertinent to the decision, and the nature of the discussion in the progress notes. This order may be in the form of a POLST.

f. The limited treatment plan may be rescinded at any time by those originally involved in the decision and the plan shall be subject to review at least annually.

(BT-3/86) (Retained 2004) (Retained as edited BT 01/17)

240.17 Artificially Administered Nutrition and Hydration

It is the MMA's position that the artificial administration of nutrition and hydration is a medical treatment. Decisions to initiate or forego this treatment should be governed by the same decision-making procedures and principles that govern medical treatment in general. (HD-R14-1986) (Retained 2004) (Retained 01/17)

240.18 Limited Treatment Orders

The MMA's position on limited treatment orders is as follows:

1. Orders to limit (withhold or withdraw) treatment should not be undertaken without full discussion with the patient and appropriate family members of the diagnosis, prognosis, benefits, risks and consequences of various treatment alternatives.

2. With the concurrence of the patient and/or appropriate family members, the physician should seek to involve the nursing staff or other caregivers in the discussion.

3. If the patient is competent, the decision to limit treatment will be reached consensually between the patient and the physician.

4. For patients who are not competent, the decision to limit treatment will be reached consensually by the appropriate family members and/or the patient's designated proxy or legal guardian and the physician.

5. If the relevant parties agree that treatment should be limited, the physician shall record and note the patient's medical condition, other facts and considerations pertinent to the decision, and the nature of the discussion in the progress notes.

6. The limited treatment plan may be rescinded at any time by those originally involved in the decision and the plan shall be subject to review at least annually.

7. The MMA will initiate an educational effort for physicians regarding the writing of and guidelines consistent with reasonable standards of medical practice. (HD-R13-1986) (Retained 2004)

240.19 Futility

The MMA approves the following:

1. Cardiopulmonary resuscitation should not be instituted for patients or nursing home residents in the event that it can be shown to be of no benefit.

2. The determination of no benefit of cardiopulmonary resuscitation to the patient or nursing home resident must be made on the basis of published, valid, scientific evidence that demonstrates negligible chance of survival after cardiopulmonary resuscitation of similar classes of patients.

3. A No CPR or DNR order should be written to withhold cardiopulmonary resuscitation in the event of a cardiac arrest for individuals where cardiopulmonary resuscitation can be predicted to be of no benefit.

4. A decision to withhold cardiopulmonary resuscitation should be fully disclosed to the patient or nursing home resident in the event that cardiopulmonary resuscitation can be predicted to be of no benefit.

A discussion about withholding cardiopulmonary resuscitation should be documented in the patient's or nursing home resident's medical record. (HD-R37-1992) (Retained 2004)

240.2 Decisions Near End of Life -- Patient Autonomy

The MMA approves the principle of patient autonomy requiring physicians to respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration. (HD-SR30-1992) (Retained 2004)

240.21 Decisions Near End of Life

1. The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment of a patient who possess decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration.

2. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

3. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. (HD-SR30-1992) (Amended by BT 05-17)

240.23 No CPR or DNR Orders in the Operating Room

The MMA approves the following:

1. The consent to surgery and anesthesia does not imply consent to resuscitation if the expressed wish of an informed patient or of his or surrogate is to not be resuscitated.

2. The existence of a No CPR or DNR order does not preclude a patient from undergoing anesthesia and surgery, if those procedures would be of benefit to the patient.

3. The MMA adopts as ethical and moral the policy that physicians, preferably the primary care physician or surgeon, fully discuss with patients who have No CPR or DNR orders the patients' wishes with respect to resuscitation during anesthesia and surgery and comply with their mutual decision, and fully document the results of those discussions in the medical record. (HD-R33-1992) (Retained 2004)

240.34 Palliative Medicine Education

The MMA encourages inclusion of formal programs in palliative care as a component of undergraduate, graduate, and continuing medical education for appropriate physicians in Minnesota. (HD-R406-1997) (Retained BT 07-17)

240.35 Out-of-Hospital Do-not-Resuscitate Orders

The MMA reaffirms its Emergency Care Guidelines for Resuscitation and will work with other appropriate agencies to develop strategies for effective dissemination of the document to the members and to the public. (HD-R409-1997) (Retained 2007)

240.37 Anencephalic Neonates as Organ Donors

The MMA opposes the AMA Council on Ethical and Judicial Affairs' opinion regarding the use of Anencephalic neonates as organ donors. (HD-R23-1995)

240.45 Encouraging Advance Directive Completion

The MMA will implement policies to encourage physician practices to discuss the utility and importance of advance directives in end-of-life decisions with every adult patient on an ongoing basis. The MMA will encourage all physician practices to provide resources (e.g., written information) to patients to assist in completion of an advance directive, and will promote a nonbinding goal for physician group

practices to document a discussion with at least eighty percent of adult patients regarding advance directive completion. (HD-R303-2012) (Retained BT 09-22)

240.46 Guardianship Process

The Minnesota Medical Association will participate in the development of a multi-disciplinary task force to investigate the problems associated with the guardianship process. (BT-09/14)

240.47 Provider Orders for Life-Sustaining Treatment

The MMA endorses the Provider Orders for Life Sustaining Treatment form as a valid and valuable tool for effective end-of-life planning. POLST establishes medical orders and captures patient preferences for key,

emergency measures, and can enhance patient autonomy and dignity at end of life. Use of POLST should always be voluntary for both patients and physicians. POLST must be completed and used in accordance with best practices and appropriate documentation. A POLST may be rescinded at any time.

The MMA will continue educational efforts to raise awareness of POLST and to properly use POLST in practice. (BT 01-17)

240.48 Physician Aid-In-Dying

Physician aid-in-dying raises significant clinical, ethical, and legal issues. A diversity of opinion exists in society, in medicine, and among members of the Minnesota Medical Association. The MMA acknowledges that principled, ethical physicians hold a broad range of positions on this issue.

The physician-patient relationship is a sacred trust. This relationship must be protected through all stages of life including the dying process. The trust and honesty central to this

relationship applies to the difficult decisions made at end-of-life, and encompasses any decision

to engage in aid-in-dying.

The MMA will oppose any aid-in-dying legislation that fails to adequately safeguard the

interests of patients or physicians. Such safeguards include but are not limited to the following:

 must not compel physicians or patients to participate in aid-in-dying against their will;

 must require patient self-administration;

 must not permit patients lacking decisional capacity to utilize aid-in-dying;

 must require mental health referral of patients with a suspected psychological or psychiatric condition; and

 must provide sufficient legal protection for physicians who choose to participate.

All physicians who provide care to dying patients have a duty to make certain their patients are

fully aware of hospice and palliative care services and benefits.

(BT 05-17) (Reaffirned BT 04-21)

240.49 Euthanasia

The MMA is opposed to euthanasia. (BT 05-17)

240.5 Sedation to Unconsciousness at the End of Life

The duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation it can be appropriate to offer sedation to unconsciousness as an intervention of last resort. Sedation to unconsciousness must never be used to intentionally cause a patient's death. When considering whether to offer palliative sedation to unconsciousness, physicians should: (a) Restrict palliative sedation to unconsciousness to patients in the finalstages of terminal illness. (b) Consult with a multi-disciplinary team (if available), including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment. (c) Document the rationale for all symptom management interventions in the medical record. (d) Obtain the informed consent of the patient (or authorized surrogate when the patient lacks decision-making capacity, unless the physician has reason to believe that the patient would have objected to the surrogate's decision). (e) Discuss with the patient (or surrogate) the plan of care relative to: 1. Degree and length of sedation 2. Specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments (f) Monitor care once palliative sedation to unconsciousness is initiated. Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, notto respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate physiological, social, psychological, or spiritual support. (BT 09-18)

250 Fees

250.02 Release of Physician Prices

To bolster the continued development of a market mechanism in which the price of services is a relevant factor, the MMA supports the voluntary release of prices by providers. The MMA has frequently encouraged consumers to discuss fees for services with their physicians. In fact, physicians generally release fee information for specific services upon request. The MMA encourages its members to make fee information available in their office and over the telephone. The MMA urges its members to post in their offices or reception area a statement of the availability of the fees for the most frequently performed procedures. (BT-2/82) (Retained 2004) (Reaffirmed: HD-R305-2010) (Retained BT 09-22)

250.04 Defining "Illegal Fee-Splitting"

Consistent with current state law, the MMA adopts the following definition of illegal fee-splitting: (1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices; (2) referring a patient to any health care provider in which the referring physician has a financial interest, unless the physician has disclosed that financial interest; (3) dispensing for profit any drug or device, unless the physician has disclosed his or her profit interest; (4) dividing fees with another physician or a professional corporation unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division. (BT-7/87) (Retained 2004) (Retained as edited BT 07-17)

250.08 Telephone Fees

The MMA believes that charging for telephone calls related to medical consultation and management is an individual physician's decision and one which should include an appropriate risk management assessment. In situations where charges are assessed, the MMA supports public and private reimbursement for telephone calls, as defined by CPT case management services guidelines. (BT-7/93) (Retained 2004)

250.09 Fee Review Companies

The MMA supports legislation or regulation that would put in place, within the appropriate state regulatory agency, a process to review the financial arrangements between for-profit fee review companies and insurance or managed care companies, to ensure that these arrangements do not inappropriately induce fee review companies to decrease reimbursement to physicians and other health care providers. (HD-R11-1993) (Retained as edited 2007)

250.13 Self-Referrals To Independent Radiation Therapy Facilities

The MMA generally has positions supporting capital spending decisions being left to market forces, and therefore opposes legislation banning self-referrals by medical oncologists to independent radiation therapy facilities. (EC-2/03)

260 Firearms and Dangerous Weapons (See also, Health Education)

260.02 Firearm Related Deaths and Injuries

The MMA regards firearm-related deaths and injuries as a medical problem. The MMA will utilize the report of the Firearm Injury Prevention Task Force and promote a program to educate fellow physicians and their patients regarding the ownership of handguns and assault weapons derived from semi-automatic firearms and the concurrent risk of accidents, injury and death, and will seek legislative action to require a locking mechanism, such as a trigger guard, to be sold with each firearm purchased. (HD-R23-1992) (Retained 2004)

Violence

260.04 Firearms

The MMA supports the legislation protecting children from carelessly stored firearms. (BT-2/93) (Retained 2004)

260.05 Drive-by Shootings

The MMA supports increasing the penalty for drive-by shootings to a felony with a high classification increasing the sentence to the maximum. (BT-2/94) (Retained BT 01-15)

260.06 Minimum Sentencing

The MMA supports a minimum three year mandatory sentence with no plea-bargaining for a gun-related crime. (BT-2/94) (Retained BT 01-15)

260.07 Firearms and Dangerous Weapons

The MMA supports efforts that would 1) encourage physicians, as part of general patient history/questioning, to ask patients/parents if they have a firearm and, if so, if the ammunition is stored apart from the firearm; 2) encourage physicians to ask depressed patients and their families whether they have access to firearms; and 3) encourage physicians to provide information or resources on how to safely store a firearm to patients who choose to keep a firearm in their home. (HD-R43-1994) (HD-R43-1994) (Retained as Edited 2006)

260.08 Public Education About Firearm Injuries and Death

The MMA supports and promotes educational programs to reduce the number of deaths and injuries caused by firearms and to alert the public to the dangers of keeping firearms at home. (HD-SR42-1994) (Retained 2006)

260.09 MMA Policy on Handguns and Automatic Repeating Weapons

The MMA adopts the following components of the AMA policy related to handguns and automatic repeating weapons:

1. The destruction of any weapons obtain in local buy-back programs after checking to determine whether the gun is evidence from a crime or stole property.

2. Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

3. Support stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

4. Reaffirm AMA policy and create MMA policy supporting waiting periods and background checks for purchasers of handguns and automatic repeating weapons. (HD-R39-1994) (Retained 2006)

260.1 Firearms and Dangerous Weapons

The MMA supports federal legislation addressing the following: 1) the federal government should resume asking questions in the National Health Interview Survey about firearm-related injury as was done prior to 1972; 2) Congress should mandate that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and 3) the National Electronic Injury Surveillance System should expand its activities to begin tracking firearm-related injuries.

The MMA encourages the appropriate state agency to collect data and develop a study on the number of firearms in schools and the misuse of firearms by Minnesota youth and encourage the state to share the results of such a study with the MMA.

(HD-SR31-1994)(Retained as edited BT 01-15)

260.11 Firearm Locks

The MMA supports mandating the use of a locking device on all firearms stored in homes where children 18 years-of-age and younger are present or reside. (HD-R57-1995) (Retained as edited BT 07-16)

260.12 Gun Control

The MMA reaffirms its support for stricter enforcement of existing firearm laws and advocates for tighter handgun control laws. (HD-R38-1995) (Retained 2005) (Retained BT 07-16)

260.13 Permit to Carry a Concealed Weapon

The MMA supports that issuing permits to carry concealed weapons should remain at the discretion of local law enforcement. (HD-R38-1996) (Retained 2006) (Retained as edited BT 07-16)

260.14 Student Pledge Against Gun Violence

The MMA endorses the Student Pledge Against Gun Violence (I will never bring a gun to school; I will never use a gun to settle a dispute; I will use my influence with my friends to keep them from using guns to settle disputes. My individual choices and actions, when multiplied by those of young people throughout the country will make a difference. Together, by honoring this pledge, we can reverse the violence and grow up in safety). (HD-SR301-1998) (Retained 2008) (Retained BT 07-18)

260.16 Local Firearm Ordinances

The MMA will seek to change current Minnesota law that pre-empts local ordinances regulating the sale and use of firearms. (BT-7/2001) (Retained as edited BT 08-21)

260.17 Firearm Mortality Surveillance System

The Minnesota Medical Association strongly supports the Minnesota Department of Health's effort to implement a Minnesota Violent Death Reporting System in order to better understand the factors that impact firearm-related deaths. Furthermore, the Minnesota Medical Association strongly urges the Minnesota Department of Health (MDH) to institute an ongoing enhanced surveillance system of firearm deaths comprised of:

1. The formulation of agreements with Minnesota medical examiners to report to the MDH on a timely basis additional, enhanced information about firearm deaths such as blood alcohol concentration and toxicology results of the deceased, the place and circumstances of death, the characteristics of the firearm that caused the death, the psychiatric history of the deceased as far as can be determined;

2. The one-to-one matching, without hindrance, of the death certificate and public health surveillance data of firearm-related fatalities with crime investigation records, and be it further

The Minnesota Medical Association also urges the Minnesota Department of Public Safety and the Minnesota Department of Health to issue a joint, annual, public report correlating the public health firearm death surveillance data with information about the firearms and shooters involved in crimes. (BT-07/2004)

260.18 Firearm Safety

The MMA will promote conversations between providers and patients on responsible firearm ownership and safe storage in the home (much like current conversations on the use of child-restraint systems in the car).

The MMA supports the growing movement for common-sense changes to gun laws to promote responsible gun ownership and support efforts in Minnesota to require criminal background checks on all purchases and transfers/exchanges of firearms, with reasonable exceptions for immediate family and law enforcement and

military acting in an official capacity.

The MMA urges elected leaders to ensure that law enforcement officials have adequate resources to enforce the laws that hold sellers accountable when they sell firearms to prohibited purchasers.

The MMA supports state investment in Minnesota's firearm surveillance system to improve data collection, analysis, and research on firearm injury prevention.
The MMA supports the renewal and strengthening of the assault weapons ban, including

banning high-capacity magazines. (BT 11-16) (Retained as edited EC 03-18)

260.19 Gun Violence Prevention

The MMA adopts AMA policy H-145.983 as follows: School Violence H-145.983 –

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

The MMA adopts AMA policy H-145.972 as follows: Firearms and High-Risk Individuals H-145.972 –

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

The MMA adopts the following AMA policy on gun safety: It is the policy of the AMA to support (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21; (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel).

The MMA adopts the following AMA policy on federal concealed carry reciprocity: It is the policy of the AMA to oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. The AMA supports the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful controls. (BT 11-18)

270 Gambling

270.01 Compulsive Gambling

The MMA requests that all gambling institutions post signs indicating that gambling may be addictive and lead to serious health and family problems and that the signs list a contact number for help/assistance. (BT-5/94) (Retained 2006) (Retained BT 07-16)

280 Health Care Costs/Cost of Health Care

280.07 Data Collection to Reduce Health Care Spending

The MMA will continue to work with the state to assure that data collected for purposes of a public commitment to reduce health care spending will be protected as private through legislation or a temporary classification. (BT-2/93)

280.09 Reporting Health Care Expenditures

The MMA will work with the Minnesota Department of Health and other appropriate agencies to develop reporting methods for health care expenditures that will give the public an accurate accounting of where resources are spent in the health care system, including all resources spent on administrative services. (HD-R28-1994) (HD-R28-1994) (Retained as Edited 2006)

280.12 Employer Disclosure of Health Care Benefit Costs

The MMA encourages Minnesota employers to disclose and itemize the costs of health care premiums, including employer contributions, on all payroll checks for their employees. (HD-R201-1998) (Amended by HD-SR207-2006) (Retained 2008) (Retained BT 07-18)

280.14 Consumer Cost Sharing And Payment Information Disclosure

The Minnesota Medical Association (MMA) recognizes that changes in the health care marketplace are increasing patients' out-of-pocket costs, and supports patients' ability to use cost and quality information in making appropriate health care decisions. The Minnesota Medical Association supports physicians' ability to use cost and quality information in making appropriate health care recommendations. (HD-R308-2002) (Retained BT 09-22)

280.17 Payment Disclosure By Insurance Entities To Patients And Physicians

The Minnesota Medical Association will advocate that health plans and insurance companies make readily available to all enrollees and their physicians allowable payment amounts and patient co-payments for all covered tests and procedures, and pharmaceuticals in the patient's insurance contract; such information, as well as information about provider prior authorization requirements, shall be made easily accessible to patients preferably through a Web interface. (HD-R204-2005) (Retained as edited BT 07-16)

280.18 Physician Tiering

The Minnesota Medical Association continues to support health care cost and quality transparency to foster improved decision making by patients. The MMA does not support the tiering of physicians if such tiering does not make available the methodology used to assign tiers, and does not use validated benchmarks when making quality comparisons. (HD-SR300-2005) (Retained BT 07-16)

280.19 MMA Policy Principles on Health Care Supply

Universal Principles (applicable to all types of facilities):

1. The principal driving force behind health care facility development should be the health of Minnesotans/members of the community.

2. State public policy should encourage, not stifle, innovation in health care delivery.

3. A one-size-fits-all approach to medical facility review/development/siting is inappropriate

a. Health care facilities come in many shapes and sizes and new models of care delivery continually are being devised. The development of a new health care facility will depend on many factors that may be unique to the particular community – the population size, the range of services already available, the land use proposal, the employment opportunities, etc. The level of interest in a large urban area will be different than the level of interest in a rural community. The level of interest in a new ophthalmology practice will differ from the level of interest in a new outpatient surgical center; and both likely will differ from the level of interest in a new or expanded hospital.

4. Government involvement in reviewing/monitoring health care facility supply should be scaled relative to the size of the investment, the population served, the established need, and the tax status of the facility.

5. Certificate of need (CON) is an ineffective mechanism for regulating health care supply; it adds cost and there is little compelling evidence to suggest that it provides for more rational development and/or distribution of supply.

6. Collaborative models of facility development/investment should be explored

a. Within legal constraints, physicians and institutions should explore opportunities to enter into joint ventures before proceeding with formation of separately owned facilities.

b. Ownership or investment in a health care facility should not be restricted, but specific ownership or investment requirements also should not be required.

7. All stakeholders (patients, employers, health plans, hospitals, integrated systems, physicians) respond to financial incentives

a. There is no objective way to characterize the motivations of an entity seeking to expand a facility or develop a new facility – any attempts to claim that one entity is more altruistic in its motivations than another are suspect.

b. Physicians or other health care providers with an employment or ownership interest in a facility or service to which the physician or other health care provider refers patients must disclose to the patients this employment or ownership interest.

8. Federal (Stark) limitations on physician self-referral are sufficient and the current exceptions, including the in-office ancillary exception to physician self-referral laws, should be maintained.

9. Further research into the impact and nature of supply-sensitive care should occur

a. There is compelling evidence that supply-sensitive care – care that is driven by the availability of services rather than by scientific evidence or guidelines – can contribute to variation in the utilization and cost of health care. While evidence suggests that utilization and cost differences are related to greater capacity and supply of particular resources (e.g., ICU beds, medical specialists)[1], more information is needed about the effects of supply to better inform public policy.

10. The role of the MMA in health care facility issues must be evaluated on a case-by-case basis using MMA policy to guide involvement

a. The MMA should actively engage in those issues that have quality of care implications

i. For example, issues that address licensure standards, personnel, accreditation, credentialing, or data reporting merit MMA involvement

b. The MMA should minimize its involvement in those debates that appear to be local or isolated in nature, even where MMA policy direction may be clear.

Hospital-Specific Principles:

11. To minimize the need for cross-subsidization of services, efforts to change the inpatient and outpatient Medicare prospective payment systems to more accurately reflect the relative costs of hospital care should be supported.

12. The impact of hospitals on the health care infrastructure of Minnesota suggests the need for significant public involvement in their growth, expansion, and/or consolidation.

a. By nature of the range and type of services offered by hospitals, they are critical components of the health care infrastructure, not only within a community, but, often, at a statewide level.

b. Greater hospital capacity is associated with higher hospitalization rates for medical, non-surgical, services (Dartmouth Atlas).

a. The public reporting and airing of information related to ambulatory care facility expansion and development is a reasonable expectation in order to provide communities and the state with information about changes in health care facility supply.

c. Minnesotans can benefit from an informed and transparent process by which hospital expansion and/or growth occurs.

13. The not-for-profit status afforded to hospitals necessitates public review, oversight, and accountability.

a. Unlike most other medical facilities, nearly all hospitals are not-for-profit entities. As such, service obligations and public accountability are reasonable and necessary.

14. The current hospital moratorium has provided tempered growth in hospitals, but lacks sufficient detail to respond to competing exception requests.

a. Prior to the Maple Grove hospital discussions, few if any of the legislatively-approved exceptions to the moratorium have involved competing proposals; the lack of clearly articulated criteria to guide exception requests is inefficient – it delays decisions and results in unnecessary spending aimed at influencing the outcome.

b. Clear criteria for hospital expansion and creation should be articulated by the legislature.

Non-Clinic Ambulatory Care Facilities (e.g., surgery centers, diagnostic imaging facilities):

15. Given the more limited capacity and the narrower range of services that can be and are provided in ambulatory care facilities, government involvement in expansion or development of such facilities should be limited.

16. Minnesotans can benefit from greater information about ambulatory care facilities and, as such, targeted data collection needs should be identified.

17. To ensure high quality care delivery, the need for licensure and accreditation of ambulatory care facilities should be evaluated.

18. To improve the health of all Minnesotans, ambulatory care facilities have a responsibility to serve patients consistent with current requirements.[2]

[1] Fisher, Elliott et al, "The Implications of Regional Variations in Medicare Spending," The Annals of Internal Medicine, Vol. 138, No. 4 (Feb. 18, 2003).

[2] M.R. Parts 9505.5200-9505.5240 (also known as Rule 101). The rules require, as a condition of participation in other state health care programs (workers' compensation, public employees, etc.), that at least 20% of a provider's annual active caseload be enrollees in M.A., GAMC, or MinnesotaCare before limitations on the acceptance of new patients may be imposed. (BT-3/06) (Reaffirmed: BT-03/08) (Retained BT 07-18)

280.2 Radiation Therapy Facilities

The MMA opposes the current moratorium on construction of new radiation therapy facilities that are not owned or built in partnership with a hospital. (Retained as edited BT 07-16)

280.21 Radiation Therapy Restrictions

The MMA opposes restrictions on the development and construction of new radiation therapy facilities in Minnesota by physician practices, hospitals or hospital/physician partnerships. (HD-R203-2007) (Retained BT 07-17)

280.22 Transparency of Tiering Products

The MMA shall advocate for a requirement that health plans or other entities that use tiering products provide transparency in their methodology, and make their methodology for ranking understandable and available to the public. (HD-R212-2007) (Retained BT 07-17)

280.24 Prisoners' Health Care

The MMA supports efforts to extend health care coverage for catastrophic and chronic care services to prisoners who are out on work release. The financial responsibility for such coverage should fall to the state for offenders confined to state facilities and to counties/cities for offenders confined at the local level. (BT 05/08) (Retained BT 07-18)

280.26 Minnesota Action to Reduce Costs in Healthcare (MARCH) Steering Committee Framework

The MMA adopts the following framework from the MMA MARCH Steering Committee and supports advancement of the following recommendations to address the unsustainable growth in prescription drug spending:

I. Increase appropriate prescribing

A. Pursue evidence-based, point-of-order prescribing decision support tools

B. Work to expand the availability of independent, comparative evidence to support appropriate prescribing (i.e., academic detailing)

II. Ensure supportive laws and policies

A. Pursue improvements to prescription drug market

1. Prohibit drug coupons

2. Support adoption of biosimilar and interchangeable substitution law

3. Support improved transparency – by manufacturers of patient assistance programs; and, by health plans of drug benefits and formulary design (currently part of MMA's PA legislation)

B. Add patient protections

1. Support a monthly cap on patients' out-of-pocket prescription drug costs

C. Improve accountability

1. Explore strategies to improve pharmaceutical benefit manager (PBM)

accountability and oversight (e.g., conflicts of interest, rebate pass through, price spread)

D. Reduce administrative burdens

1. Support adoption of a common managed care Medical Assistance/MinnesotaCare (PMAP) formulary.

2. Support reform of medication prior authorization processes (current policy)

III. Promote complementary education & information

A. Partner with other prescribers, employers/purchasers, and patient groups to develop information and resources to support improved prescribing and medication usage.

(BT 11-16)

280.27 Minnesota Public Option

The MMA will advocate that any state-level public option must meet the following standards:

a) The first goal of the public option is to decrease the rate of the uninsured in Minnesota. To that end, plans offered under a public option must result in lower premiums than private plans with equivalent actuarial values.

b) The second goal of the public option is to decrease the rate of the underinsured in Minnesota, or the percentage of covered Minnesotans with cost-sharing burdens which exceed 10% of household income. To that end, the public option may not offer plans with actuarial values below 70%.

c) The public option must include offerings in the individual market and may include offerings in the small and large group markets.

d) The public option must reimburse professional services at rates no lower than Medicare levels. The state should meaningfully engage providers for input on appropriate reimbursement levels.

e) The public option may not require provider participation as a requirement for state licensure.

f) The public option should not depend solely on provider reimbursement caps to offer more affordable products. The MMA supports medical loss ratio (MLR) requirements above the current 80% minimum for plans offered under the public option.

g) The state should not use its own funds to subsidize premiums or cost-sharing under the public option. Enrollees eligible for advance premium tax credits and cost-sharing reductions under existing federal law should be allowed to use said credits and reductions toward the purchase of plans offered under the public option.

h) Prior to the implementation of the public option, the state should contract with a nonpartisan research entity to conduct an actuarial analysis to provide a best estimate as to the net effects of the public option on the uninsured and underinsured rates in Minnesota. This analysis should examine potential effects of the public option on provider cost-shifting, the stability of private plan premiums, and healthcare supply.

i) Should a public option be implemented, the state should publish easily accessible public data at least biennially to monitor relevant performance metrics, including, but not limited to, variables listed in the previous subsection. (BT 03-22)

290 Health Care System Reform (see also, Ethics, Public Programs)

290.14 Mid-Level Practitioners

The MMA supports the intent of the 1993 MinnesotaCare legislation that seeks to encourage and facilitate the use of mid-level practitioners (nurse practitioners and physician assistants). The

implementation of such policies must include appropriate patient safeguards, such as adequate physician supervision. In addition, these legislative initiatives should recognize education and training differentials of independent practitioners in unsupervised settings. (BT-11/93)

290.18 Definition of Terms

The MMA adopts the following broad definitions for "universal coverage" and "universal access" adopted by the Minnesota Health Care Commission:

"Universal coverage" implies every Minnesotan has health coverage and contributes to the costs of coverage based on ability to pay.

"Universal access" implies quality health services are accessible to all Minnesotans. In order to achieve universal access in Minnesota, the Commission believes non-financial barriers, such as limited access to providers due to geography; a shortage of providers in the community; cultural, racial and language barriers; lack of transportation; dependence upon out-of-state providers; age-related needs; and lack of knowledge regarding how the system works must be addressed. (BT-7/94) (Retained 2006)

290.2483 Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association (MMA) adopts the following health care reform policy statements (developed by the Health Care Reform Task Force):

I. MMA Vision for Health Care Reform

The MMA vision for health care reform is as follows:

A. The MMA envisions a health care system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner.

B. Strong patient/physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine.

C. Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost conscious choices, and incentives that reward all parties for a greater focus on prevention and enhanced health.

D. The ideal health system will deliver significantly greater returns in improved health status for the dollars invested and will deliver equity for all in access, treatment quality, and outcomes.

E. Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state.

F. In order to achieve this higher-performing system, we need a fundamental change in the financing approach and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices, with a patient-centered market in which incentives are aligned to encourage the use of preventive services and effective care without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.

II. Stakeholder Responsibilities in Health Care Reform

The MMA anticipates that the roles of all stakeholders will change in a reformed health care system, including new or renewed levels of responsibility. Those expectations are as follows:

A. The community has a responsibility

1. To ensure affordable access to basic care.

2. To broadly share the risk and cost of medical needs.

3. To assist the population in using health care resources wisely.

4. To provide the conditions and environment in which people can be healthy and make healthy choices.

5. To maximize the proportion of health spending that goes to effective care for all who need it.

6. To secure the future capacity of the health care system to provide sustained high quality and affordable health care, through investments in prevention, medical education, medical research, and improvements in the system's infrastructure.

B. Individuals have a responsibility to the community

1. To participate financially in sharing the cost of the system that benefits all.

2. To use the system wisely and draw on collective resources judiciously.

3. To take personal responsibility for their own health behaviors and reduce their own health risks.

4. To become more health literate (e.g., educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision making process).

C. Physicians and other clinicians have responsibilities to individual patients and to the broader community

1. To accurately assess patient needs and recommend appropriate and effective care.

2. To advocate honestly for needed and effective care for their patients.

3. To help individuals achieve measurable improvements in health.

4. To exercise stewardship over collective health care resources.

5. To participate in care management as members of an effective multidisciplinary health care team.

6. To foster health literacy among patients and the broader population.

7. To create and foster continuous learning environments in the organizations in which they practice.

D. Group purchasers (private-sector employers and government) have responsibilities as members of the community

1. To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers.

2. To emphasize prevention strategies (including those with longer-term payoff) in benefits design.

3. To share in the needed investments in improvements to the infrastructure of the health system.

4. To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care funds.

E. Health plans/insurers have responsibilities as members of the community

1. To create payment systems that foster care efficiency and health improvement.

2. To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs.

3. To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits.

4. To minimize the complexity of the system and the costs of administration, and to assist patients/members in navigating the system.

5. To share in the needed investments in prevention strategies and infrastructure improvement.

6. To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results.

7. To create and foster continuous learning environments for the improvement of health care administration and delivery.

III. The MMA Model for Health Care Reform

The MMA model for health care reform includes four interconnected features: 1) A strong public health system; 2) A reformed insurance market that delivers universal coverage; 3) A reformed health care delivery market that creates incentives for increasing value; and, 4) Systems that fully support the delivery of high quality care.

IV. A Strong Public Health System

A. Public Health Leadership

To strengthen the public health system, the MMA will provide greater leadership in making public health more prominent by linking its public health policies to broader health care reform and cost containment efforts.

B. Coordinated Action to Improve Health

To improve the health of individuals and the population of Minnesota, the MMA urges the creation of a statewide, coordinated and strategic action agenda to address the leading modifiable risk factors for disease.

V. A Reformed Insurance Market

A. Universal Insurance Coverage

The MMA supports universal insurance coverage to be achieved through a requirement that all individuals have coverage for an essential set of benefits that provides for the protection of individuals and public health.

The MMA believes that behavioral health services should be covered on the same basis as any other clinical service.

Affordability of coverage shall be ensured through financial subsidies to those individual with limited financial means.

B. Fairness in Insurance Risk

The MMA supports a fairer system of spreading insurance risk and sharing the cost of health care to be achieved, in part, through the establishment of statewide community rating and guaranteed issuance of an essential benefit set.

VI. A Reformed Delivery Market

A. Value, Not Volume

The MMA supports reforms in the health care delivery market that will replace the current incentives for volume with incentives for value.

B. Patient Engagement

To transform changes in the delivery of care, the MMA supports efforts to more effectively engage patients in making value-based health care decisions – for both the choice of physician/provider and the options for treatment. Patients can make better health care decisions if they have access to valid and useful information about the cost and quality of care.

C. Cost-Shifting

The MMA urges the elimination of cost-shifting by all payers, particularly government payers, that only serves to distort the cost of health care.

VII. Systems to Support High-Quality Care

A. Increase the Delivery of Effective Care

While recognizing the high quality care delivered in Minnesota, which is among the best in the nation, the MMA strongly supports efforts to increase further the amount of effective care that is provided to Minnesota patients. Several immediate efforts that the MMA supports to expand quality care are the following:

1. Appropriate Use of Evidence-Based, Physician-Developed Guidelines

The MMA supports the appropriate use of evidence-based, physician-developed clinical guidelines as an important tool for clinical and shared decision-making. The MMA believes that guidelines must be developed in an open, multi-specialty process and that closed, proprietary development models are unsupportable.

2. Expansion of the Information Infrastructure

The MMA urges statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions.

3. A Medical Home for Every Minnesotan

To promote continuous healing relationships and to better coordinate care, the MMA urges the establishment of a "medical home" for every Minnesotan. In an effort to increase the likelihood that patients can identify and sustain a relationship with their medical home, the MMA will encourage employers and public and private payers to adopt supportive payment and enrollment policies.

4. Chronic Disease and Cost Control

Recognizing the disproportionate consumption of health care resources by a small percentage of the population, the MMA will urge employers and health plans to support efforts to improve care delivery for patients with chronic disease through refinements in payment policies and by eliminating barriers to primary and secondary prevention.

B. Transparent Quality Measurement and Reporting

The MMA supports transparent measurement and public reporting of changes and improvements in various dimensions of the health system's performance in order to improve the quality of care, to improve information available to both patients and physicians, and to improve the function of the health care marketplace.

The MMA supports performance measurement at the medical group and hospital/facility level. Given the need for statistical validity and the limitations of current measurement techniques, the MMA does not support clinical performance measurement at the individual physician level.

The quality of health care is multi-dimensional and it must be measured comprehensively. The MMA supports approaching performance measurement using the six aims defined by the Institute of Medicine (IOM) – safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

The MMA recognizes that the implications for physicians of performance measurement and public reporting can be significant in terms of both business/economic impact and professional reputation. The selection of appropriate measures is, therefore, critical. The MMA supports, at a minimum, clinical performance measures that are statistically valid, evidence-based, clinically important, cost-effective, and prospectively defined.

The MMA recognizes two primary types of measures to evaluate the clinical quality of care delivered – process and outcome.

• Process measures measure some aspect of the process of care that was performed (e.g., proportion of heart attack patients given aspirin).

• Outcome measures measure a result or experience of care (e.g., proportion of treated patients with pressures below 140/90; proportion of hypertensive patients who have heart attacks).

While the MMA believes that performance measures that publicly report health outcomes are the ideal, real and significant barriers to adequately measuring health outcomes require that their use be limited. Among the barriers to using outcomes measures are the low frequency of many clinical events, the

probability associated with outcomes/the need for large numbers, and the often limited (or unknown) amount of the variance in outcome that is actually controlled by the subject of the measurement.

Given current methodological limitations, the MMA believes that in most circumstances process measures that are linked to meaningful differences in outcomes are the most viable metrics for evaluating the quality of clinical care.

The MMA will take a leadership role in working with stakeholders to identify, collect, and report appropriate measures that can be used for system improvement and to aid in improved decision making by all stakeholders.

The MMA supports the following minimum parameters to guide its involvement in this area:

-Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;

-Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;

-Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;

-The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and,

-Criteria to be used for selection of measures should include whether good evidence exists, and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

C. Simplified Measurement and Reporting Transactions.

The MMA will work to eliminate duplicative quality measurement and reporting efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA will explore opportunities to facilitate the transition from manual to electronic chart abstracting.

D. Payment Systems to Support Quality Practice

The MMA will advocate for the adoption and expansion of payment policies by public and private payers (sometimes referred to as "pay for use") that will financially reward physician actions to improve their capacity and ability to deliver more efficient, effective care (e.g., the installation of electronic health records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc).

The MMA recognizes that significant national and local attention is being paid to the notion of "pay-for-performance" with little or no existing evidence to indicate that it will achieve the desired improvements in quality or cost reduction that many seek to achieve.

Under the MMA model for a reformed health care system, the concept of pay-for-performance becomes moot, because patients will decide for themselves about the value offered in terms of performance and cost. In the short-term, however, the MMA will support payment models that link payment with

process measures, but will oppose pay-for-performance models that link payment with outcomes measures. (BT-07/2005) (Reaffirmed, in part (VII(D)), HD-SR203-2006) (Retained BT 07-16)

290.2486 Universal Health Insurance and Appropriate Compensation

The MMA recognizes that universal access, clinic-based chronic disease management and the concept of a medical home must include adequate funding to be successful. (HD-R305-2007)(Retained BT 07-17)

290.2488 Access to High-Deductible Insurance Policies and Medical Spending Accounts

The Minnesota Medical Association will continue to monitor the development of Minnesota's health insurance exchange and recommend that the state consider a variety of options in the types of eligible insurance policies offered by the exchange, including eligible high-deductible policies. (HD-R307-2010) (Retained BT 08-20)

290.26 Two Percent Tax

The MMA will continue to constantly encourage legislators, the Governor, and Health Care Commission members to adopt broad-based taxing sources to improve access to health care. The MMA continues to support the pass-through language and the elimination of Medicare copays and deductibles from taxable gross income definition. The MMA will pursue the repeal of the 2% tax. (BT-2/93) (Retained 2004)

290.27 Health Services Tax

The MMA reaffirms its strong opposition to the imposition of a health services tax on physicians and other providers and will continue to constantly encourage legislators, the Governor, and Health Care Commission members, to adopt broad based taxing sources to improve access to health care. The MMA continues to support the pass-through language and the elimination of Medicare co-pays and deductibles from taxable gross income definition. The MMA will pursue the repeal of the provider tax. (HD-SR7-1993) (Retained 2004)

290.35 Substitution of Tax for 2% Provider Tax

The MMA supports legislation to repeal the 2% provider tax and replace the revenue with alternative funding sources such as increased tobacco, alcohol, or income taxes, as needed. (HD-R30-1996) (Retained as edited BT 07-16)

290.412 2% Provider Tax

The MMA reaffirms its current policy that the 2% provider tax funding mechanism for MinnesotaCare be replaced with general revenues. (HD-R206-2007) (Retained BT 07-17)

290.42 Removal Of Congressional Restrictions On Qualified Indemnity Health Insurance Products

The Minnesota Medical Association will contact the Minnesota Congressional delegation urging them to support legislation that is consistent with MMA and AMA policy related to medical savings accounts and the tax deductibility of individual health insurance premiums. (HD-R215-2003)

290.44 Consolidation Of Oversight Of Health Plan Contracts

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society will develop legislation during the 2004 session to consolidate oversight of health plan contracts within one state agency. (HD-R409-2003)

290.45 Creation Of An Oversight Position In The Department Of Health That Specifically Addresses Psychiatric Disorders In The General Population

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society develop legislation during the 2004 session creating an oversight position in the Minnesota Department of Health that specifically addresses psychiatric disorders in the general population. Activities would include:

1. Epidemiological studies of psychiatric disorders;

2. Coordination of mental health identification and treatment data;

3. Dissemination by the Health Department of a newsletter outlining the best practices for treatment of these disorders to primary care physicians (as is now done for infectious diseases);

4. Promotion of mental health screening activities by primary care professionals and public health nurses;

5. Promotion of the public health mental health model;

6. Working with professional societies, medical schools, primary care residency programs, and continuing education programs to promote mental health education to primary care physicians;

7. Encouragement through state grants, policy changes, etc., of improved coordination and shared care arrangements between psychiatrists and primary care physicians;

8. Working with professional societies and advocacy groups to clarify best practices for medical necessity treatment criteria;

9. Aiding in oversight of health plan contractual agreements for accessible mental health services; and

10. Providing outcome analysis of clinical and cost-offset outcomes of these activities. (HD-R410-2003)

290.46 Psychiatric Access Data Compilation, Management, And Health Plan Contract Enforcement By State Departments

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society develop legislation during the 2004 legislative session that requires appropriate state agencies (such as the departments of Commerce, Human Services, and Health) to:

1. Monitor access to inpatient and outpatient psychiatric services in Minnesota;

2. Monitor health plan network coverage of psychiatric services to ensure that geographic and timely access are provided in accordance with Minnesota Statute 62D.124 (geographic accessibility) and Minnesota Rule 4685.1010;

3. Require health plans to publish their mental health medical necessity criteria for access to inpatient and outpatient services. The agencies will review the criteria to ensure that they are in compliance with standards of care as defined by provider groups including the Minnesota Medical Association and the Minnesota Psychiatric Society (Minnesota Rules re: Health care programs, 9505.0175 subp. 25);

4. Collect data regarding geographic and timely access to inpatient and outpatient psychiatric services, including frequency of patients diverted to another city or state beyond 30 miles or 30 minutes from their primary place of residence due to capacity constraints;

5. Following a six-month period of data collection, if there is significant evidence that psychiatric access is not meeting state guidelines, the state departments of Health, Human Services, and Commerce will take steps to vigorously enforce the contracts in order to ensure that health plans and insurance entities aggressively enlarge their networks and facilitate mental health care and reimbursement for care that is delivered by psychiatrists, psychiatric clinical nurse specialists, and primary care clinicians. This would include ending the administrative roadblocks that have delayed and disrupted the delivery of timely mental health care to Minnesotans up to this point. The legislature should require health plans to show how they are successfully improving access to psychiatric and primary care clinicians, according to their respective levels of expertise. If these steps are not followed within a reasonable timeline, the state departments will address these contract violations with all available methods, including financial penalties and consideration of contract probation or cancellation;

6. Produce an annual report to the legislature and to the citizens of Minnesota with aggregate data collected; and

7. Provide the legislature with recommendations as appropriate regarding the need for increased access to psychiatric treatment in Minnesota. (HD-R411-2003)

290.47 Any Willing Provider (AWP) Legislation

The Minnesota Medical Association Board of Trustees approves the Executive Committee recommendation to not adopt 2003 Resolution 211: that the Minnesota Medical Association develop and lobby for an Any Willing Provider law in Minnesota and that the MMA delegation to the American Medical Association (AMA) carry a resolution to the AMA urging the AMA to develop model state Any Willing Provider legislation.

The MMA will take a major leadership role focusing on health care financing and be out in front leading the discussion on policy rather than responding to other efforts. (BT-11/2003)

290.52 Principles for Sustainable Health Care Payment Systems

Effective health care reform in the United States will require delivery system and payment system reforms that will address the significant problems of uneven quality and rapidly rising costs. The payment systems currently used represent a frayed patchwork of solutions that were intended to solve a variety of problems. Generally, the predominant method of payment, fee-for-service, has become substantially distorted in its ability for patients and consumers, as well as others, to make true value judgments and purchasing decisions. The profound payment inequities imposed by Medicare and Medicaid have forced cost shifting that exacerbates the problems of inequity in costs and access. Years of imposed price controls in these government programs have not produced greater quality nor have they helped to constrain overall health care spending. In short, current payment systems have not helped to foster the creation of value in the health care system. Physicians and other health care providers must work to create value in health care and government and payers must work to implement payment systems that reward value. The combination of delivery system reform and payment system reform should improve individual and population health, make affordable health insurance accessible to all, and slow the rate of increase in overall health care spending. Many proposals have been made for payment system reform, and some will soon be implemented in the State of Minnesota. Federal reforms are several years away. The following principles are intended to guide future MMA policy making as well as to inform state policy makers about the need to link payment system and delivery system reform. The goals or expected outcomes of payment systems should be to: 1) Promote the development of continuous healing relationships between physicians and patients. Payment systems should reward physicians for understanding the needs and desires of patients and jointly making better decisions about health care; 2) Promote the development and support of coordinated care. Payment systems should reward better outcomes with better coordination of care, especially for patients with chronic disease and patients who require inpatient care, or care provided by multiple clinicians; 3) Improve clinical outcomes and safety. Payment systems should reward better clinical outcomes and safer care, which will improve health; 4) Improve the efficiency of care. Payment systems should reward physicians for their efforts to maximize the efficient use of health care resources; payment systems should reward care that demonstrates value to patients; 5) Improve the effectiveness of care. Payment systems should reward the appropriate use of care and should not support care that causes harm without benefit. The attributes of effective payment systems should include: 1) Transparency. The payment system – from collection of premium dollars to payment for services delivered – should be completely transparent to all users. The measures of clinical outcomes, patient-reported outcomes, costs and payments should be clear and easily understood by all users; 2) Understandable. The payment system should be easy for all users to understand, including the price and actual amount paid for care; the payment system should help patients make better decisions about their care in consultation with their physicians; 3) Flexibility. The payment system should utilize multiple payment options and structures to promote the creation of value by providers. Multiple payment options/structures allows for recognition of differences in geography, specialty, practice size, and practice type. Such options include creating payment structures that support primary care, as well as encouraging creation of value in procedural-based care and complex diagnostic care and treatment. Different payment mechanisms, and blends of mechanisms, will be needed to achieve the goals of payment reform; 4) Support for innovation in delivery systems. The payment system should encourage physicians and others to work together in finding better care methods, including non-visit care or care delivered outside a traditional

office or hospital setting that would improve outcomes and reduce overall costs; 5) Support for development of evidence-based care. The global payment system – including payments by states and the federal government, industry, and insurers – should facilitate clinical trials and studies for patients and physicians to determine the best approaches where evidence is lacking; 6) Equity. The payment system should not create barriers to access or create unfairness by allowing cost-shifting among purchasers of care; 7) Preventive Health. The payment system should encourage and reward preventive care and strategies that improve health; 8) Support for medical education. The payment system should support education of medical students and other health care providers. (BT 05/10) (Reaffirmed: HD-R305-2010) (Retained BT 08-20)

290.53 Support for Whole-System Health Reforms

The Minnesota Medical Association continues to support reforms in health care that aim to accomplish the principles of the Patient-Centered-Medical Home (patient-centeredness, comprehensiveness, enhanced access, quality and safety, teamwork, coordination of care, continuous (relational) care, and the payment reforms to support those principles), and supports whole system health care reform that recognizes the shared responsibility for coordination of care between primary care physicians and other specialist physicians as needed to ensure the optimal care of the patient. The MMA supports reforms in health care that bolster patients' access to primary care physicians and supports the viability of practice of primary care and other specialty medical practices, and, at the state and national levels, shall support reforms in health care that apply the principles of the Patient-Centered-Medical Home for all patients and across the entire health care system. The MMA supports reform in health care that supports patients making informed decisions in the context of the trusting relationship with their personal physician. (HD-R200-2009) (Retained 07-19)

290.58 Affordable Care Act

The MMA opposes repeal of the Patient Protection and Affordable Care Act (ACA) of 2010. (EC 01-11) (Retained BT 08-21)

290.61 MMA Principles to Guide Development of Minnesota's Health Insurance Exchange

A) All information provided through the insurance exchange for use by consumers (individuals and small employers, in particular) should be clear, concise, understandable, and relevant to their insurance purchasing decision.

o Keep it simple – do not overwhelm users with too much data and information

o Require use of plain language

o Define terms clearly (e.g., copayment, co-insurance, deductible)

o Provide visual displays of data to illustrate differentiation (e.g., Consumer Reports model)

o Accommodate language and cultural differences among expected users

o Ensure that navigators are able to help consumers evaluate options and understand trade-offs and are able to explain and interpret performance data (i.e., measure methodology and interpretation of results)

B) Information reported through the insurance exchange about physician clinic performance should be timely, valid, reliable and useful; should identify only actual differences in performance; should be based on standardized methodologies; should be verifiable by physicians/clinics (the subjects of the data); and, should be developed with limited burdens on practices.

o Existing MMA policies with respect to the public reporting of physician quality measures are relevant to any data reported through the insurance exchange (e.g., not at the individual physician level; use of valid, reliable, and useful measures; application of risk adjustment; etc.)

o Show data that demonstrate real differences in performance (i.e., statistically significant differences); do not display data that imply differences where they do not exist.

o Provide visual displays of data to illustrate differentiation (e.g., Consumer Reports model), but development of criteria/thresholds (e.g., stars or rankings) must be accomplished via a stakeholder group that includes physicians.

o To the extent possible, reported data should not contradict other commonly used sources (e.g., MNCM, Joint Commission, CMS, etc.).

C) The insurance exchange should promote further uniformity and streamlining of health plan administrative policies and processes.

o Utilize the exchange to drive further administrative cost reductions (e.g., require all health plans participating in the exchange to adopt common prior authorization processes, such as medical necessity criteria)

o Incorporate and report health plan data on measures of administrative complexity/hassles (e.g., percentage of prior authorization denials)

o Report data on denial of services (e.g., percentage of claims, by diagnosis, denied on retrospective review)

D) Governance of the exchange should be a shared public-private model with broad representation. (BT 01-12) (Retained BT 09-22)

290.63 NCQA Recognition as Alternative Health Care Home Certification in Minnesota

The MMA supports the NCQA's Patient-Centered Medical Home recognition as an alternative for meeting the requirements of certification as a Health Care Home in Minnesota. (HD-R306-2012) (Retained as edited BT 09-22)

290.64 Insurance Exchange

The MMA supports a state-based insurance exchange that will function as an active purchaser to support real transformation in the market and to support care and delivery improvements. The MMA will work to ensure physician representation on the insurance exchange governance board. The MMA

further supports financing for the insurance exchange through an insurance premium withhold, as currently recommended, but remains open to other sources of revenue. The MMA will strongly oppose efforts to use the Health Care Access Fund to finance Minnesota's insurance exchange. (EC 02-13)

290.65 MNsure

The Minnesota Medical Association will facilitate improved access to existing information about MNsure and will continue to keep membership informed as it evolves. (HD-R203-2013)

290.66 Patient Choice of Physician

The Minnesota Medical Association supports efforts to promote greater equity for physicians in independent medical practices with respect to health plan contracting, and will pursue action to support physicians' and patients' choice of physician, regardless of their practice arrangement. (BT-07/14)

290.67 MMA Principles for Health Care Reform

1. Insurance coverage for all Minnesotans

– Individual mandate for essential health benefits

– Fair spreading of risk (guaranteed issue, community rating)

– Subsidies/tax incentives

2. Preserve patient-physician relationship

– Guard the trust and ethical foundations of the physician-patient relationship

– Recognize need for patent and public accountability

– Oppose third-party interference in personal care decisions

3. Ensure access to appropriate care for all Minnesotans

– Insurance coverage, alone, does not guarantee that patients will have access to physicians and other providers of care that they need

– Reasonable payment rates are necessary to ensure access to care and viability of physician practices

– Invest in health care workforce – education and training

4. Improved affordability of care

– Support evidence-based, effective care

– Promote continuous healing relationships and a "medical home" for every Minnesotan

– Work to reduce administrative waste and low-vale or unnecessary care

– Changes to the ACA must strive to improve affordability and should not result in greater financial barriers to care and coverage.

5. Invest in public health and prevention

– Recognize the significant influence of social determinants of health on health care costs and utilization

– Support payment and coverage policies that can limit development/exacerbation of chronic conditions

– Preventive care must continue to be covered as part of any insurance coverage

6. Health equity

– Recognize that structural and institutional racism that exists in hospitals and health care systems in Minnesota has contributed to current racial and ethnic health disparities

– Support policies that will improve health for all Minnesotans, acknowledging the impact of housing, transportation, education, economic opportunity and criminal justice policies in pursuit of that goal

7. Support innovation in care delivery and payment

– Recognize challenges and limitations of a predominantly fee-for-service based payment system

– Support experimentation with value-based payment models – no one-size-fits-all method is appropriate

8. Broad-based, stable and adequate financing

– Ensure adequate investment in system

– Financing systems should reflect broad social benefit of
care
– That doesn't outright exclude consideration of any one financing model

(Confirmed by BT 01-17)(Retained as edited BT 11-18)

290.68 Behavioral Health Care in Medical Settings

The MMA will support legislative efforts to transition payment for behavioral health services from standalone payment to integrated payment models covering all other health benefits. (BT 11/17)

300 Health Education

300.1 Domestic Violence and Abuse Campaign

The MMA will continue to work with the Minnesota Coalition for Battered Women, Womankind, Inc., the Minnesota Department of Health, the Consumer Incentive Subcommittee of the Minnesota Health Care Commission, members of the media, and other coalitions interested in achieving a violence-free society by the year 2010 and continue its campaign against violence in Minnesota and assist physicians in being as effective as possible in helping patients achieve both a healthy and safe environment. The MMA urges all physicians in Minnesota to join the National Coalition of Physicians Against Family Violence. (HD-R45-1993) (Retained 2004)

300.12 Public Education About Firearm Injuries and Death

The MMA supports and promotes educational programs to reduce the number of deaths and injuries caused by firearms and alerts the public to the dangers of keeping firearms at home. (HD-SR42-1994) (Retained 2006)

300.14 Conflict Resolution Training

The MMA supports the expansion of conflict resolution and reconciliation training in educational settings (K through 12) and parenting classes, as appropriate. (HD-R44-1994) (Retained 2006)

300.22 Cigars, E-Cigarettes, Pipe Tobacco and Smokeless Tobacco

The MMA, as part of its anti-tobacco campaign, will incorporate and identify cigars, e-cigarettes, pipe tobacco, and smokeless tobacco as dangerous products in order to protect the public health. (HD-LR319-1997) (Retained 2007) (Retained as edited BT 07-17)

300.23 Passive Smoking

The MMA encourages all parents to protect the health of their children by declaring their home a smoke free home.

The MMA supports a requirement that all licensed day care homes and centers be smoke free 24 hours a day. (HD-LR321-1997) (Retained as edited BT 07-17)

300.26 Guidelines for Adolescent Preventive Services (GAPS)

The MMA will (1) strongly advocate the universal incorporation of Guidelines for Adolescent Preventive Services (GAPS) into routine patient care settings in which care is provided to adolescent patients, including HMOs and hospital clinics; (2) urge appropriate physician payment for health education related to patient care when reported with the appropriate CPT codes; and (3) work with third party payers to provide coverage and payment for proper adolescent care at appropriate intervals. (HD-R304-1998) (Retained as edited BT 07-18)

300.29 Drivers Education Regarding Sleepiness

The MMA supports the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in the state of Minnesota. (HD-R315-1999) (Retained as edited 2009) (Retained 07-19)

300.31 Antibiotic Resistance Public Education Campaign

The Minnesota Medical Association recognizes the need for ongoing education about the appropriate use of antibiotics and the potential dangers of antibiotic resistance (HD-R314-2000) (Retained as edited 2010) (Retained as edited BT 08-20)

300.37 Public Education Program That Emphasizes The Benefits Of Having A Personal Physician

The Minnesota Medical Association will work collaboratively with primary care specialty societies and other appropriate organizations to study the possibility of developing a public education program that emphasizes all of the benefits to the patient, other specialists, and the entire health care system of having a personal physician who can provide high quality health care and can assist patients in obtaining other appropriate health services in a more efficient and effective manner. (Retain as edited BT 01-15)

300.38 Responsible Sexuality Education

The Minnesota Medical Association (MMA) supports comprehensive, developmentally appropriate, and medically accurate sexuality education programs. (HD-R412-2004) (Retain as edited BT 01-15)

310 Health Fraud and Quackery

310.03 MMA Position Regarding Iridology

The MMA believes the practice of iridology is without a scientific basis and has the significant potential for false positive and false negative diagnoses. The MMA questions the negative impact of the emotional and economic burden of falsely labeling the healthy as having disease. Further, a false negative analysis has the potential for harm when patients rely on iridology and fail to receive proper treatment. (BT-11/84) (Retained 2004) (Retained BT 01-15)

310.04 Chelation Therapy

The MMA adopts the following position on chelation therapy: "The use of sodium ethylenediaminetetraacetic acid (sodium EDTA) to treat atherosclerosis is not supported by available data. All studies claiming therapeutic benefit are flawed in one or more aspects of experimental design, the most important of which is the lack of suitable control groups. The clinical use of sodium EDTA to treat any form of atherosclerosis has no scientific basis and is not an acceptable therapy for this disease. Sodium EDTA chelation therapy should be regarded as investigational because of a lack of objective evidence of its efficacy and questions regarding its safety. Studies involving the use of sodium EDTA should be performed by trained investigators using rigorously designed protocols capable of providing useful information. It is inappropriate and misleading for medical practitioners to offer chelation to patients as an "experimental" therapy if the drug is being administered as a routine clinical treatment rather than as part of such a study." (BT-11/84) (Retained 2004)(Retained BT 01-15)

330 Hospitals

330.06 Risk Management Activities

The MMA (1) actively supports the development of formal risk management activities within the hospital; (2) encourages the involvement of medical staffs in the development and ongoing operation of those risk management activities; and (3) encourages educational activities for physicians in risk management activities and programs. (HD-R31-1986) (Retained 2004)

330.082 Workplace Violence and Abuse Prevention

The MMA encourages all hospitals and clinics to adopt policies to reduce and prevent workplace violence and abuse and develop policies to manage reported occurrences. (HD-R103-1998) (Retained 2008) (Retained as edited BT 07-18)

330.083 Elimination of Sexual Discrimination and Harassment in the Medical Workplace

The MMA endorses further research on the prevalence and causes of sexual discrimination and harassment in the medical workplace and the elimination of this type of abuse in the medical workplace. (HD-R110-1998) (Retained 2008) (Retained BT 07-18)

330.0892 Moratorium from Additional Prohibited Medical Abbreviations from Joint Commission on Accredidation of Healthcare Organizations

The Minnesota Medical Association delegation to the American Medical Association (AMA) will carry a resolution to the AMA calling on the AMA to request (through the AMA representatives on the Joint Commission on Accreditation of Healthcare Organizations Board) that the JCAHO Board slow the pace of implementation through a moratorium of additional "do not use" abbreviations until there is evidence of overall compliance with the currently recommended list; work with the American Hospital Association to develop an acceptable interim mechanism to correct abbreviations that are legible but on the "do not use" list; and support the continued exemption of "do not use" abbreviations, acronyms, and symbols on dictated, transcribed, or computerized forms of clinical documentation from the JCAHO standard. (HD-R209-2004)

330.09 Voluntary Publication of Hospital Price Reports

The MMA supports voluntary publication of hospital price reports and dissemination of hospital utilization information. (BT-2/82) (Retained BT 09-22)

330.131 Hospital Outpatient Billing/Provider-Based Billing

It is the position of the MMA that payment policy, whether public or private, should ensure that patients have access to settings of care that provide the appropriate level of care. If the same service can be safely provided in different settings, and if the service is not dependent on a hospital facility and its associated technologies, there should be site-neutral payment for that service. The MMA encourages hospitals and hospital-owned outpatient practices to be transparent about their billing policies with patients prior to providing care, particularly if patients, and/or their health plans, will be responsible for both physician and hospital facility fees. (BT 01-16)

330.14 JCAH Accreditation Standards

The MMA supports the following five principles, developed and approved by the AMA Board of Trustees, for use in reviewing future revisions of the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals:

1. continue the use of the term "medical staff";

2. delete references to dentists, podiatrists, oral surgeons and other limited licensed practitioners in the medical staff chapter;

3. provide for consideration of qualified limited licensed practitioners when authorized by state law and approved by the executive committee of the medical staff;

4. require greater than a majority of fully licensed physician membership on the executive committee of the medical staff in acute care general hospitals; and ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admission and the responsibility for the medical care of patients. (HD-R12-1983)

330.17 Study and Issue Guidelines for the Immunization of Physician Members of Hospital Medical Staffs

The MMA will study the legal and regulatory aspects of requiring physician members of hospital medical staffs to be immunized in order to prevent the infection of patients and employees for the purpose of adopting guidelines to be disseminated throughout the state, and will request the Minnesota Delegation to the AMA Hospital Medical Staff Section Assembly to sponsor a similar resolution in the 1993 Interim HMSS Assembly. (HD-R46-1993)

330.19 Organized Medical Staff Section

The MMA approves the following recommendations proposed by the Hospital Medical Staff Section and relating to organized medical staffs:

1. That the name of the MMA Hospital Medical Staff Section be changed to Organized Medical Staff Section.

2. That representation to the Organized Medical Staff Section be offered to any group of physicians that share a common contracting relationship with an HMO or PPO, a common employer, or a common membership in a new health care delivery system.

3. That the representative of the Medical Staff must be a member of the MMA and membership in the AMA is encouraged.

4. That the representative preferably should be elected by the physician members of the Medical Staff or a Medical Staff Executive Committee. (BT-8/95) (Retained 2007)

330.2 Physician Participation On Hospital Governing Boards

The Minnesota Medical Association will support the inclusion of physician membership on hospital governing boards. (HD-R404-2002) (Retained 09-22)

330.21 Remuneration for Physicians on Call

The MMA recognizes the need for hospitals to maintain adequate on-call physician coverage to serve the needs of patients in their communities. Paying physicians for on-call coverage may, in some cases, be a reasonable practice for hospitals and/or medical groups. The MMA urges physicians, however, to be mindful of ethical and legal ramifications that may be associated with payment for on-call services, including possible violation of medical staff bylaws, federal and state anti-kickback laws, and self-referral prohibitions. (BT 05/08) (Retained BT 07-18)

330.22 Support of Lactation Services

The Minnesota Medical Association supports lactation support services for a duration of at least six months post-partum by lactation consultants and support reimbursement of such services by third-party payers. (HD-SR203-2005) (Retained as edited BT 07-16)

330.24 Hospital Bylaws (Legislative protection for medical staffs in non-accredited hospitals)

The MMA will work to pursue a change in Minnesota law on hospital licensure to limit or preclude unilateral medical staff bylaws amendments by hospital boards of directors or medical staffs, consistent with current Joint Commission and CMS requirements. (BT 02-16)

340 Infection Control (See also, Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus)

340.03 MMA Opposes Current HEPA Mask Requirement

The MMA will work with the Minnesota Hospital Association to protest the current regulation on HEPA masks as an expensive and unproven safety measure, until their efficacy can be proven with appropriate epidemiologic studies. (HD-R36-1994) (Retained BT 01-15)

340.04 Use of Anti-Microbials in Agriculture, Pesticides, or Growth Promoters

The Minnesota Medical Association adopts the following positions on the use of Anti-Microbials:

1. The MMA opposes the use of anti-microbials used in human medicine at less than therapeutic levels in agriculture, or as pesticides or growth promoters, and will urge appropriate officials that these uses be phased out by regulation.

2. The MMA urges that increased surveillance of anti-microbial use and resistance be funded and instituted as recommended by the Institute of Medicine and American Society of Microbiology.

The Minnesota Medical Association shall encourage the appropriate state agencies to investigate the role that antibiotic use plays in antibiotic resistance. (BT-5/01) (Retained as edited BT 08-21)

340.07 Triclosan

The MMA acknowledges the public health concerns associated with exposure to triclosan, an antimicrobial active ingredient, contained within products such as antibacterial soaps

and cleaning products, and will support efforts to restrict the use of triclosan in consumer

hand and body cleansing products. Further, the MMA encourages the Food and Drug Administration (FDA) to continue to evaluate the effectiveness and safety of antibacterial consumer products containing triclosan. (BT-03/14)

350 Laboratories

350.01 Reference Laboratory Contracts

The MMA approves the encouragement of Minnesota health care plans to enlist the input and advice of plan physicians, consider the effects of reference lab contracts on good patient care, provide an adequate period of time from announcement to introduction of such arrangements, and communicate the announcement to physicians in an appropriate manner. (HD-R23-1993) (Retained 2004)

350.04 Laboratory Billing

It is the position of the Minnesota Medical Association that it is an ethically permissible billing practice whereby an ordering and billing physician adds to the charge of the professional services rendered by a pathologist for anatomic and cytologic services if those added charges reflect the reasonable costs incurred by the ordering and billing physician during the billing process (such added charges would not include costs otherwise incorporated in the ordering physician's professional services associated with the patient visit, specimen collection and handling (i.e., inconsistent with CPT coding standards)). Therefore, the MMA will oppose any legislative or regulatory efforts to prohibit such billing practices. The MMA will educate Minnesota physicians about the complex issues involved in the billing of anatomic and cytologic pathology services. (BT-11/06)

360 Litigation

360.01 Expert Witnesses

The MMA recognizes participation by physicians in the professional liability judicial process as ethical behavior and of benefit to society. (HD-SR21-1982) (Retained as edited 2007) (Retained as edited BT 09-22)

360.04 Damage Awards for Mental Anguish

The MMA opposes legislation which expands damages for wrongful death actions to include mental anguish. (BT-11/85) (Retained 2004) (Retained BT 07-16)

360.05 Litigation Support Program

The MMA endorses the concept of malpractice insurance coverage or other proof of indemnification for all practicing health professionals. Further, we believe that this should be part of a comprehensive reform proposal based on MICRA-type reforms, including limits on non-economic damages, limits on attorney contingency fees based on a sliding scale proposal, apportionment of damages based upon percentage of fault, and equal access to health care providers for both the plaintiff and defense. (BT-2/94) (Retained 2006) (Retained BT 07-16)

380 Medical Education

380.02 University of Minnesota Health Sciences Program

The MMA supports a strong health sciences program at the University of Minnesota and opposes any actions leading to the deterioration of the program. (BT-7/87) (Retained 2004) (Retained BT 07-17)

380.082 Physician Training in Violence Prevention/Intervention

The MMA supports the education of medical students and physicians in family violence prevention and intervention. (HD-R101-1998) (Retained as edited 2008) (Retained BT 07-18)

380.088 Minnesota Board Of Medical Practice Support For Clinical Skills Assessment Exam

The MMA urges the Minnesota Board of Medical Practice to rescind its support of an additional medical student clinical competency examination as these already occur in LCME-accredited medical schools (including Mayo, University of Minnesota). In addition, the MMA reaffirms its support of the AMA's decision not to support this examination. (BT-3/03)

380.0893 Primary Care Physician Workforce Recommendations

The Minnesota Medical Association adopts the following recommendations from the MMA Primary Care Physician Workforce Expansion Advisory Task Force:
1. The MMA will work with health systems, hospitals, large practices and the state's medical schools to examine ways to increase the number of available clinical training sites in Minnesota, and examine ways to remove barriers that exist in allowing medical students to have more meaningful experiences.

2. The MMA will address the high cost of medical school and the resulting medical school debt by supporting efforts that target loan forgiveness and loan repayment programs specifically to primary care, and that restores funding to levels equal to or greater than those of 2008.

3. The MMA will support efforts to sustain beyond 2014 the ACA-required Medicaid payment bump for primary care, which increases primary care Medicaid rates to Medicare levels for 2013-2014.

4. The MMA will further examine the feasibility of seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) that would provide for state management of GME distribution in Minnesota. For example, the waiver could link GME funding to Minnesota's primary care physician workforce needs and set up a distribution mechanism.

5. The MMA will promote the creation by the state legislature of a state medical education council that includes a representative from each of the state's medical schools, representatives from teaching hospitals and clinical training sites, and other relevant stakeholders. The council would serve the purpose of providing analysis and policy guidance on how Minnesota can meet its physician workforce objectives.

6. The MMA will advocate that the 2011 Budget Control Act cuts to funding for Medicare-supported graduate medical education (GME) be restored and maintained at levels prior to the sequestration, which took effect in April 2013.

7. The MMA should take a leadership role in advocating for an adequate number of residency slots, adequate number of faculty and adjunct faculty support, and the required resources to increase the number of primary care residency slots.

8. The MMA acknowledges the role that income plays in specialty choice and believes that primary care physician capacity could be improved if this disparity was addressed.

(BT-05/14)

380.1 Informing Retiring Physicians Regarding CME Requirements

The MMA requests that the Board of Medical Practice inform, annually, each physician of the necessity of fulfilling CME requirements in order to maintain licensure, whether or not in active practice. (HD-R12-1982) (Retained 2004) (Retained 09-22)

380.2 Public Sector Medical Reimbursement Education Program

The MMA approves working in conjunction with its component medical societies and appropriate state and federal agencies to develop an education plan for physicians and/or their clinic managers to enhance understanding and to facilitate patient utilization of local, state, and federal health care programs such as TEFRA, SSI, MCHA, MinnesotaCare, EPSDT, Medicaid, Medicare, GAMC, etc. (HD-R9-1993) (Retained 2004)

380.22 Regulation of CME Subject Matter

The Minnesota Medical Association reiterates its current policy opposing any legislation or government regulation that defines the subject matter or content of continuing medical education required for physician relicensure in Minnesota. (HD-R10-1994)(Retained 2006)

380.275 Employer Compensation to Physicians for Time to Acquire CME

The Minnesota Medical Association supports the concept that all physicians be allowed adequate time and payment to acquire required continuing medical education (CME). (HD-R101-2000) (Retained 2010) (Retained as edited BT 08-20)

380.276 Resolution Regarding Discontinuing the Secure Examination as Part of The ABMS MOC Program

The Minnesota Medical Association supports discontinuing the requirement for a secure examination as part of their Maintenance of Certification program. (HD-R205-2011) (Retained as edited BT 08-21)

380.277 Maintenance of Certiciation (MOC)

The MMA, consistent with AMA policy, does not support the use of maintenance of certification (MOC), as it is currently structured, as a mandatory requirement for licensure, credentialing, credentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

(BT 11/17)

380.38 Student Loan Deferment

The MMA supports deferment programs for government-sponsored guaranteed student loans which would delay repayment of such loans by medical students until one year after the completion of a residency program. (HD-R34-1994) (Retain as edited BT 01-15)

380.43 Disease-Specific Research Initiatives

The Minnesota Medical Association supports increased funding to provide a stable base for medical education and research.

The MMA supports unrestricted funding of research, rather than directing funding to disease-specific research initiatives that have not been subject to scientific peer review.

The MMA shall work with the Minnesota Department of Health and the Medical Education Research Advisory Committee to create a state policy to use scientific peer review for any legislative decision to fund research initiatives. (HD-R208-2000) (Retained 2010) (Retained BT 08-20)

380.44 Discourage University of Minnesota Medical School Tuition Increases

The Minnesota Medical Association supports adequate state funding for medical schools to avoid inordinate tuition increases, and reminding state legislators and the public of the public interest in the quality of medical education and the training of students who will be the future physicians of Minnesota. (HD-R204-2002) (Retained as edited BT 09-22)

390 Medical Records

390.03 Timely Completion of Medical Records

The MMA believes that incomplete medical records not affecting quality of care should not be the basis, in any hospital, clinic, or other health care arrangement, for filing a report against a physician with the Board of Medical Practice or the National Practitioner Data Bank. (HD-R27-1990)

390.04 Sales Tax on Medical Records

The MMA supports a repeal of the current requirement that physicians charge and collect state sales tax on the provision of medical records and reports to requesting parties. (HD-R18-1991) (Retained 2004) (Retained as edited BT 08-21)

390.08 Amending the Access to Health Care Records Statute

The MMA will continue to support legislative efforts to allow medical and scientific researchers to review medical information for research without obtaining a patient's written general authorization, provided reasonable safeguards have been taken to ensure the validity and importance of the research project and that patient confidentiality is protected. (HD-R45-1996) (Retained 2006) (Retained BT 07-16)

390.09 Minor Consent Law

The MMA supports Minnesota Statute Sections 144.341-347 regarding parents' access to the medical records of their unemancipated minor children. (HD-R401-1998) (Retained 2008)

390.12 Medical Record Access

The Minnesota Medical Association reaffirms its support of state law that the medical record shall be made available promptly to the health care facility of the patient's choice. (HD-R101-2002) (Retained as edited BT 09-22)

390.13 Patient Consent To Release Medical Records

The Minnesota Medical Association will notify and educate its members regarding the provisions of Minnesota Statutes Sec. 144.335, subdivision 3(a) requiring patient consent to release medical records to an insurer, health plan, HMO or third party administrator. The MMA supports as policy and will advocate for inclusion in health plan contracts the following language in the AMA/MMA Model Contract Section 6.1:

Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians consistent with the dictates of medical ethics. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Medical Services Entity's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or the Enrollee's legal representative) and present to Medical Services Entity an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to accomplish the sole purpose of such release, which the parties agree is to determine whether care was properly and efficiently rendered. (BT-5/03)

390.14 Enforce Minnesota Law Requiring Patient Consents For Medical Records Releases

The Minnesota Medical Association affirms existing MMA policy 390.13, Patient Consent to Release Medical Records, which states:

390.13 Patient Consent to Release Medical Records

The Minnesota Medical Association will notify and educate its members regarding the provisions of Minnesota Statutes Sec. 144.335, subdivision 3(a), requiring patient consent to release medical records to an insurer, health plan, HMO, or third party administrator. The MMA supports as policy and will advocate for inclusion in health plan contracts the following language in the AMA/MMA Model Contract Section 6.1:

Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians consistent with the dictates of medical ethics. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Medical Services Entity's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or the Enrollee's legal representative) and present to Medical Services Entity an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to accomplish the sole purpose of such release, which the parties agree is to determine whether care was properly and efficiently rendered. (BT-5/03), and, that the MMA call on the Attorney General to enforce Minnesota Statutes Section 144.335. (HD-SR405-2003)

390.15 Reporting All Immunizations to the Minnesota Immunization Information Connection (MIIC)Antimicrobial Resistance (STAAR) Act

The Minnesota Medical Association encourages hospitals, nursing homes, clinics, private practice health care practitioners, retail pharmacies, and all individuals and organizations that provide immunizations for children and adults, to report all immunizations to the Minnesota Immunization Information Connection (MIIC) to allow for an accurate, up-to-date immunization record that is available for providers who require vaccine information. In addition, the MMA will work with the Minnesota Department of Health to take whatever legislative or regulatory steps necessary to allow for transfer of

existing historical immunization information from statewide schools to Minnesota Immunization Information Connection (MIIC), and rescinds policy 110.279 (Immunization Data). (HD-R404-2008) (Retained BT 07-18)

390.16 Patient Access to Clinical Notes

The MMA supports voluntary efforts to increase patient access to clinical notes and other medical record information as a means to improve patient engagement in care, health literacy, and communication between patients and physicians. BT 11-16 (BT 11-16)

390.17 Limited Exceptions to Patient Access to Clinical Notes

The MMA supports a patient's ability to promptly access their clinical notes and other medical record information as a means to improve patient engagement in care, health literacy, and communication between patients and physicians, while recognizing the right of adolescent minors to access confidential care consistent with state and federal law. The MMA will support efforts to ensure that patient access to certain clinical results that may have the potential to cause significant physical or mental distress can be briefly restricted until the discussion of te results with the healthcare provider occurs. (BT 03-22)

400 Mental Health/Mental Illness

400.05 Community-Based Mental Health Programs

The MMA endorses development of effective community-based treatment of acutely and chronically mentally ill persons. The MMA also endorses public and private financial support for such community-based programs only if treatment of mentally ill persons is adequately supervised by a psychiatrist or other physician if no psychiatrist is available. (BT-10/82) (Retained 2004) (Retained as edited BT 09-22)

400.06 Discrimination Against Mental Health Benefits in Insurance Programs

The MMA endorses voluntary disclosure by insurance companies and HMOs of information regarding payment for mental health services. (BT-2/84) (Retained 2007)

400.14 Utilization Review of Psychiatric and Chemical Dependency Cases

The MMA endorses the principle of prospective and concurrent review, encourages physicians to make appropriate review information available in a timely fashion, and discourages denial of payment based on retrospective utilization review in both the public and private sector. The MMA will educate its membership concerning contract problems with third party payers which hold the third party harmless from suit in the case of adverse patient outcome. The MMA recommends establishing community based standards for inpatient and outpatient psychiatric and chemical dependency treatment. (HD-R5-1987) (Retained 2004)

400.19 Mental Illness Services

That a separate negotiation take place with the Department of Human Services regarding reimbursement for outpatient medical management services. The MMA supports state policy changes that would consolidate administrative, clinical, and financial components of service delivery systems and establish a local mental health authority in each catchment area. The MMA also supports increased state funding of the Anoka Treatment Center in order to care for the committed mentally ill from the Twin Cities metropolitan area, and increased funding for the establishment of outpatient services as an alternative to hospitalization and for adequate facilities for hospitalized patients upon discharge. (HD-RPT48-1991) (Retained 2004) (Retained BT 08-21)

400.2 Funding for Mental Health Treatment Programs

The MMA encourages the state of Minnesota to appropriate adequate funding for mental health treatment programs that will serve as an alternative to nursing home care, and advocates individualized treatment planning for mental health patients. (HD-RPT48-1991) (Retained 2004) (Retained BT 08-21)

400.21 Non-Discriminatory Insurance Coverage for Mental Disorders

The MMA supports legislation for non-discriminatory insurance coverage for treatment of mental disorders by physicians in a like manner to any other medical condition. (HD-R29-1991) (Retained 2004) (Retained as edited 08-21)

400.22 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

The MMA supports the efforts of the National Alliance for the Mentally Ill, the American Psychiatric Association, and other organizations working toward parity in coverage and reimbursement for medical problems which are currently discriminated against as "mental health disorders." The MMA approves the pursuit, with appropriate state regulatory agencies and the legislature, a requirement that all third party payors provide coverage and reimbursement for the evaluation and medical treatment of learning disabilities and of Attention Deficit Hyperactivity Disorder (ADHD) at the same level as provided for other neurodevelopmental conditions. (HD-R12-1993) (Retained 2004)

400.23 MMA Opposes Health Plan Restrictions

The MMA supports efforts to end discriminatory restrictions on the treatment of mental illness and addictive disorders; supports removal of health plan restrictions to appropriate mental illness and addictive disorder treatment by primary care physicians; and seeks similar support from the AMA on those items which are not already AMA policy. (HD-R23&25-1994)(Retained 2006)

400.25 Mental Illness Awareness Week

The MMA supports the annual activities of Mental Illness Awareness Week, promoting awareness and educational efforts concerning mental disorders among the membership and their patients. (HD-R105-1998) (Retained 2008) (Retained BT 07-18)

400.26 Insurance Parity for Mental Health and Chemical Dependency

The MMA supports national and state parity bills to ensure standard health care coverage for mental health and chemical dependency. (HD-R212-1998) (Retained as edited BT 07-18)

400.27 Appropriate Evaluation and Treatment of Patients with Mental Health Conditions

The MMA urges managed care health plans and other third-party insurance providers to pay a reasonable sum for the preparation of additional prior authorization requests they require after the initial submission of a plan for the treatment of patients with mental health conditions. (HD-R310-1999) (Retained as edited 2009) (Retained 07-19)

400.35 Consolidation Of Oversight Of Health Plan Contracts

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society will develop legislation during the 2004 session to consolidate oversight of health plan contracts within one state agency. (HD-R409-2003)

400.36 Creation Of An Oversight Position In The Department Of Health That Specifically Addresses Psychiatric Disorders In The General Population

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society develop legislation during the 2004 session creating an oversight position in the Minnesota Department of Health that specifically addresses psychiatric disorders in the general population. Activities would include:

1. Epidemiological studies of psychiatric disorders;

2. Coordination of mental health identification and treatment data;

3. Dissemination by the Health Department of a newsletter outlining the best practices for treatment of these disorders to primary care physicians (as is now done for infectious diseases);

4. Promotion of mental health screening activities by primary care professionals and public health nurses;

5. Promotion of the public health mental health model;

6. Working with professional societies, medical schools, primary care residency programs, and continuing education programs to promote mental health education to primary care physicians;

7. Encouragement through state grants, policy changes, etc., of improved coordination and shared care arrangements between psychiatrists and primary care physicians;

8. Working with professional societies and advocacy groups to clarify best practices for medical necessity treatment criteria;

9. Aiding in oversight of health plan contractual agreements for accessible mental health services; and

10. Providing outcome analysis of clinical and cost-offset outcomes of these activities. (HD-R410-2003)

400.37 Psychiatric Access Data Compilation, Management, And Health Plan Contract Enforcement By State Departments

The Minnesota Medical Association in collaboration with the Minnesota Psychiatric Society develop legislation during the 2004 legislative session that requires appropriate state agencies (such as the departments of Commerce, Human Services, and Health) to:

1 Monitor access to inpatient and outpatient psychiatric services in Minnesota;

2 Monitor health plan network coverage of psychiatric services to ensure that geographic and timely access are provided in accordance with Minnesota Statute 62D.124 (geographic accessibility) and Minnesota Rule 4685.1010;

3 Require health plans to publish their mental health medical necessity criteria for access to inpatient and outpatient services. The agencies will review the criteria to ensure that they are in compliance with standards of care as defined by provider groups including the Minnesota Medical Association and the Minnesota Psychiatric Society (Minnesota Rules re: Health care programs, 9505.0175 subp. 25);

4 Collect data regarding geographic and timely access to inpatient and outpatient psychiatric services, including frequency of patients diverted to another city or state beyond 30 miles or 30 minutes from their primary place of residence due to capacity constraints;

5 Following a six-month period of data collection, if there is significant evidence that psychiatric access is not meeting state guidelines, the state departments of Health, Human Services, and Commerce will take steps to vigorously enforce the contracts in order to ensure that health plans and insurance entities aggressively enlarge their networks and facilitate mental health care and reimbursement for care that is delivered by psychiatrists, psychiatric clinical nurse specialists, and primary care clinicians. This would include ending the administrative roadblocks that have delayed and disrupted the delivery of timely mental health care to Minnesotans up to this point. The legislature should require health plans to show how they are successfully improving access to psychiatric and primary care clinicians, according to their respective levels of expertise. If these steps are not followed within a reasonable timeline, the state departments will address these contract violations with all available methods, including financial penalties and consideration of contract probation or cancellation;

6 Produce an annual report to the legislature and to the citizens of Minnesota with aggregate data collected; and

7 Provide the legislature with recommendations as appropriate regarding the need for increased access to psychiatric treatment in Minnesota. (HD-R411-2003)

400.39 Medical, Surgical And Psychiatric Service Integration And Reimbursement

The Minnesota Medical Association will advocate for health care policies that ensure access to and reimbursement for integrated medical, surgical and psychiatric care regardless of the clinical setting, including the clinical and administrative management of all psychiatric services as a part of general medical care, and general medical care as part of psychiatric care. (HD-R306-2005) (Retained BT 07-16)

400.41 Mental Health Access and Insurance

The MMA reaffirms existing MMA policy regarding psychiatric and mental health care, specifically parity, usual and customary fees, mental health carve-outs, network and HMO barriers or restrictions to patient referrals, and patient access to mental health services. (HD-R402-2007) (Retained as edited BT 07-17)

400.42 Promoting Psychiatric Care

The MMA opposes the discrimination and the societal stigma associated with psychiatric care. (HD-R405-2007) (Retained as edited BT 07-17)

400.43 Psychiatric Bed/ER Diversion Task Force

The MMA Board of Trustees adopts the following strategic goals for reforming the mental health system: reduce psychiatric bed shortage by 200 beds per year, for the next three years, to include transitional beds, (e.g. crisis center), acute care psychiatric beds, and complex (med-psych) beds, and pre-designed regional distribution to ensure equal access across the region; reimbursement of Mental Health care and Substance Abuse Disorders treatment through medical benefits instead of behavioral health benefits; with the following success metrics: less than 6 hour wait time for admit from ER to a psychiatric or complex intervention (med-psych) unit; 95% of patients should be admitted within 6 hours; admission location within 20 miles (metro) to 60 miles (rural); wait time for commitment for Anoka Regional Treatment Center and other state operated facilities 2 weeks or less by January 2009 and 1 week or less by January 2010; and measurement: MDH funded outcome measurement of success metrics with annual report to the legislature, MMA, and medical community. In addition, the MMA will work on implementing strategies to accomplish the above goals in the next 12-18 months. (BT 03/08)

400.47 Serious Mental Illness and Support for the "MN 10 by 10 Initiative"

The Minnesota Medical Association will support the MN 10 by 10 Initiative through posting a link on the MMA's website and encouraging ongoing education in all medical settings regarding this and similar efforts to close the life span gap between those with serious mental illness and those in the general population. (HD-R404-2010) (Retained BT 08-20)

400.5 Corporate Foster Care Moratorium

The Minnesota Medical Association will work in cooperation with other stakeholders to examine the impact and, as appropriate, address the consequences of the 2009 moratorium on the growth of adult

and child corporate foster care licenses on the access and availability of community-based outpatient services for vulnerable populations. (The MMA Board of Trustees decided to pursue no additional action. BT-01-15) (HD-R206-2013)

400.51 Conversion Therapy

The MMA should draft, advocate, and endorse legislation that broadly: (1) prohibits licensed mental health and medical professionals from providing, referring, or billing medical assistance for conversion therapy in Minnesota; and (2) sanctions offending licensed mental health and medical professionals, requiring disciplinary action determined by a state licensing board or other agency. (BT 11-18)

410 Health Disparities and Health Equity

410.02 Racial and Ethnic Disparities in Health Care

The MMA opposes racially and culturally based disparities in health care in Minnesota and support initiatives to alleviate these disparities in Minnesota. (HD-R39-1996) (Retained 2006) (Retained as edited BT 07-16)

410.03 Reimbursement For Language Interpreter Services

The Minnesota Medical Association actively supports efforts to require health plans to pay for language interpreter services. (HD-R305-2005) (Retained BT 07-16)

410.04 National Standards for Culturally and Linguistically Appropriate Services

The MMA supports the Culturally and Linguistically Appropriate Standards (CLAS) released by the U.S. Department of Health and Human Services Office of Minority Health as part of ongoing efforts to help reduce health disparities. (BT 11/07) (Retained as edited BT 07-17)

410.05 Reducing Racial and Ethnic Health Disparities

Raising Physician Knowledge/Awareness of Racial and Ethnic Health Disparities

1. The Minnesota Medical Association will raise physician knowledge and awareness of racial

and ethnic health disparities by providing education to physicians, residents and medical

students on topics related to race and racism, including structural/instituti

onal racism,

implicit bias, and the role of the social determinants of health and their historical and unequal

distribution.

Providing Resources to Assist Physicians and their Practices in Addressing Racial and Ethnic

Health Disparities

2. The Minnesota Medical Association will connect physicians with available practical tips, tools, and resources to assist them in reducing racial and ethnic health disparities in their practices.

Tips, tools, and resource will focus on the following topics:

a. Overcoming racial bias.

b. Cultural humility training.

c. How to make a clinic more welcoming to racially and ethnically diverse populations.

d. Using interpreters.

e. Enhancing physician-patient communication.

f. How to screen a patient for socioeconomic issues.

g. Value of medical and support staff from underrepresented racial and ethnic minority groups.

Policy Statements/Advocacy

3. The Minnesota Medical Association recognizes that factors such as health care financing, non-diverse health care workforce, living wage, housing, and public transportation have had a negative effect on the quality of and access to health care experienced by racial and ethnic minorities. The Minnesota Medical Association further recognizes that racial and ethnic health disparities are also a consequence of the structural and institutional racism that exists in hospitals and health care systems in Minnesota.

4. The Minnesota Medical Association supports initiatives that will lead to increased funding for those social services that are essential to a patient's health and help them overcome the health inequities that they face (i.e., housing, transportation, food security).

5. The Minnesota Medical Association will support efforts to incorporate information on health disparities, health equity, and the social determinants of health into the undergraduate and graduate medical education curricula of the University of Minnesota Medical School and Mayo Medical School.

6. The Minnesota Medical Association supports an increase in the number of underrepresented minorities in health care fields.

7. The Minnesota Medical Association's Board of Trustees will assess MMA policy and advocacy recommendations through a health equity lens, as a way of maintaining a focus on reducing health disparities. (BT 09-16)

410.06 Deferred Action for Childhood Arrivals and H-1B Visas

The MMA opposes deportation of undocumented medical students, residents, fellows, and practicing physicians who came to the United States as children due to the actions of their parents and have or are eligible for Deferred Action for Childhood Arrivals (DACA) status ("dreamers").

The MMA supports the J-1 and H-1B visa programs that support graduate medical education training for international medical graduates and that further provide access to physician care for thousands of people in rural and underserved communities. The MMA delegation to the AMA will submit a resolution to the AMA urging the Trump Administration to immediately reinstate "premium processing" of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities.

(BT 04-17)

410.07 Advancing Gender Equity

The MMA endorses the AMA's "Principles for Advancing Gender Equity in Medicine." The MMA:

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. (BT 11-19)

410.08 Race-Based Medicine

The MMA recognizes that race is a social construct and is distinct from ethnicity. The MMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice. The MMA recommends using the experience of racism and social determinants of health when describing risk factors for disease. Finally, the MMA will bring a resolution to the AMA House of Delegates asking the AMA to adopt the same. (BT 03-20)

410.09 Racism and Policing

The MMA acknowledges that racism is a public health crisis – a crisis rooted in the institutional, structural, and systemic barriers that continue to affect Black, Indigenous, and other people of color within our communities. The MMA calls on policymakers and our health care community to work to address these barriers, and to do what is needed to eliminate the health inequities that disproportionately affect Black, Indigenous, and other people of color.

The MMA acknowledges that police brutality and police violence are products of structural racism. The MMA calls on policymakers and our health care community to (1) recognize the detrimental effects that racism and violence have on the mental, physical and economic health of Black, Indigenous, and other people of color, particularly members of our community who are Black and Indigenous; (2) advocate for racial justice and criminal justice reform; and (3) put in place systems to address the adverse health outcomes that are occurring as a result of police brutality and negative police interactions. To support these efforts, the MMA will:

a) advocate for the creation of an ICD-10 code for experiencing racism, a code that will provide physicians with the tools necessary to address racism within the clinical encounter, and capture the data needed to provide more effective patient care;

b) advocate for a change to the standard death certificate to include a check box that would categorize deaths in criminal justice custody and would create a new statistical grouping with explanations of the range of causes within the spectrum of criminal justice custody;

c) advocate for research to be conducted that examines the public health consequences of negative police interactions:

d) advocate for law enforcement to be trained on implicit bias and structural racism;

e) develop a toolkit/set of best practices for practicing physicians to assist them in having conversations with their patients about racism and the trauma that has resulted from negative police interactions;

f) urge medical schools and residency programs in Minnesota to include education in their curriculums about (1) implicit bias and structural racism; (2) how to identify and confront racism and police brutality; and (3) past incidents and examples of how the medical profession has (mis)treated Black, Indigenous, and o ther people of color, and how this has led to a mistrust of medical professions; and

g) urge clinics, hospitals and other healthcare systems and providers to review and reconsider their policies and their relationships with law enforcement that may increase harm to patients and our communities. (BT 11-21)

410.10 MMA Barriers to Workforce Diversification in Physician Education, Training and Licensure Task Force - Recommendations

Barrier #1: Lack of Exposure and Preparation Options

1. The Minnesota Medical Association will conduct an inventory of current gateway programs within Minnesota that are available for students from backgrounds underrepresented in medicine and explore ways to disseminate the information to primary and secondary schools throughout Minnesota.

2. The Minnesota Medical Association will explore the creation of a medical careers program to help facilitate exposure to careers in medicine for elementary, middle, and high school students in schools

with a high proportion of students who are historically underrepresented in medicine (e.g., components could include presentations, events, etc.).

3. The Minnesota Medical Association will explore potential ways to collaborate with The Ladder, a program designed to help children and young adults in North Minneapolis and St. Paul explore and learn about careers in the healthcare industry.

4. To help facilitate the development of a more diverse physician workforce in Minnesota, the Minnesota Medical Association will work to expand its MMA Mentorship Program (1) to include shadowing as an option; (2) to include other pre-med programs in Minnesota who are looking for mentorship and shadowing opportunities for their students; and (3) to include information on effective medical school admissions interview techniques.

Barrier #2: Financial Barriers to Medical Training

1. To address the financial barriers faced by students from backgrounds underrepresented in medicine, the Minnesota Medical Association will explore ways to help offset the non-tuition costs associated with pursuing a career in medicine (e.g., MCAT (Medical College Admission Test) prep courses and MCAT exam costs; Step prep courses and Step exam costs; application costs; interview costs; etc.)

2. The Minnesota Medical Association will encourage medical schools and residency programs in Minnesota to explore ways to reduce the non-tuition financial barriers associated with medical school and residency for medical students, residents and fellows who come from backgrounds underrepresented in medicine (e.g., utilizing alumni networks, offering grants and scholarships, etc.)

3. The Minnesota Medical Association will urge the University of Minnesota Medical School to explore the inclusion of Step 1 and Step 2 exam costs in medical school tuition, thereby allowing this as an educational student loan expense, as is currently the practice at the Mayo Clinic Alix School of Medicine.

Barrier #3: Historic Bias and Systemic Racism in Medicine

1. The Minnesota Medical Association will encourage medical schools and residency programs in Minnesota to use the Association of American Medical College's (AAMC) holistic review and its accompanying core principles when assessing applicants. According to the AAMC, holistic review refers to "mission-aligned admissions or selection processes that take into consideration applicants' experiences, attributes, and academic metrics as well as the value an applicant would contribute to learning, practice, and teaching. Holistic review allows admissions committees to consider the "whole" applicant, rather than disproportionately focusing on any one factor."

2. The Minnesota Medical Association will encourage medical schools and residency programs in Minnesota to have their admissions committee and interview teams represent diverse backgrounds to strive to reflect the cultural and racial diversity of the population.

3. The Minnesota Medical Association will urge the Mayo Clinic Alix School of Medicine and the University of Minnesota Medical School to continue to offer virtual interviews as an option in the medical school application process. Virtual interviews provide students with an equitable interview option, as there are students from backgrounds underrepresented in medicine who may have travel and related costs serve as a barrier to pursuing a career in medicine.

4. To foster a culture of diversity, equity and inclusion, the Minnesota Medical Association will continue to offer training on anti-racism, implicit bias, and microaggressions to physicians and physicians-

intraining. The Minnesota Medical Association will ensure that medical school and residency program leadership are made aware of Minnesota Medical Association resources, so that they may offer them to their medical students, residents, fellows, faculty, and staff.

5. In an effort to change the culture of medicine at all levels, including within the licensure, employment and disciplinary processes, the Minnesota Medical Association will encourage all physicians, including those involved in health professional credentialing and regulation, to avail themselves of the implicit bias and anti-racism training resources developed by the Minnesota Medical Association.

6. The Minnesota Medical Association urges its Medical Student Section (MSS) and its Resident and Fellow Section (RFS) to consider potential roles they can play in addressing concerns raised by medical students, residents, and fellows about feelings of isolation and a lack of community within their medical schools and residency programs.

7. In response to concerns expressed by medical students, residents and fellows, the Minnesota Medical Association will advise medical schools and residency programs in Minnesota that the mechanisms available for reporting an incident of discrimination, mistreatment, bias, or harassment require adequate follow through and/or support options in order to be considered effective. (BT 09-22)

420 MMA Administration/Membership

420 On-Line Access to Physician Regulations

The Minnesota Medical Association will develop a resource on the MMA's web site that provides links to the most commonly used federal and state regulations relevant to the practice of medicine. (HD-R402-2004)

420.03 Committee Appointment Process

The MMA approves the revision of the committee appointment process to change the terms of member appointments to two years (with the exception of the Committee on Accreditation and CME); that the terms be staggered to maintain continuity; an that a maximum of three terms (six years total) be established. This maximum number of years does not include appointments to fill an unexpired term. (BT-3/93) (Retained 2004)

420.04 Committee Year

The MMA approves the committee year to be the calendar year. (BT-3/93) (Retained 2004)

420.05 Gender Neutrality Policy

The MMA adopts the following policy on gender neutrality:

1. The MMA adopts a policy of gender-neutral language, to be incorporated into its bylaws, policies, procedures, and publications, during the normal process of printing and updating/reprinting documents;

2. The term "chairman" no longer will be used to designate the head of a committee and that the term "chair" or "chairperson" be used instead; and

The MMA encourages component medical societies and state chapters of national specialty societies to review their bylaws and policies and eliminate gender-based language where it exists. (BT-5/93) (Retained 2004)

420.11 Investment in Tobacco

Existing MMA policy not to invest in tobacco company stocks and not to accept contributions, financial or otherwise, from tobacco companies is reaffirmed.

The MMA will encourage all MMA members and their practice groups to consider not investing in tobacco company stock and to consider not displaying magazines which contain tobacco advertising in patient waiting areas.

(HD-R109-1997) (Retained as edited BT 07-17)

420.35 AMA Federation Unity Project

The MMA reaffirms its continuing recognition of the contributions made by county and multi-county medical societies as an integral part of organized medicine and will advocate for continuing involvement of county and multi-county societies in the American Medical Association's ongoing efforts to improve the effectiveness of organized medicine. (HD-R100-2000) (Retained 2010) (Retained BT 08-20)

420.41 Aesculapius As A Symbol Of Organized Medicine

The Minnesota Medical Association recognizes the staff of Aesculapius (with a single entwined serpent), and oppose the caduceus, as a symbol of organized medicine in Minnesota. The MMA will work to educate the community, including the media and health care institutions, about choice and use of medical symbols. (HD-R103-2002) (Retained BT 09-22)

420.43 Secondhand Smoke

The Minnesota Medical Association and its constituent societies will choose facilities for their meetings, conferences, and conventions based on the facility's smoking policy (including its restaurant and bar policies) as an equal criterion to the facility's size, service, location, cost, and other similar factors, and that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA asking that a similar policy be adopted by the AMA to encourage national medical specialty societies,

other state and county medical societies, and other health care organizations to adopt such a policy. (HD-R105-2003)

420.44 Ten-Year Sunset Evaluation Of Policy

The Minnesota Medical Association will establish a mechanism to evaluate all policies ten years after their adoption for current relevance and contradiction or superseding by later House action, at no time changing the will of the organization without full deliberation of the House through its usual procedures, and, the MMA establish a task force to evaluate all policies adopted prior to 1994 for current relevance and later contradiction or supervening, and that this task force report to the 2004 House of Delegates any recommended action with the recommendation that this report procedure be done through a special reference committee of the 2004 House established for this purpose. (HD-R106-2003)

420.45 Bylaws Committee And Committee Membership Selection

The Minnesota Medical Association responding to recommendation of the Executive Committee will

1. Dissolve the Committee on Committees By-Laws and Membership and transfer the by-laws responsibilities to the MMA Executive Committee, and

2. The "Committee Appointment Process" memorandum be adopted and used starting with appointments that are effect 2005. (EC-12/2003)

420.49 Sunset Evaluation MMA Policy

The Minnesota Medical Association (MMA) will create a compendium of archived MMA policies that will contain MMA policies that are no longer relevant but can be consulted for historical or informational reasons. The archived policy compendium will include the recommended archive policies. (HD-R108-2004) (Retained BT 01-15)

420.5 On-Line Access to Physician Regulations

The Minnesota Medical Association will develop a resource on the MMA's web site that provides links to the most commonly used federal and state regulations relevant to the practice of medicine. (HD-R402-2004)

420.89 Dissolution of the Park Region Medical Society

The Park Region Medical Society will be dissolved, and the former Park Region Medical Society members will continue membership in the Minnesota Medical Association, consistent with MMA bylaws. (HD-R100-2013)

420.9 Dissolution of the East Central Minnesota Medical Society

The East Central Minnesota Medical Society will be dissolved, and the former East Central Minnesota Medical Society members will continue membership in the Minnesota Medical Association, consistent with MMA bylaws. (HD-R101-2013)

420.91 Merging of the Component Medical Societies in the Southwest Trustee District

The Mid-Minnesota, Camp Release, Lyon-Lincoln, Southwester, Blue Earth County, Blue Earth Valley Medical Societies, and Brown, if it chooses, will merge. (HD-R102-2013)

420.92 Dissolution of the Mower County Medical Society

The Mower County Medical Society will be dissolved, and any future Mower County Medical Society members assume at-large membership in the Minnesota Medical Association consistent with MMA bylaws. (HD-R103-2013)

420.93 Sunset Policy Review

The three "questionable" policies identified during the 2013 sunset policy review process will be subject to further review by Minnesota Medical Association staff and leadership and recommended action on them will be brought to a future meeting of the MMA House of Delegates. The MMA compendium of archived MMA policies, which contains MMA policies that are no longer relevant but can be consulted for historical or informational reasons, will include the recommended "archive" policies (27). The MMA reaffirms support for the recommended "retain" policies (6), and approves and reaffirms support for the recommended "retain as edited" policies (16). (HD-R108-2013)

420.94 Committee Sunshine Rules

The Minnesota Medical Association's regular and ad hoc committee or task force meetings will remain open to all members. All committee meeting schedules, agendas and minutes will be available as soon as possible to the membership. Final actions and reports will be available to the membership as well. The only open meeting exceptions will be those involving staff personnel issues. Finally, the MMA will continue to explore additional options for member engagement in committee and task force activities. (HD-R111-2013)

420.95 Dissolution of Headwaters and Red River Valley medical societies, and creation of Heart of the Lakes Region Medical Society.

The Board of Trustees approves shifting members inMahnomen, Clearwater and Hubbard

counties from their current CMS (Headwaters and Red River Medical Socieites) to the Clay Becker Medial Society. Furthermore, the new society will be called the Heart of the Lakes Region Medical Society. (BT 07-15)

430 Motor Vehicle Safety (See also, Driving While Intoxicated/Driving While Impaired)

430.04 Repeal of the Seat Belt "Gag Rule"

The MMA supports efforts to repeal the Minnesota seat belt "gag rule" which disallows the introduction of evidence of seat belt use in lawsuits. (BT-1/90) (Retained 2004) (Retained BT 08-20)

430.05 Motor Vehicle and Bicycle Safety

The MMA supports legislation specifying: that the nonuse of vehicle restraints is a primary offense punishable by a $100 fine; that the nonuse of helmets for motorcycle, snowmobile and all-terrain-vehicles is a misdemeanor punishable by a $25 fine; and that the use of bicycle helmets be required for all minors in the state of Minnesota. (BT-12/94) (BT-12/94) (Retained as Edited 2006)

430.06 Speed Limit

The MMA recognizes the relationship between driving speed and severity of injury in accidents, and urges policy makers to consider this impact prior to the adoption of any changes in state speed limits. (HD-R56-1995) (Retained 2005) (Retained BT 07-16)

430.12 Proper Vehicle Lighting

The Minnesota Medical Association supports requiring all motorists to use headlights or daytime running lights when driving motor vehicles in Minnesota. (HD-R303-2002) (Reaffirmed: HD-R408-2008) (Retained as edited BT 09-22)

430.13 Road Rage

The Minnesota Medical Association supports the collection of data on driver behaviors and highway infrastructure issues that most often lead to angry or violent responses, and the use of the data to implement public education programs to improve drivers' awareness of offensive driving behaviors to thereby reduce road rage incidents. (HD-R309-2002) (Retained as edited BT 09-22)

430.14 Cell Phone Use Prohibited/Illegal While Driving a Vehicle

The Minnesota Medical Association will request that the Minnesota State Legislature pass a law forbidding the use of cell phones, handheld or otherwise, while driving a vehicle, but allowing use while parked and out of traffic. (BT-11/2004) (Retained BT 01-15)

430.15 Children in Cars

The Minnesota Medical Association supports legislative and educational efforts to protect young children from being injured or killed when left alone in a motor vehicle. (BT-07/2004) (Retained BT 01-15)

440 Nursing Homes/Long-term Care (See also, Elderly Persons, Ethics)

440.01 Medical Directors in Skilled Nursing Facilities

The MMA supports the continued requirement of a physician medical director in every skilled nursing facility. (HD-R29-1982) (Retained 2004) (Retained BT 09-22)

440.02 Food Requirements in Nursing Homes

The MMA believes that food requirements in nursing homes conform with currently recognized nutrition standards for weight, sex and activity. (HD-R15-1983) (Retained 2004)

440.07 Nursing Home Policies Regarding Cardiopulmonary Resuscitation

The MMA adopts the following:

1. Advocates the development of nursing home policies and procedures that promote the proper use of cardiopulmonary resuscitation.

2. Supports nursing home cardiopulmonary resuscitation policies that are drafted in accordance with the Federal Patient Self Determination Act, the Minnesota Nursing Home Residents' Bill of Rights, and the Minnesota Living Will Law (formerly the Adult Health Care Decisions Act.)

3. Advocates nursing home cardiopulmonary resuscitation policies that specifically state that cardiopulmonary resuscitation not be provided by nursing staff or other personnel in the presence of a written physician order to withhold cardiopulmonary resuscitation.

4. Advocates nursing home cardiopulmonary resuscitation policies that require informed consent from the resident to withhold cardiopulmonary resuscitation; or, in the event that CPR can be predicted to be of no benefit, that the policy will require fully informed disclosure to withhold CPR.

5. Advocates that some criteria for the definition of "no benefit" of cardiopulmonary resuscitation be delineated in nursing home cardiopulmonary resuscitation policies.

6. Advocates that nursing home cardiopulmonary resuscitation policies include provisions to communicate "No CPR" or "DNR" orders to nursing home personnel and emergency providers.

7. Discourages the use of nursing home cardiopulmonary resuscitation blanket policies mandatorily providing or withholding cardiopulmonary resuscitation to all residents.

8. Advocates nursing home cardiopulmonary resuscitation policies drafted with state law, that require the presence of an individual trained in cardiopulmonary resuscitation 24 hours a day in the facility.

9. Advocates nursing home cardiopulmonary resuscitation policies that require periodic review of cardiopulmonary resuscitation orders and the clinical policies that govern their use. (HD-R35-1992) (Retained 2004)

440.08 Nursing Home Individualized Treatment Planning Regarding CPR

The MMA approves the following:

1. Nursing home residents or their surrogates be made aware of the probability of successful cardiopulmonary resuscitation and that this prediction be based on scientific, valid, published studies of patients with similar conditions.

2. If CPR is to be withheld, informed consent should be obtained from nursing home residents, or, if CPR is predicted to be of no benefit, the decision to withhold CPR should be fully disclosed to the patient.

3. Regardless of what a resident's decision will be regarding cardiopulmonary resuscitation, the resident will continue to get medical and nursing care appropriate to his or her individual needs.

4. Physicians initiate discussions about cardiopulmonary resuscitation with all residents within a reasonable period of time of admission to nursing home facilities and clearly document these discussions and their indications for instituting or not instituting cardiopulmonary resuscitation in the event of cardiac arrest. (HD-R36-1992) (Retained 2004)

440.09 The Role of the Nursing Home Medical Director

The MMA adopts the following:

1. Nursing home medical directors be involved in developing institutional policies regarding the provision of cardiopulmonary resuscitation to residents in their facilities.

2. Nursing home medical directors be responsible for providing information and valid studies to their facilities regarding the probability of successful resuscitation following cardiopulmonary resuscitation in various populations.

3. Nursing home medical directors review deaths in their facilities to insure that the appropriate medical care is provided to the dying patient.

4. Nursing home medical director should be available if necessary to interpret clinical policies as they apply to an individual resident.

5. The nursing home medical director should serve as an integral member of the ethics committee if such a committee exists at his or her nursing home facility. (HD-R34-1992) (Retained 2004)

440.1 Determination of Death in the Nursing Home

The MMA approves the following:

1. The determination of death can be made in certain situations without a trial of cardiopulmonary resuscitation.

2. Cardiopulmonary resuscitation should not be instituted on nursing home residents with "No CPR" or "DNR" orders written by the physician in the medical record.

3. When the determination of death is made using reliable criteria by the nursing personnel, cardiopulmonary resuscitation need not be instituted.

4. The criteria for the determination of death in the nursing home require that no signs of life be present, including no pulse, no respiration, no pupillary response, no neurologic activity, and the resident was not seen to collapse, have a sudden cardiac arrest, or other immediately reversible cause such as choking or airway obstruction.

5. A policy to withhold cardiopulmonary resuscitation at the time of death is in no way intended to encourage nursing personnel to abandon dying patients, or to avoid witnessing their cardiac arrest.

6. Nursing personnel be trained to recognize nursing home residents in distress and seek help in their management.

7. Nursing personnel be trained to recognize and treat choking and airway problems and the initiation and performance of cardiopulmonary resuscitation.

8. A nursing home policy that allows nurses the opportunity to determine death at the bedside without initiating cardiopulmonary resuscitation in no way releases the physician of his/her obligation for advanced treatment planning, including a discussion of cardiopulmonary resuscitation with nursing home residents or their surrogates. (HD-R38-1992) (Retained 2004)

440.11 Timely Nursing Home Transfers

The MMA will identify barriers to timely transfer of patients from hospitals to nursing homes and will work with physicians, nursing homes, and others, as appropriate, to decrease barriers to nursing home transfers. (HD-R17-1994) (Retained 2006)

440.13 Nursing Home Medical Directors

The name of the MMA Nursing Home Medical Directors Section shall be change to the Long Term Care Physicians Section. Representation in the Long Term Care Physicians Section shall be offered to any physician serving in long-term care who is a member of the MMA. (BT-11/95) (Retained 2007)

440.18 Physician Responsibility For Long-Term Care Patients

The Minnesota Medical Association supports the principle that prior to transferring a patient from a hospital to a long-term care facility an accepting physician is identified; communication between the hospital physician and accepting physician occurs; and adequate information regarding the hospitalization accompanies the patient at the time of patient transfer. (HD-R203-2002) (Retained BT 09-22)

440.19 Nursing Home Therapeutic Management Appeal Process

The Minnesota Medical Association will work with the Minnesota Departments of Health and Human Services to devise a simple review process in which there is physician-to-physician discussion of disallowed medications or treatments so as to determine a reasonable and appropriate plan. (HD-R401-2003)

450 Organ Donation & Transplantation

450.01 Sale of Organs

The MMA supports legislation which prohibits the sale of human organs. (BT-3/84) (Retained 2004) (Retained BT 01-15)

450.07 Anatomical Gifts: Informed Consent

The Minnesota Medical Association (MMA) supports legislation to change the informed consent forms and procedures under the Uniform Anatomical Gift Act to advise donors or donors' legal representatives about the following potential uses of donated tissue and to expressly require consent for each: 1) use of the tissue by a for-profit tissue processor or distributor; 2) use of skin for purposes of cosmetic or reconstructive surgery; and, 3) use of tissue for transplants outside of the United States." (BT-3/07) (Retained BT 07-17)

450.08 Non-transplantable Tissue

The Minnesota Medical Association (MMA) supports legislation that implements a uniform informed consent process for anatomical gifting. Furthermore, the MMA supports legislation aimed at tracking the uses and disposal of non-transplantable tissue. (BT-3/07)

460 Peer Review

460.01 Peer Review

The MMA believes that peer review performed by physicians is necessary to achieve a high level of quality health services and can be useful to understand the relationship between cost of services and quality of services. (HD-RPT101-1982) (Retained as edited 2007) (Retained BT 09-22)

460.02 Protection of Peer Review Records in Litigation

The MMA believes the AMA should work for Congressional clarification so that state peer review confidentiality laws are binding on actions for damages or other relief in both state and federal courts. The AMA should also seek Congressional action affirming that participants in peer review activity are exempt from antitrust scrutiny. (BT-11/85) (Retained 2004)

460.15 Quality Improvement Organizations (QIOs) in peer case review

The MMA will draft a letter of support for retaining local case review and the need for clearly defined boundaries between organizations that review and provide QI assistance and those organizations that disclose and regulate. The letter will be sent to State and Federal health care policymakers and appropriate leaders at CMS. (Retain as edited BT 01-15)

470 Practice of Medicine

470 "Best Practices Guidelines" are not Clinical Care Guidelines and Evidence Based Medicine

The Minnesota Medical Association (MMA) defines "evidence-based medicine" as individualized patient care based on controlled, clinical care trials; systemic medical care literature reviews; meta-analyses of peer-reviewed research and reference to reputable disease guidelines. The MMA recognizes that implementation of evidence-based medicine guidelines must reflect the need to individualize care that may require modification of the guidelines based on peer and collegial professional consultation, patients' health status, illness severity, response to past treatments, demographic variations (HD-R206-2004) (Retain as edited BT 01-15)

470.04 Professional Corporation Act

The MMA opposes any amendments to the Professional Corporation Act that would further erode the corporate practice of medicine doctrine, or reduce physician autonomy. (BT-2/95) (Reaffirmed: BT-03/08)

470.13 Preparticipation Athletic Examinations

The MMA defines preparticipation in athletic physical examinations solely as the practice of medicine as defined by the Medical Practice Act and to require that the physical examination conform to published, acceptable standards. (HD-R409-1998) (Retained as edited BT 07-18)

470.15 State Action Immunity Doctrine

The MMA supports further exploration of the concept of using the state action doctrine to provide antitrust protection and allow independent physicians and clinics to jointly negotiate contracts with health plans and other payers. (BT-9/99) (Retained 2009) (Retained 07-19)

470.17 Patient Safety

The Minnesota Medical Association will continue to work with local and national efforts to reduce medical errors and improve patient safety.

The MMA shall grant particular attention to the following issues:

1. The need for and methods to identify root causes of errors;

2. Data privacy and confidentiality;

3. Mechanisms to reduce the culture of blame in the health care industry;

4. Mechanisms for the equitable distribution of associated costs. (HD-R408-2000) (Retained 2010) (Retained BT 08-20)

470.23 Improving Interest In Primary Care Among Graduating Medical Students

The Minnesota Medical Association supports efforts to identify and implement effective methods to reverse the trend of U.S. medical students away from the primary care professions. (HD-R102-2002) (Retained as edited BT 09-22)

470.28 Patient Safety Task Force

The MMA adopts the following recommendations of the MMA Patient Safety Task Force:

Recommendation 1: Sunset The Task Force In Its Present Form

As of May 1, 2003, sunset the MMA Patient Safety Task Force in its current form (an ad hoc task force that meets every other month). Retain the option of reconvening the Task Force to discuss specific issues that may arise from time to time.

Recommendation 2: MMA Continue to Monitor Patient Safety Issues Addressed in Various Forums Within Minnesota

MMA staff will continue to monitor and represent MMA physician membership on the health care groups that currently address patient safety issues, such as MAPS, MHA, BMP, JCAHO, Minnesota legislature, and other forums. Staff will use information and pending actions as a guide to alert the leadership and membership of potential opportunities and directions for improving patient safety.

Recommendation 3: Develop an MMA List Serve

The MMA will create an electronic list serve hosted by MMA to facilitate discussions and information sharing about patient safety issues. The list serve would be comprised of MMA Patient Safety Task Force members as well as other MMA physicians who state an interest in participating in discussions and sharing learning about patient safety.

Recommendation 4: Develop a Dedicated Patient Safety Page on The MMA Website

Update the patient safety/medical error area on the MMA website to facilitate a dedicated page that is titled "Patient Safety". This page will direct members to up-to-date information on patient safety issues, articles specific to patient safety, and links to other information patient safety web sites. Also develop a list serve that accommodates discussions on patient safety issues.

Recommendation 5: Highlight Patient Safety Issues in MMA Publications

The MMA should publish a series of articles spotlighting individual physicians or groups of physicians who have made changes in their practice to improve patient safety as well as disseminate evidence-based patient safety initiatives to physicians. The focus of the articles would be: 1.) Real-life, practical examples of areas in which physicians are making changes in their practice that have a positive impact on safety. 2.) Detail initiatives for patient safety that are developed and approved by other forums/entities/organizations. 3.) Facilitate debates regarding patient safety initiatives and proposals to allow for a wider discussion of their impact to physicians and patients. The articles could be a series featured in Minnesota Medicine or a website-based series. Consider regularly publishing a column on patient safety in every Minnesota Medicine with member physicians as guest columnists.

Recommendation 6: Continue to Monitor and Encourage Education of Patient Safety Responsibilities At The Graduate Medical Education Level Within The State

MMA should continue to develop a relationship with the University of Minnesota and Mayo medical schools to advocate for inclusion of patient safety education for medical students. MMA should monitor the impact of the resident work hour restrictions (effective July 1, 2003) in association with the teaching institutions, residency sponsors and hospitals, and assist where necessary to educate physicians about the impact of extended work hours on patient safety.

Recommendation 7: The Task Force Recommends that Resolution 210 (referred to the Board of Trustees in 2002) Not Be Adopted.

This recommendation is being made because the resolution emphasized standardizing computerized and other systems in hospitals including the abbreviations that would be found acceptable for use in acute care settings. Although standardized abbreviations are an important issue, this issue is being moved forward by the Safest in America group as well as the issue of safe surgery site identification. Therefore, the MMA does not need to address an issue that is already being addressed by another patient safety group. (BT-5/03)

470.29 Model Employment Agreements

The Minnesota Medical Association will develop a Minnesota-specific model employment agreement based upon the AMA's model employment agreement, the MMA will disseminate the model employment agreement to all MMA members and encourage all Minnesota organizations that employ physicians to use the model agreement. (HD-SR404-2003)

470.36 "Never" Event Payment

The Minnesota Medical Association adopts as policy opposition to HealthPartners' decision to withhold hospital payments for "never" events. (BT-11/2004)

470.37 Chronic Care

The Minnesota Medical Association (MMA) approves the following recommendations as presented by the Chronic Care Task Force:

Practice

• The MMA should explore the feasibility of creating a consortium of medical practices willing to provide disease management (paid for by health plans or employers) to patients with chronic, complex illnesses.

• The MMA should conduct a campaign to generate physician and payer enthusiasm for better chronic care delivery.

• The MMA should work to ensure that every patient with a chronic or complex illness has a medical home where much of that patient's care is provided and from which other care is arranged and coordinated. For patients with chronic conditions, the medical home generally will be a primary care practice, although there are certain conditions where a specialty practice may be better suited to provide the medical home.

• The MMA should endorse evidence-based guidelines (those developed by ICSI and others) that pertain to chronic illness.

Public & Private Sector Advocacy

• The MMA should submit a request to the AMA CPT Editorial Panel for the development of CPT codes for group visit, inter-visit (including consultant codes), and other adaptive codes to support chronic care delivery models.

• The MMA should work with Minnesota public and private payers to obtain payment for non-visit care, such as telephone consultation and online E&M services (CPT code, 0074T).

• The MMA should encourage the AMA to lobby Congress and the Centers for Medicare and Medicaid Services (CMS) to allow payment for the broader array of services that are critical to ideal chronic care delivery. Advocacy is vital to expand Medicare coverage from payment for individual face-to-face services, to payment for effective chronic care delivery such as group, internet, and inter-visit services.

• The MMA should encourage Minnesota public and private payers to increase payment for clinical systems that utilize the Chronic Care Model.

• The MMA should work with Minnesota health plans/payers and employers/purchasers to encourage changes in the way in which disease management is conducted by exploring opportunities to pay physician practices directly for disease management services.

• The MMA should work with Minnesota public and private payers to obtain payment for specialized services delivered to patients with qualifying conditions that are provided by non-physician professionals (e.g., pharmacists, social workers) who are actively linked with physicians in co-managing patients' care.

• The MMA should explore opportunities to support the expansion of the electronic transfer of information across sites of care, including the use of public and private capital investments to stimulate the adoption of electronic medical record systems.

• The MMA should explore ways to improve communication between the providers of community-based services and the primary medical care team. (Note – this item is most immediately applicable to

Medicaid and Elderly Waiver beneficiaries participating in the new statewide Minnesota Senior Health Options program and the new Minnesota Senior Care program [integrating PMAP and Elderly Waiver] in which health plans and care systems have extensive covered benefits and special flexibility in clinical delivery.)

• The MMA should seek opportunities to work with the Department of Human Services to conduct pilot projects of case and disease management consistent with these recommendations for public program enrollees with complex, chronic illnesses.

Education

• The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve knowledge of and skills in team management of chronic conditions and the working relationships among team members.

• The MMA should provide information to Minnesota physicians about local and state community resources that are available to assist patients with chronic conditions. This information should be community-specific.

• The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve physician practices' ability to teach patients self-management skills.

• The MMA should develop or sponsor opportunities for Minnesota physicians and patients to learn how patients and physicians can set priorities and focus resources for patients with chronic conditions.

• The MMA should encourage Minnesota medical schools and teaching programs to improve curricula on and give students and trainees increased opportunities for delivery of care to patients with chronic, complex illnesses.

• The MMA should help physicians increase their awareness of opportunities for grants or demonstration projects in treating patients with chronic conditions.

Research

• To help overcome the lack of evidence regarding treatment for the "old-old" and for patients with multiple chronic conditions, the MMA should encourage research that will identify a stronger evidence base for the treatment of chronic conditions among those over 75 and those with several chronic conditions.

• The MMA should encourage public and private payers to coordinate data collection and pursue research that improves the quality of data available to those wishing to use clinical care data to determine best practices in patients with chronic and complex illnesses.

(1) Note that this is a Category III CPT Code: 0074T- Online evaluation & management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient.

Online Medical Evaluation

An online medical evaluation is a type of Evaluation and Management (E/M) service provided by a physician or qualified health care professional, to a patient using Internet resources, in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the

patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service should not be reported for patient contacts (egg, telephone calls) considered to be pre-service or post-service work for other E&M or non E&M services. A reportable service would encompass the sum of communication (e.g., related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s). (BT-01/2005) (Retained BT 07-16)

470.38 Multiple Chronic Diseases

The Minnesota Medical Association (MMA) supports the development of quality indicators and best practice guidelines when caring for patients with multiple chronic diseases when guidelines are in conflict. The MMA also supports improved payment to physicians who care for patients with multiple chronic medical diseases. (HD-R215-2006) (Retained as edited BT 07-16)

470.39 Improving Communication

The Minnesota Medical Association (MMA) supports improved communication among the physicians and health care professionals providing care for a patient, and encourage timely communication between a hospitalized patient's established outpatient treating clinician(s) and the inpatient and outpatient clinician(s) providing care, especially at the time of admission and at discharge, in order to speed the accurate diagnostic assessment of the patient, reduce errors, arrange timely follow up, and improve awareness of treatment recommendations. (HD-R216-2006) (Retained as edited BT 07-16)

470.4 Promotion of Primary and Medical Care Continuity

The Minnesota Medical Association (MMA) 1)reaffirms our historic opposition to "carved-out" or diagnosis-specific care, whether external or internal to the third-party payer, which is not done at the specific request of the primary physician; 2) oppose disease management by vendors, internal or external to third-party payers based on inferences of diagnosis or medication without prior consultation with the primary or treating physician; 3) oppose inference of presumptive diagnosis from medication records by third-party payers, triggering inaccurate and unwelcome calls to patients already treated and educated by their physicians and their staff; 4) advocate that such services, if offered, be required to bear full medical liability for the advice and management thus rendered; 5) encourage health plans to direct their focus and resources dedicated to disease management programs into physician-provided care; 6) reaffirm our support for thorough assessments and quality care guidelines, including those drawn from evidence-based medicine, which are appropriate to the patient. The MMA supports the statement that care should be: 1) given by the providers who know the patient's condition directly; 2) coordinated with the primary physician or referral specialist; 3) integrated at the point-of-care, including diagnosis and medication, rather than through inference by "benefit managers" or PBM vendors; and 4) accessible, patient-centered, diagnosis-specific and cost-efficient. (HD-R301-2006) (Retained as edited BT 07-16)

470.42 Estimated Payments for Health Savings Accounts (HSAs)

The Minnesota Medical Association (MMA) supports the principle that physicians should have the ability, if desired, to bill patients with high deductible health plans for an estimated payment for services delivered before the claim for services is adjudicated. (BT-3/07)

470.43 Tools for Informed Patient Choice and Shared Decision Making

The Minnesota Medical Association supports physicians in Minnesota using shared decision-making tools that will assist the medical community of Minnesota in moving towards patient-centered care. (HD-R203-2008) (Retained as edited BT 07-18)

470.44 Physician Payment for Adverse Events

The following principles can be used to guide physicians, payers, and policy makers in implementing billing and payment procedures for care related to adverse health care events: 1. The intent of the Minnesota Adverse Health Care Event Reporting Law is to encourage reporting of adverse events so that the entire health care delivery system can learn from these experiences and develop effective interventions to prevent future events. Therefore, payment policy should not impede reporting of these events. 2. Physicians do not expect payment from patients or payers for care that directly contributed to a preventable adverse health care event. 3. Physicians who provide care for patients who have suffered an adverse event under the care of another physician, or in another health care facility, should be paid for the care they provide to mitigate the consequences of the initial event. 4. These billing recommendations apply only to the serious reportable adverse health care events as defined under Minnesota's Adverse Health Care Event Reporting Law. 5. These billing recommendations do not apply to events that occur in spite of the physician's or facility's care according to accepted guidelines of care. 6. These billing recommendations would not apply if a subsequent investigation determined that an adverse event was not preventable by the physician or hospital. 7. Any settlement or legal agreement reached in an action related to a specific event would supersede these billing recommendations. Recommendations for Billing of Physician Services Related to Serious Adverse Health Care Events: 1. Physicians should not bill for care that directly contributes to a preventable adverse health care event. 2. Physicians who provide care for patients who have suffered an adverse event under the care of another physician, or in another health care facility, should be paid for the care they provide to mitigate the consequences of the initial event. 3. The MMA will work with payers, policy makers, and the Minnesota Alliance for Patient Safety (MAPS) to facilitate implementation of payment policies that encourage reporting of serious adverse health care events. 4. The MMA will work with physicians, hospitals, the Minnesota Alliance for Patient Safety (MAPS), and other groups to identify and encourage implementation of strategies to prevent serious adverse health care events.The MMA will oppose payment policies that penalize physicians for events that could not have been prevented and for adverse outcomes that occur in spite of care delivered that is based on evidence and guidelines or is part of a best-practice protocol. (BT 07/09) (Retained 07-19)

470.47 Interstate Medical Licensure Compact

The Minnesota Medical Association endorses the proposed interstate licensure compact, and will act to pass legislation necessary for adoption of the compact. (BT 11-14)

470.48 Independent Practice Work Group Recommendations

1. That the MMA advocate for equitable reimbursement rates for independent practice; and work to develop transparency in the reimbursed rates of health care services offered to all physicians and clinics.

2. That MMA continue to work on the administrative burdens that plague independent practice. Burdens such as: quality measurement, pre-visit information, prior authorization for medications, electronic medical record use and others that take time away from patient care and create financial and time burdens for independent practices.

3. That MMA work to provide independent practice a stronger voice on internal MMA discussions; and on external medical decision making. Having this voice will ensure that the opinions of independent practice are heard in the Minnesota medical environment.

4. That MMA offer regular education, networking and support meetings for independent practice physicians.

o This meeting would provide education and give physicians the opportunity to

discuss practice-related issues and learn from each other.

o AMA speakers may be available to provide educational content.

o AMA also offers practice management educational modules that could be helpful to independent practice.

5. That MMA conduct more frequent research with independent physicians to better understand their issues and concerns.

6. That MMA create a discussion group or "community" of independent physicians to encourage communication within this group. (BT 07-15) (Reaffirmed BT 11-19)

480 Pregnancy (See also, Abortion, Birth Control/Contraception)

480.03 Mandatory Implementation of Reduced Hospital Stays

The MMA supports the development of positive discharge criteria that recognize and address family needs for obstetric patients and their offspring that are based on objective, recognized standards as opposed to reliance on mandated lengths of stay. (HD-R21-1992) (Retained BT 09-22)

480.05 Post-Partum Length of Stay

The MMA believes that the appropriate post-partum length of stay and any required follow-up care, including nursing home visits, should be determined by the physician and the patient and not by an arbitrary time interval.

(HD-SR31-1995) (Retained 2005) (Retained as edited BT 07-16)

480.08 MDH Folic Acid Guidelines

The MMA endorses and supports Minnesota's Folic Acid Guidelines for the Prevention of Neural Tube Defects (NTDs), developed by the Minnesota Department of Health. (BT 11/07) (Retained BT 07-17)

480.1 Birth Centers

The Minnesota Medical Association, in the interest of patient safety, supports the certification of midwives by the American College of Nurse Midwives or the American Midwifery Certification Board. The MMA further recognizes the importance of the certification of freestanding birth centers by the Accreditation Association for Ambulatory Health Care, the Joint Commission, or the Commission for the Accreditation of Birth Centers. (HD-R400-2010) (Retained BT 08-20)

480.11 Gestational Carriers

The Minnesota Medical Association adopts the following policy on gestational carriers: The utilization of a gestational carrier is an ethical medical procedure when practiced consistent with professional guidelines. The decision to participate in a gestational carrier arrangement is a decision between a physician and patients, both the initiating parents and the gestational carrier. The legal rights and responsibilities of all parties to a gestational carrier arrangement should be clearly defined. (BT 03/15)

480.12 Improving outcomes for those with maternal substance use disorder

The MMA will support appropriate efforts to improve outcomes for maternal substance use disorder that include the following: (1) promoting public health efforts to improve outcomes with maternal substance use disorder; (2) oppose punitive legislation against pregnant women with substance use disorder; (3) support implementation of laws to ensure access to appropriate care for pregnant women with substance use disorder and babies born with NAS.; (4) protect against mandatory prenatal reporting to local welfare agencies; and (5) maintain protections for women undergoing medically assisted treatment (MAT). (BT 11-18)

480.13 Maternal Morbidity and Mortality

The MMA will support efforts to reduce rising rates of severe maternal morbidity and mortality in Minnesota, especially those relatedto the social determinants of health and racial/ethnic disparities. Specifically, the MMA will support federal and state funding for (1) Minnesota's maternal mortality review committee and (2) Minnesota's perinatal quality care collaborative. (BT 05-19)

490 Prescription Drugs/Prescribing Authority

490.03 MMA Policy on Generic Drug Substitution

The MMA opposes any change in the anti-substitution law to permit brand interchange except for those drug products that can be certified to be bio-equivalent or therapeutically-equivalent as well as generically-equivalent. (BT-10/80) (Retained 2004) (Retained BT 07-16) (Retained BT 08-20)

490.08 Therapeutic Substitution of Drugs by Pharmacists

The MMA vigorously opposes therapeutic substitution of drugs by pharmacists, and opposes efforts to authorize pharmacists to independently dispense therapeutic substitutes to a physician's prescription. (HD-R25-1984) (Retained 2007)

490.14 The PDR and Physician Prescribing

The MMA (1) believes that the Physicians' Desk Reference (PDR) is a set of manufacturers' guidelines and is not a standard for prescribing; and (2) affirms that drug manufacturers do not define the standard of medical practice, and (3) that a deviation from the manufacturers' recommendations should not be considered prima facie evidence of negligent prescribing. (HD-R12-1989) (Retained 2004) (Retained 07-19)

490.17 Off-Label Drug Reimbursement

The MMA believes that a physician may lawfully use an FDA approved drug product for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion. When the prescription of a drug represents safe and effective therapy, third party payers should consider that drug as reasonable and necessary medical care irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy. (HD-R42-1992) (Retained 2004) (Retained BT 09-22)

490.19 Volume Purchasing/Statewide Formulary

The MMA supports the increased use of volume purchasing, where appropriate, as a means to achieve the lowest cost possible for the consumer. The MMA does not support the establishment of a statewide drug formulary because of concern that it may adversely impact access to specific necessary drugs. The MMA supports the educational efforts for its physician membership in better use of less expensive alternatives. (BT-3/93) (Retained 2004)

490.24 Protect Prescriber from Fraudulent Use of DEA Number

The MMA supports state and federal legislation to outlaw the practice of requiring Drug Enforcement Agency (DEA) numbers for noncontrolled substance prescriptions and the sale or release of DEA number data to nongovernmental entities. Such legislation should also outlaw the use of DEA number data to track prescription histories of physicians for commercial use. (HD-R407-1997) (Retained as edited 2007) (Retained BT 07-17)

490.33 Payment for Out-of-Network Prescriptions

The Minnesota Medical Association will work with Minnesota health plans to provide coverage for pharmaceutical prescriptions that are compliant with plan formularies, when written by physicians who are otherwise eligible for health plan reimbursement according to the enrollee's health plan contract. (HD-R310-2000) (Retained 2010) (Retained BT 08-20)

490.37 Pharmaceutical Industry Issues

The Minnesota Medical Association adopts the report "Minnesota Medical Association Report on Pharmaceutical Issues," issued in 2001.

The Minnesota Medical Association ratifies the following recommendations regarding pharmaceutical issues:

1. The MMA encourages HMO's/insurers to disclose to physicians with whom they contract the rationale for choosing a formulary drug, whether a rebate of discount has been negotiated, and the actual cost of formulary drugs.

2. The MMA encourages pharmaceutical benefit management companies to inform HMO's/insurers with whom they contract about the actual cost of the drugs they obtain on behalf of HMO's/insurers.

3. The MMA encourages HMO's/insurers to develop and provide information to consumers about the true cost of pharmaceuticals and provide ways in which consumers can positively impact the rising cost of drugs.

4. The MMA supports HMO's/insurers offering a multiple-tiered pharmaceutical co-payment system to their enrollees.

5. The MMA urges HMO's/insurers to discontinue the use of physician financial incentives that could influence prescribing choices that may not be in the patients' best interest.

6. The MMA encourages HMO's/insurers to disclose to enrollees and physicians with whom they contract whether they have negotiated a rebate with a drug manufacturer or pharmaceutical benefit management company.

7. The MMA supports physicians' use of electronic, computerized devices, e.g., handheld aids/"palm pilots," as well as non-electronic tracking methods to help them recognize individual HMO/insurer formulary options and, where available, the cost benefit ratios of comparable medications available on formularies.

8. The MMA supports and encourages efforts to develop electronic prescribing technologies.

9. The MMA supports access to prescribing drug coverage for all Americans.

10. The MMA will provide physicians with information about the benefits and consequences of accepting drug samples from pharmaceutical manufacturer representatives.

11. The MMA will work with the Minnesota Department of Human Services and other appropriate organizations to develop and disseminate information about pharmaceutical patient assistance programs available in the state for the uninsured, underinsured, and indigent patients.

12. The MMA encourages physicians to disclose to patients whether they have negotiated a rebate with a pharmaceutical manufacturer.

13. The MMA supports and will participate in the development of educational materials for consumers on DTCA that physicians can provide to patients in their office settings to assist in balancing information provided to DTCA.

In addition the MMA will carry the following resolutions to the AMA Annual Meeting in 2001:

1. The MMA requests the AMA staff responsible for ongoing communications with PhRMA to forward the recommendations to PhRMA that were made by the MMA Pharmaceutical Issues Task Force that are designed to enhance and improve the Prescribing Drug Patient Assistance Programs. (Please see Appendix E for the specific list of recommendation).

2. The MMA delegation to the AMA will request the AMA to do the following:

a. Work with appropriate organizations to investigate the use of large group purchasing coalitions as a strategy for controlling escalating pharmaceutical costs for all segments of the population;

b. Develop and make available specific informational materials to increase physicians' awareness of drug programs that are available for the uninsured, underinsured, indigent patients;

c. Study the positive and negative affects associated with physicians dispensing drug samples and issue a report describing the impact of this practice on pharmaceutical costs and patient care;

d. Develop policy that specifically limits the gifts pharmaceutical manufactures can offer physicians;

e. Request that the FDA promulgate rules that prohibit pharmaceutical manufactures from engaging in prescription drug marketing strategies such as offering coupons or free drug samples directly to consumers;

f. Study the total affects of discount and rebate arrangements on the health care systems, including how these arrangements affect the drug costs of insured, underinsured, and Medicare beneficiaries;

g. Continue to monitor the relationships between PBMs and the pharmaceutical industry and strongly discourage any arrangements that result in potential conflicts of interest that could cause a negative impact on the cost or availability of essential drugs

h. Work with the Food and Drug Administration (FDA) to assure DTCA guidelines support the provision of patient information that is accurate, backed by scientific evidence, identifies potential side affects, and encourages patients to contract their physician for information about pharmaceuticals;

i. Continue to work with the FDA to investigate the impact of DTCA on the price of drugs and how DTCA impacts consumers' knowledge of drugs; and

Develop and disseminate printed materials to educate consumers about the risks, benefits, determents, and potentially misleading information provided in DTCA. (BT-3/01) (Retained BT 08-21)

490.4 Reimbursement for Processing Formulary Changes

The MMA supports the goal of physician reimbursement for time spent processing formulary changes. (HD-R211-2001) (Retained as edited BT 08-21)

490.45 Prescription Medication Refills

The Minnesota Medical Association advocates that pharmacy benefit management (PBM) companies allow refill intervals of at least 100 days, unless otherwise restricted by state or federal regulation. (HD-R206-2002) (Retained as edited BT 09-22)

490.46 Optometrists Prescribing

The MMA opposes the increased authority of optometrists in the prescribing and administering of oral drugs proposed in current legislation (HF373/SF418, introduced during the 2003 legislative session) and opposes both compromises recommended by the optometrists and ophthalmologists. (BT-3/03)

490.47 Physician-Specific Prescribing Data

The MMA supports current language in Minnesota House File 437, Omnibus Health and Human Services Bill, Article 2, page 119, line 21 (2003 legislative session) that would prohibit pharmaceutical manufacturers and wholesale drug distributors from purchasing physician-specific prescribing data. Should the above language in House File 437 not pass this session, the MMA will work with the Minnesota Pharmacists Association to reintroduce this language in the 2003-2004 legislative session. (EC-4/03)

490.48 National Uniform Pharmacy Refill Form

The Minnesota Medical Association delegation to the American Medical Association will submit a resolution to the AMA encouraging the AMA to collaborate with appropriate national organizations to develop a uniform refill format and process for prescription refills to be used throughout the United States. (EC-4/03)

490.49 Propose Printing Chemical Name And Strength On Each Pill

The Minnesota Medical Association adopt a policy that would support the creation of a code for legend and over-the-counter medications that would indicate compound and strength and be printed on each tablet and capsule, and that the MMA investigate the development of a system of copyrights on this coding system and, that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA endorsing Federal legislation to enact this policy. (HD-R204-2003)

490.5 Pharmaceutical Benefits Manager

The Minnesota Medical Association will

1. Opposes mandating the use of "fail first" and step therapies for pharmaceuticals based on acquisition costs rather than therapeutic efficacy;

2. Support Minnesota state government initiatives to join coalitions with other state governments to negotiate favorable pharmaceutical prices for products on the Minnesota Medical Assistance formulary;

3. Recommend that all Minnesota health plans and pharmaceutical benefits managers that utilize pharmacy and therapeutics committees, and state drug utilization boards, have a membership that consists of a majority of physicians who are primarily involved in the provision of patient care; and

4. Support compensation for physician time/work spent on pharmaceutical prior authorization procedures. (HD-SR208-2003)

490.51 Drug Importation Policy

The MMA endorses efforts that help to increase patient access to more affordable prescription drugs with attention to product integrity and safety. (BT-11/2003)

490.52 Drug Reimportation

The Minnesota Medical Association (MMA) supports state and federal efforts to safely reimport drugs into the United States as one possible interim step toward a more affordable system of prescription drugs. (HD-SR205-2004) (Retain as edited BT 01-15)

490.53 NASPER Prescription Services

The MMA supports a controlled substances electronic monitoring system in Minnesota (based on NASPER criteria and federal start-up funds) in order to aid physicians in providing care to their patients, and in recognition of the increasing rates of drug abuse, drug-seeking behavior, and the non-medical use of controlled substances. (BT-3/06) (Retained as edited BT 07-16)

490.57 Use of Prescription Information for Marketing Purposes

The MMA supports restricting the sale of prescribing data for the purpose of marketing pharmaceutical products. (BT 03/09) (Retained as edited BT 07-19)

490.58 Pharmacy Benefit Managers

The MMA supports the licensure of Pharmaceutical Benefit Managers (PBMs) that are engaged in prior authorization as utilization review organizations. In addition, the MMA will work to reduce the administrative burdens associated with prior authorization by convening health plans and other interested stakeholders in discussions aimed at developing a standardized process for prior authorization. The MMA will further explore the value of a single statewide formulary as means to reduce the complexity, burden, and delays in patient care associated with pharmaceutical prescribing. (BT 05-12) (Retained as edited BT 09-22)

490.59 Prohibiting Low-Cost Medication Prior Authorization

The Minnesota Medical Association supports prohibiting requirements for prior authorization for medications that are administered for costs less than $25.00. (HD-R207-2011) (Retained as edited BT 08-21)

490.62 Eliminate Duplication of Prescription Refills in the Automated Refill and Electronic Prescribing Systems

The Minnesota Medical Association recognizes the importance of prescription refills being carefully monitored in the pharmacy database so that duplication errors can be caught at the pharmacy level to avoid overprescribing of medications. (HD-R202-2012) (Retained as edited BT 09-22)

490.64 Minnesota Prescription Monitoring Program and Electronic Health Records

The Minnesota Medical Association will work to advance efforts to ease physicians' use of the Minnesota Prescription Monitoring Program as part of physician electronic health record workflow processes.Minnesota Prescription Monitoring Program and Electronic Health Records (HD-R207-2013)

490.65 Medical Cannabis

The Minnesota Medical Association adopts the following policy on medical cannabis:
(1) The Minnesota Medical Association calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

(2) The Minnesota Medical Association urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical and public health research and development of cannabinoid-based medicines, and alternate delivery methods.

(3) The Minnesota Medical Association believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

(4) Until such time as marijuana is approved for use by the Food and Drug Administration and is no longer classified in schedule I by the Drug Enforcement Administration, the Minnesota Medical Association cannot support legislation intended to involve physicians in certifying, authorizing, or otherwise directing persons in the area of medicinal marijuana outside of scientific clinical trials.

(BT-03/14)

490.66 Medical Cannabis Reporting to the Prescription Monitoring Program (PMP)

The MMA supports efforts to improve physician access to patients' medical cannabis use in order to improve care and treatment decisions. The MMA will work with the Minnesota Board of Pharmacy and the Minnesota Department of Health Office of Medical Cannabis to explore ways of incorporating medical cannabis dispensing information into the Minnesota Prescription Monitoring Program (PMP).

(BT 11-15)

490.67 Medical Cannabis and Intractable Pain

The MMA reiterates its call for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. The MMA further reiterates that until such time as marijuana is approved for use by the Food and Drug Administration and is no longer classified in Schedule I by the Drug Enforcement Administration, it cannot support legislation intended to involve physicians in certifying, authorizing, or otherwise directing persons in the area of medicinal marijuana outside of scientific clinical trials. The MMA will not, however, actively oppose expansion of Minnesota's medical cannabis program to include other qualifying conditions if such expansion is deemed scientifically justifiable by the Commissioner of Health, if such expansion is limited to carefully defined and targeted persons, and if such expansion allows for narrowly defined conditions for which physician certification is clear and objective. (BT 11-15)

490.68 Improving Use of the Prescription Monitoring Program (PMP)

The Prescription Monitoring Program (PMP) is an effective tool for physicians to use when confronted with patients for whom there are concerns about diversion, abuse and/or misuse of prescriptions for controlled substances. The MMA will support efforts to increase prescriber use of the PMP that are focused on education/awareness, best practice dissemination, improved functionality, integration with e-prescribing systems, and a requirement for PMP registration for relevant prescribers. Until there is greater experience with the impact and utility of the PMP's unsolicited reporting functionality, the MMA will continue to oppose mandates for PMP use. (BT 11-15)

490.69 Prescription Drug Importation for Personal Use

The MMA supports legislation that would allow for the personal purchase and importation of

prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity.

The MMA delegation to the AMA will submit a resolution to the AMA urging adoption

of AMA policy consistent with this position.

(BT 05-17)

500 Preventive Medicine

500.04 Primary Care Providers

The MMA approves lobbying appropriate regulatory and legislative agencies to assure that a patient's access to primary care services provided by a physician are not limited by the specialty or sub-specialty designation of the physician, but should be determined by the training and competence of the physician. (HD-R3-1993) (Retained 2004)

500.05 Direct Access to Preventive Health, Diagnostic & Treatment Services of Obstetricians/Gynecologists

The MMA supports the preservation of a woman's ability to directly access preventive health, diagnostic, and treatment services provided by obstetricians and gynecologists. (HD-R7-1995) (Retained 2005) (Retained BT 07-16)

500.07 Preventive Services Principles

The MMA endorses the following statement based on the United States Preventive Services Task Force principles:

Interventions that address patient, personal health practices are vitally important.

Physicians and patients should share decision-making.

Physicians should be selective in ordering tests and providing preventive services of unproven effectiveness.

Physicians should take every opportunity to deliver appropriate, effective preventive services, especially for persons with limited access to care.

For some health problems, community-level interventions may be more effective than clinical preventive services. (HD-23-1996) (Retained 2006) (Retained as edited BT 07-16)

500.09 The Role of Primary Care Medical Providers in Reducing Caries as Part of Well-Child Care

The Minnesota Medical Association encourages primary care medical providers to work toward preventing childhood caries by performing an oral examination, conducting a risk-assessment, offering anticipatory guidance about caries etiology and prevention, and applying fluoride varnish quarterly to the teeth of those children at high-risk. (HD-R201-2009) (Retained as edited 07-19)

510 Professional Liability/Professional Liability Insurance (See also, Litigation, Tort Reform)

510.03 Enterprise Liability

The MMA actively opposes enterprise liability as an option in Minnesota for controlling professional liability costs. The MMA supports AMA efforts to work with the federal government to accomplish the same end at the national level, and will continue to call for meaningful tort reform as exemplified by current MMA and AMA policy in the area of professional liability. The MMA supports tort reform similar to the MICRA reforms enacted in California. (HD-R17-1993) (Retained as edited 2007)

510.04 Malpractice Insurance Coverage

The MMA endorses the concept of malpractice insurance coverage or other proof of indemnification for all practicing health professionals. Further, we believe that this should be part of a comprehensive reform proposal based on MICRA-type reforms, including limits on non-economic damages, limits on attorney contingency fees based on a sliding scale proposal, apportionment of damages based upon

percentage of fault and equal access to health care providers for both the plaintiff and defense. (BT-2/94) (Retained 2006)

510.05 Liability for the Substitution of Physician Orders for Inpatients

The MMA will study the problem of changes in physician orders for inpatients and develop recommendations for requiring a timely notice to the treating physician prior to initiating alterations in medications, nursing orders, dressings, implantable surgical devices, or other physician directives and for establishing the liability for changing physician orders. (HD-R407-1999)

510.06 Legal Protection for the Ethical Duty to Disclose Adverse Events

The AMA Code of Medical Ethics Identifies a Duty to Disclose Adverse Events

The American Medical Association Code of Medical Ethics Opinion 8.6 states that physicians have a duty to actively disclose adverse events, including medical errors, to patients. This duty stems from the importance of trust and communication in the physician-patient relationship and corollary ethical duties, including the duty to:

•Help patients understand their health and the implications of any treatment or lack of treatment

•Encourage patients to raise questions or concerns about their health and treatment plans

•Be truthful and forthcoming in response to patient questions or concerns

•Refrain from withholding pertinent medical information from patients

A physician meets his or her ethical duty following an adverse event by explaining the nature of the harm or potential harm to the patient, providing enough information for the patient to make future medical care decisions, and expressing professional, compassionate concern toward the patient. A physician may fulfill his or her ethical duties without admitting fault, causation, or liability for an adverse event.

Fear of Legal Liability May Discourage Adequate Disclosure

Although existing ethical norms suggest that a physician should fully disclose all adverse events, including expressing compassionate concern where appropriate, physicians practice within a legal structure that may discourage adherence to these principles. Pervasive concern exists among Minnesota physicians that expressions of compassion or concern following an adverse event may be used in a malpractice action as an admission of fault, resulting in legal liability, restriction of practice, or reporting to the National Practitioner Data Bank. Due to this concern and the existing legal structure of medical malpractice actions, physicians are forced to weigh their ethical obligations against protection of their professional standing –a conflict that ultimately undermines the physician-patient relationship. To facilitate Minnesota physicians' pursuit of ethical imperatives and strengthen the physician-patient relationship, the MMA supports the passage of an open disclosure law in Minnesota. To protect the physician-patient relationship, the MMA supports exclusion from evidence, unless offered by the physician, any statement, affirmation, gesture, or conduct expressing apology, responsibility, liability, sympathy, compassion, or a general sense of benevolence made at any time to a patient, relative, friend, or representative of the patient regarding the outcome of the patient's medical care.

Educational and Engagement Opportunities

The MMA supports ongoing education to help physicians, trainees, and students understand their rights, obligations, and options for disclosing adverse events. The MMA will support efforts of the MMA Student Section and Resident and Fellows Section to engage with academic leadership to understand current educational offerings related to physician liability following adverse events and, if appropriate, engage with academic leadership to ensure that new physicians have the tools needed to navigate the complexities of their legal and ethical obligations. The MMA will likewise consider collaboration with facility and clinic administrators to ensure that physicians are able to pursue their ethical obligations and care for patients that suffer an adverse event without increasing exposure to legal liability. (BT 11-18)

520 Provider Contracting (See also, Ethics)

520.05 Exclusive Contracts

The MMA supports the following concepts regarding exclusive contracts: Subdivision 1. No provider or third party payor shall restrict any person's right to provide services or procedures to another provider or third party payor unless the person is an employee.

Subdivision 2. No provider or person providing goods or services to a provider shall enter into any contract or subcontract with any third party payor on terms that require the provider or person not to contract with any other third party payor.

Subdivision 3. Enforcement. The commissioner shall periodically review contracts among health care providing entities to determine compliance with this section. Any provider may submit a contract to the commissioner for review, if the provider believes this section has been violated. Any provision of a contract found to violate this section is null and void, and the commissioner may seek civil penalties in an amount not to exceed $25,000 for each such contract. (BT-2/94)

(BT-2/94) (Retained as Edited 2006)

520.14 Collective Bargaining

The MMA will consider developing and supporting legislation that permits the physicians of Minnesota to negotiate the terms and conditions of contracts with health plans. (BT-7/2001) (Retained BT 08-21)

520.15 Prohibiting Restrictive Covenants in Physician Contracts

The Minnesota Medical Association directs its American Medical Association Delegation to request that the AMA Council on Ethical and Judicial Affairs undertake an in-depth review of existing Code of Medical Ethics Opinion 9.02, which addresses the use of restrictive covenants in physician contracts. (BT 5/13)

530 Public Health & Safety (See also, Health Education)

530 Mercury in Foods as a Human Health Hazard

The Minnesota Medical Association (MMA) supports that the results of any mercury testing of fish, and advisories based upon them, be readily available where fish are sold, including labeling of packaged/canned fish. The MMA encourages physicians to educate their patients about the dangers of mercury toxicity from ingestion of food items, especially fish, and especially to advise pregnant women, parents, and children to review and revise fish consumption habits to maximize the nutritional benefits while avoiding fish higher in mercury and other contaminants.

Furthermore, the Minnesota Medical Association urges that food sources that contain significant levels of methyl mercury be excluded from federally funded programs such as the Women Infant and Children program and free school lunch programs for children. (BT-1/2005) (Retained as edited BT 07-16)

530.02 Pasteurized Milk

The MMA supports the pasteurization of all milk sold for human consumption. (BT-2/86) (Retained 2004) (Retained as edited BT 07-16)

530.03 Bovine Somatotropin (BST) Use in Dairy Cows

The MMA supports the current evidence that the use of BST in the production of milk poses no additional health threat to the public. (BT-1/91) (Retained 2004) (Retained as edited BT 08-21)

530.041 Food Irradiation

The MMA (1) endorses food irradiation as a safe and effective process (which does not cause the food to become radioactive) that increases the safety of food when applied according to governing regulations; (2) believes that the value of food irradiation is diminished unless it is incorporated into a comprehensive food safety program based on good manufacturing practices and proper food handling, processing, storage, and preparation techniques; and (3) encourages the American Medical Association to continue to work with the Food and Drug Administration (FDA) and the U.S. Department of Agriculture to continue the requirement that all irradiated fruits, vegetables, meats, and seafood carry the international logo that has become recognized as indicating that the food has been subjected to gamma irradiation. (HD-R311-1998) (Retained 2008) (Retained BT 07-18)

530.06 Prevention of Nuclear War

The MMA supports a worldwide non-proliferation of nuclear weapons and a reduction of nuclear arms as rapidly as possible in order to prevent nuclear war which would result in death, injury and disease on a scale which has no precedent in the history of human existence. (HD-SR5-1982) (Retained 2004) (Retained as edited BT 09-22)

530.105 Using 5-2-1-0 as A Guide to Discuss Healthy Weight with Pediatric Patients and Their Families

The Minnesota Medical Association supports and encourages Minnesota physicians to use 5-2-1-0 as a guide to discuss healthy weight at every well visit: 5 fruits and vegetables per day; 2 hours or less of screen time (no screen time for children under age 2); 1 hour per day of physical activity; and 0 sugary beverages (replace with water or milk/breast milk). (HD-R205-2012) (Retained as edited BT 09-22)

530.106 Mandatory Rabies Vaccination of Dogs

The Minnesota Medical Association will support efforts for the mandatory rabies vaccination of dogs in Minnesota. (BT 01-15)

530.107 Funding for the Diagnosis, Prevention, and Treatment of Chlamydia and other Sexually Transmitted Diseases

The Minnesota Medical Association supports sufficient and sustained funding for evidence -based diagnosis, prevention, and treatment of chlamydia and other sexually transmitted diseases. (BT 09-15)

530.108 Paid Sick Leave

The MMA encourages all employers to provide paid sick leave to enhance the health of the public. (BT 02-16)

530.109 Sexually Explicit Material

The MMA cautions that violent, sexist and dehumanizing sexually explicit material has the potential to distort perceptions of healthy relationships.

The MMA urges physicians and other health care providers to communicate with families on ways to protect children from viewing sexually explicit material.

The MMA further supports comprehensive sexuality education that is medically accurate, evidence-based, age-appropriate, and that addresses forms of sexual expression, healthy sexual and nonsexual relationships, gender identity and sexual orientation, recognizing and preventing sexual violence, the need for consent, and decision making.

(BT 07-17)

530.15 Prohibition on the Public Sale of Fireworks

The MMA supports prohibitions on the sale of fireworks, including those by mail order.

The MMA also supports efforts to educate physicians, parents, children, and community leaders about the dangers of fireworks. (HD-R54-1995) (Retained as edited 2007)

530.16 Sexual Assault Resource Service

The MMA endorses the activities of groups such as the Sexual Assault Resources Services, and supports the expansion of such groups throughout Minnesota. (HD-R53-1995) (Retained 2005) (Retained BT 07-16)

530.21 Investigation of Birth Defects and Anomalies in Frog Population

The MMA supports scientific efforts to investigate the cause of abnormalities in the Minnesota frog population and their possible relationship to human birth defects. (HD-R1-1996) (Retained 2006) (Retained as edited BT 07-16)

530.26 Preparedness for Biological, Nuclear, and Chemical Terrorism

The MMA supports the efforts of state government to plan an appropriate response to any act of biological, nuclear, or chemical terrorism. (HD-R312-1998) (Retained 2008) (Retained BT 07-18)

530.28 Sleep Disorders and Driving

The MMA supports the incorporation of questions regarding sleepiness and/or sleep patterns as part of both the U.S. Department of Transportation medical examination for commercial drivers, and the Minnesota school bus driver medical examination. (BT-5/99) (Retained 2009) (Retained BT 07-19)

530.32 Drivers Education Regarding Sleepiness

The MMA supports the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in the state of Minnesota. (HD-R315-1999) (Retained as edited 2009)

530.33 Sharps Disposal

The MMA shall encourage all health care providers and organizations who prescribe or dispense sharps to educate patients at the point of contact regarding proper sharps disposal techniques. (HD-R316-1999) (Retained as edited 2009) (Retained BT 07-19)

530.39 Osteoporosis and Densitometry

The Minnesota Medical Association establishes a policy recognizing osteoporosis as a major health problem in our state.

The MMA will pursue avenues to create awareness of osteoporosis and restrict clinical densitometry practice to appropriately trained physicians, thereby improving the level of care for these patients.

The MMA adopts AMA Policy H-425.981 as MMA policy:

The MMA:

1. Advocates for the use of bone densitometry as an important tool in assessing fracture risk and in the diagnosis of osteoporosis.

2. Advocates that a clinical evaluation accompany any bone mass measurement for the evaluation of fracture risk and osteoporosis.

3. Advocates for the continued participation of the patient's physician in the diagnosis, treatment, and prevention of osteoporosis.

4. Encourages private third-party payers to provide coverage for bone mass measurement technology and services for those individuals at high risk of osteoporosis. (HD-R206-2000) (Retained BT 08-20)

530.4 Obesity

The Minnesota Medical Association recognizes obesity as a major endemic health problem, by endorsing the following existing AMA policy on obesity:

H-150.953 Obesity as a Major Public Health Problem

Our AMA will: (1) urge physicians as well as managed care organizations and other third-party payors to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13' Reaffirmed: CSAPH Rep. 3, A-13Reaffirmation: A-19)

H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; and (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity. ; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17) (HD-R307-2000) (Retained as edited BT 08-20)

530.41 Tuberculosis Testing and Treatment

The Minnesota Medical Association supports health care coverage for the testing and complete treatment (e.g., diagnostic testing and treatment, professional services, directly observed therapy [DOT] manager services, pathfinder and interpreter services, etc.) of known tuberculosis cases, suspected tuberculosis cases, and for the evaluation of individuals involved in a tuberculosis contact investigation. (HD-R316-2000) (Retained 2010) (Retained as edited BT 08-20)

530.51 Repeal State Sales Tax on Topical Sunscreen

The MMA will support legislation to repeal the State Sales Tax on commercial sunscreens and sunblock, including cosmetics, that have a sun protection factor (SPF) of 15 or greater. (HD-R206-2001) (Retained BT 08-21)

530.55 Vaccine Availability and Reimbursement

The MMA supports State efforts to ensure the targeted availability of vaccines for priority patients as identified by the Minnesota Department of Health and the Centers for Disease Control. The MMA will work to ensure that clinics are adequately reimbursed for vaccines and their administration. (HD-R312-2001) (Retained as edited BT 08-21)

530.58 Healthy Beverage Choices in Public Schools

The Minnesota Medical Association supports efforts to ensure that all beverage vending machines in the state's public schools contain only healthy choices. (HD-R310-2002) (Retained as edited BT 09-22)

530.59 Guidelines And Regulations For Tattoos And Body Piercing

The Minnesota Medical Association urges the Minnesota Department of Health to protect the public health by publishing and disseminating standards for appropriate blood borne pathogen precautions and sterile practices to be used in tattoo and body piercing establishments. The MMA encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program. (BT-7/03)

530.61 Epidemic Of Obesity

The Minnesota Medical Association supports the Diabetes Care Program of the Minnesota Department of Health (MDH) in its efforts to prevent diabetes and obesity, including disparities in diabetes that affect minority groups, the MMA endorse the goals of the Minority Affairs Consortium of the American Medical Association to address discrepancies in obesity, dysmetabolic syndrome, and diabetes in minority populations. (HD-SR311-2003)

530.62 Health Plan Coverage For The Treatment Of Obesity

The Minnesota Medical Association will continue its ongoing dialogue with the Minnesota Council of Health Plans to strongly encourage full coverage for evidence-based obesity care in the State of Minnesota, including ancillary services (such as dietitians, exercise physiologists, and psychologists) and medication coverage under appropriate physician supervision. (HD-R313-2003)

530.64 Excise Tax On Sugared Beverages

(a) The MMA supports excise taxes on sugar-sweetened beverages (SSB) as a means to reduce sugar intake and its associated morbidities.

(b) The MMA stresses that new revenues from excises taxes on SSB should be directed to support community health efforts.

(c) The MMA stresses that jurisdictions developing excise taxes on SSB should do so in a manner that substantively engages low-income and BIPOC communities, as these communities have experienced targeted marketing by the sugary drinks industry and disproportionately experience the diet related chronic diseases related to sugary drink consumption. (BT-05/2004) (Retain as edited BT 01-15) (Retained as edited 04-21)

530.65 State Authority For Isolation And Quarantine

The MMA supports the concept of state authority for isolation and quarantine. BT-11/2003

530.67 Obesity Carve-Outs from State Plan Formularies

The Minnesota Medical Association will lobby for the removal of language in Minnesota Statutes 2003, Chapter 256B, Subd. 13d, Drug Formulary, which currently specifically excludes medications to treat obesity. The MMA will take the strong position that obesity is a treatable disease and carry this position to the Minnesota Legislature and the Minnesota Department of Human Services. (HD-R210-2004) (Retained BT 01-15)

530.69 Methamphetamine Manufacture & Distribution

The Minnesota Medical Association (MMA) supports effective methods, strategies and funding to eradicate use and production of methamphetamines, and supports penalties and other intervention strategies shown to be effective to rehabilitate persons convicted of manufacturing and distributing methamphetamines. (HD-R413-2004) (Retain as edited BT 01-15)

530.73 Health Professional Emergency Volunteers

The Minnesota Medical Association supports the voluntary registration of health personnel for public health emergencies as coordinated through the Minnesota Responds! program. (BT-07/2005) (Retained as edited BT 07-16)

530.75 Obesity as a Chronic Disease

The MMA endorses and promotes the following statement: Obesity is a chronic disease. The ideal model of care for obesity includes a dietician, nurse, physician, physical fitness professional, and, when appropriate, access to psychiatric care. When the ideal model of care is impossible to attain, creative approaches should be developed that may include community groups, schools, video consultations, physical education teachers, and social workers. The MMA supports the requirements for the WIC supplemental nutrition program for women, infants and children to eliminate fruit juice from the list of WIC-eligible foods and to add fruits and vegetables. (EC-12/05) (Retained as edited BT 07-16)

530.76 Influenza Vaccination

The Minnesota Medical Association, in an effort to increase the influenza vaccination rate among Minnesota health care workers, supports the long-standing (1981) CDC recommendation that all health care workers receive the influenza vaccination. (BT-5/06) (Retained BT 07-16)

530.8 Reducing Sexually Transmitted Infection and Unwanted Pregnancy

The MMA supports programs that attempt to change behavior to reduce sexually transmitted infection and unwanted pregnancy when such programs are based on scientific demonstration of efficacy. (HD-R309-2007) (Retained BT 07-17)

530.81 Drowsy Driving

The MMA supports the education of health care employers and their employees of the dangers and health consequences of driving while sleep deprived and encourage employers to distribute informational items on the dangers of drowsy driving and ways to promote alertness in the workplace, such as the National Highway Transportation Safety Administration's "Wake Up and Get Some Sleep Campaign," and supports health care employers in educating employees about the dangers of drowsy driving and support employers' consideration of these dangers when determining shift schedules. (HD-R313-2007) (Retained as edited BT 07-17)

530.82 Removal of Artificial Trans Fatty Acids

The MMA shall call upon all health care facilities in Minnesota to remove artificial trans fatty acids from food served on their premises by July 2008, promote public awareness of the hazards of trans fatty acids in the diet through MMA publications, and advocate along with other organizations for removal of artificial trans fatty acids from food served in hospitals and nursing homes by January 1, 2009, and that such removal be a matter of public record and reported to the Commissioner of Health. (HD-R301-2007)

530.83 Influenza Vaccination of Health Care Personnel

The MMA supports universal influenza vaccination of health care personnel in order to improve patient safety and quality of care. Health care personnel should receive the vaccine annually unless it is detrimental to an individual's personal health. A declination of the influenza vaccine should be documented. Further, the MMA encourages each health care facility to implement a tracking system to monitor annual influenza immunization rates of staff. (BT 11/07) (Retained BT 07-17)

530.85 Improving Health through Healthy Food Choices

The Minnesota Medical Association calls on health care professionals to serve as models and as educators by participating in and advocating for healthier food choices, promoting better patient and public health, and supporting the long-term social, economic, and environmental well-being of communities in Minnesota. (HD-R407-2008) (Retained BT 07-18)

530.86 Public Health Committee - Expedited Partner Therapy

The MMA supports Expedited Partner Therapy as a means to reduce the incidence of chlamydia and gonorrhea in Minnesota. (BT 11/08) (Retained as edited BT 07-18)

530.89 Obesity Carve-Out Language

The Minnesota Medical Association reaffirms its opposition to the language in Minnesota Statutes 2003, Section 256B.0625, Subdivision 13d, line 3 that prohibits public program coverage for "drugs used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes." (HD-R206-2009) (Retained BT 07-19)

530.91 Vitamin D Deficiency: A Widespread Public Health Problem In Need of A Statewide Awareness Program

The Minnesota Medical Association shall make it a priority to educate all Minnesota healthcare providers and third-party payers with the best information available on reducing the high prevalence of vitamin D deficiency, and will encourage the Minnesota Department of Health to increase efforts to inform Minnesotans about the issue of vitamin D deficiency. (HD-R302-2009) (Retained BT 07-19)

530.92 Nutrional Labeling

To address obesity rates, the MMA supports efforts aimed at promoting informed food consumption and improving nutritional options. Such efforts include the elimination of trans fats, promotion of fruits and vegetables and education on sodium consumption and improved calorie balance. (BT 07/09) (Retained as edited 07-19)

530.93 Hospital Health Care Personnel Influenza Vaccination Requirements

The Minnesota Medical Association will support patient health and safety by recommending that hospitals develop influenza vaccination programs for all hospital health care personnel who have direct contact with hospitalized patients. The MMA urges such influenza vaccinations to be in accordance with the national and state recommendations in effect at the time of vaccinations and will continue to support the recommendations of the MMA Health Care Worker's Vaccination Task Force and the recently developed FluSafe program of the Minnesota Department of Health. (HD-R403-2010) (Retained BT 08-20)

530.94 Supporting the Use of Health Impact Assessments (HIAs) to Guide Policymaking

The Minnesota Medical Association supports the use of health impact assessments (HIAs) to guide community development and policy decisions at all levels of Minnesota government. (HD-R409-2010) (Retained as edited BT 08-20)

530.95 Healthy Choices in WIC Program

The Minnesota Medical Association advocates the substitution of fresh fruits and vegetables, along with healthy beverages such as milk and water, for fruit juice in the WIC program. (BT 05-11) (Retained BT 08-21)

530.96 Health Notes for Proposed Legislation

The Minnesota Medical Association supports the development of a process to request a health note for certain proposed legislation that is being considered by the Minnesota Legislature. (BT 07-11) (Retained BT 08-21)

530.97 HPV Vaccination

The Minnesota Medical Association supports immunization of both male and female adolescents against human papillomavirus (HPV) beginning at age 11, in accordance with current ACIP recommendations. (BT 03-12) (Retained BT 09-22)

530.98 Partners in Prevention

The MMA supports (non-financial) the Partners in Prevention Program. (BT 05-12) (Retained as edited BT 09-22)

530.99 Ten-Minute Physical Activity Breaks Offered as Part of the Workday

The Minnesota Medical Association (MMA) recommends that employers in Minnesota encourage increased physical activity among their employees where appropriate through worksite wellness programs such as exercise breaks, discounted membership to fitness centers, health coaching, and other proven mechanisms.

(HD-R202-2011) (Retained BT 08-21)

530.999 Recreational Cannabis

The MMA recognizes that conclusive data regarding the short- and long-term health effects of cannabis use are lacking. As such, the MMA supports efforts to review the current classification of cannabis as a Schedule I controlled substance with the goal of facilitating clinical and public health research. The MMA recognizes that there are potential negative public health impacts of legal recreational cannabis use, and also acknowledges that there are negative social impacts associated with the current status of cannabis, experienced disproportionately among populations of color. As such, the MMA urges policymakers to understand and balance the public health and social impacts of legalizing cannabis for recreational use. As policymakers contemplate whether or not to legalize cannabis for recreational use in Minnesota, the MMA urges that such efforts keep in mind the health of the general public, and that the following safeguards are taken into consideration: a) Research has consistently shown that human brain development and maturation is not complete until the age of 25. Therefore, individuals under the age of 25 should be prohibited from purchasing, possessing, or using cannabis or cannabis-infused products. b) Cannabis use may increase the risk of developing psychiatric disorders, including psychosis (schizophrenia), depression and anxiety, particularly among individuals with a preexisting genetic or

other vulnerability. c) During pregnancy, cannabis use may increase the risk of low birth weight. In addition, prenatal cannabis exposure before or after maternal knowledge of pregnancy may increase the risk for psychopathology during middle childhood. d) Additional addiction treatment capacity and resources will be needed, as cannabis use may increase the risk of developing substance use disorders. e) Recognize the potential health risks, particularly among children and adolescents, associated with various cannabis inhalation delivery systems, ingestion of edibles, and exposure to secondhand smoke or vapor. f) Drawing upon experiences with alcohol and tobacco regulation, careful attention to product packaging, marketing, and advertising is needed to prevent use by children and adolescents. g) The importance of ongoing collection, analysis and dissemination of relevant public health and safety data. (BT 11-19) (Retained as edited BT 07-21)

530.1000 Statement of Support Regarding Protections for Residents and Fellows During the COVID-19 Pandemic

The MMA believes our employed trainees must have a safe environment in which to raise concerns about their personal safety and the safety of those around them without recrimination or consequence to their employment and training. The MMA shares these recommendations to address concerns of employed trainees practicing in Minnesota:

1. The MMA supports actions by training programs that will maximize direct patient care while minimizing exposure for medical staff, including trainees (residents and fellows).

2. The MMA supports the development of alternative educational opportunities, including but not limited to, remote-access lectures and non-patient care rotations, as possible.

3. The MMA supports actions by training programs to ensure trainees who are placed in isolation or quarantine for a known or suspected exposure to COVID-19 continue to be paid and are not required to use paid time off (PTO) or vacation.

4. The MMA supports actions by training programs to include trainees in policies about hazard pay in a manner equitable to other health care workers.

5. The MMA supports actions by training programs to assign trainees who are at high-risk for medical complications from COVID-19 (including but not limited to those immunosuppressed, pregnant, or with preexisting cardiac or pulmonary conditions) to virtual or non-patient care duties when medically indicated.

6. The MMA supports actions by training programs to ensure recommended PPE for all trainees caring for COVID-19 and potential COVID-19 patients. (BT 05-20)

530.1001 Personal Protective Equipment

The MMA supports legislation creating a state stockpile of PPE for future pandemic response. Distribution of these supplies should include tribal nations' hospitals, clinics, and skilled nursing fatalities within Minnesota. (BT 11-20)

530.1002 Equity in COVID Vaccinations

The Minnesota Medical Association (MMA) supports equitable COVID-19 vaccine distribution and administration.

Our organization recognizes that BIPOC, Latinx, and other marginalized communities, who have disproportionately suffered and died from COVID-19 die to existing inequitable health care systems and infrastructure, deserve prioritized access to COVID-19 vaccines. (BT 05-21)

530.1003 Healthful Food Options in Minnesota Health Care Facilities

1. The MMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of healthcare facilities.

2. The MMA hereby calls on all healthcare facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans-fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.

3. The MMA hereby calls for healthcare facility cafeterias and inpatient meal menus to publish nutrition information. (BT 07-21)

530.1004 COVID-19 Vaccination Requirements for Healthcare Workers

Recognizing the persistent COVID-19 pandemic and the availability of safe and effective vaccines, the MMA joins other leading medical associations and institutions in calling for universal vaccination of physicians and all other healthcare workers. Physicians and

other healthcare workers have demonstrated consistent leadership, courage, and resilience throughout this pandemic. Continued leadership by physicians and other healthcare workers in accepting vaccinations will protect immunocompromised individuals, other healthcare employees, those not yet eligible for vaccination, including children, and our communities. Therefore, the MMA urges Minnesota healthcare organizations to adopt COVID-19 vaccine requirements for their staff and employees, recognizing that medical contraindications and religious exemptions may apply in limited situations. (BT 08-21)

530.1005 Housing Conscious Healthcare

The MMA affirms that people experiencing homelessness or unstable housing are deserving of effective healthcare. The MMA recognizes that the effectiveness of healthcare is dependent on how well it is adapted to the housing status of each patient. The default assumption that all patients have stable housing precludes this adaptation and leads to poor health outcomes for people experiencing homelessness or unstable housing.

To improve the effectiveness of healthcare given to people experiencing homelessness or unstable housing, the MMA will:

(1) Support the creation and implementation of medical school curricula, continuing medical education, and information campaigns which educate physicians and trainees on how to screen for, and adapt medicine to, the housing status of patients;

(2) Pursue the collaborations, payment reforms, and legislation necessary to enable healthcare providers and institutions to screen for, and adapt medicine to, the housing status of patients;

(3) Support healthcare programs tailored to serving patients experiencing homelessness or unstable housing, including, but not limited to:

(a) Recuperative Care, a program which offers healthcare providers a safe place to discharge people experiencing homeless when they no longer require hospitalization but still need to heal from an illness or injury, and

(b) Street Medicine, a program through which healthcare professionals can provide medical care to people experiencing homelessness outside of the clinic, in places like encampments, parks, and under bridges. (BT 10-22)

540 Public Programs

540.02 MMA Policy on Medical Assistance

The MMA adopts the following policy on the state Medical Assistance Program:

1. The Medical Assistance Program is designed to assure persons with insufficient financial resources access to the health care delivery system.

2. Effective and appropriate cost containment strategies of the private sector should be utilized in the public sector.

3. The physician has the professional, moral and legal responsibility to provide necessary medical care to his or her patient. As such, the physician should act as the gatekeeper to the remainder of the health care delivery system. The physician should control the access of the MA recipient to all the services covered by medical assistance, with no exclusions. The MA recipients should have the opportunity to select their gatekeeper and should remain with that provider for a specified period of time. This gatekeeper's responsibility must be adequately compensated to insure provider participation and continued quality care. Cost-effective results should be rewarded.

4. Payment methodology for hospitalization and nursing homes must be modified from a cost-based system.

Community-based services for maintaining the elderly outside of nursing homes should be utilized when, combined with all support services utilized, it is less expensive than institutionalized cared. (BT-1/83) (Retained 2004)

540.08 CMS Definition of Physician Under Medicaid

The MMA believes CMS should define "physician" as a "Doctor of Medicine or Osteopathy." (BT-1/86) (Retained 2004) (Retained as edited BT 07-16)

540.12 Medicaid Task Force Recommendations Regarding Medicaid/GAMC Reimbursements

The MMA adopts the following position in its efforts to increase Medicaid/GAMC reimbursements: (1) special monetary incentives should be given to physicians who care for a significant percentage of Medical Assistance/GAMC patients in their practice. Further, that such special consideration not require a practice to be structured as a community health clinic or other such structure. Additionally, this should not present a hardship in administrative reporting for physicians; (2) the MMA supports the Department of Human Services' study of the appropriateness of the [resource based relative value scale (RBRVS)] as a basis for the physician payment structure for Minnesota Medical Assistance and GAMC in the future. (BT-7/90)

540.264 Financing Public Healthcare Programs (Oregon Model)

If sufficient revenues are not available to meet all the needs of all the beneficiaries of public programs, the MMA supports meeting the higher level needs of all beneficiaries than to meet all the needs of some beneficiaries. (EC- 4/03)

540.265 Obesity Carve-Outs from State Plan Formularies

The Minnesota Medical Association will lobby for the removal of language in Minnesota Statutes 2003, Chapter 256B, Subd. 13d, Drug Formulary, which currently specifically excludes medications to treat obesity. The MMA will take the strong position that obesity is a treatable disease and carry this position to the Minnesota Legislature and the Minnesota Department of Human Services. (HD-R210-2004) (Reaffirmed HD-R316--2006)

540.2692 ACA Medicaid Expansion

The MMA supports Medicaid expansion in Minnesota up to 138% of poverty, consistent with the Affordable Care Act. (BT 07-12)

540.2693 Repeal the MN DHS Rule 101 "All or Nothing Rule"

The MMA will work to explore alternative mechanisms to ensure access to care for Medicaid enrollees in lieu of Rule 101. (HD-R300-2012)

540.2694 Basic Health Plan

The MMA supports development of a Basic Health Plan to cover individuals from 138 to 200% of the federal poverty level but strongly opposes the use of the Health Care Access Fund (provider tax) as its funding source. (EC 02-13)

540.2695 Rule 101

The Minnesota Medical Association supports the principle that all physicians share in the delivery of care to patients covered by Medical Assistance and MinnesotaCare. To maintain adequate access to care for patients and to minimize the financial burden to physicians associated with treating Medical Assistance/MinnesotaCare patients, the MMA will work to achieve parity with Medicare rates for Medical Assistance/MinnesotaCare physician payment rates, support improved care coordination, and help facilitate better exchange of data to help physicians monitor those patients with particularly high needs/costs. The MMA will provide resources and information to physicians to help them better understand Rule 101 and the options available to them. (BT 07/13)

540.2696 State Controlled and Medicaid-Funded First-Dollar Family Medical Accounts for Medicaid Populations

The Minnesota Medical Association will convene members in discussion about Medicaid-funded and state-controlled first-dollar family accounts coupled with Medicaid-funded major medical insurance coverage for Medicaid populations, through a policy forum or other appropriate mechanisms. (HD-R205-2013)

540.2697 State Budget Gap-2009

With respect to the budget deficit predicted for 2010-2011, the MMA will support a budget proposal that balances spending cuts with tax increases. The MMA will prioritize new revenue sources to close the budget gap in the following way: increasing alcohol and tobacco taxes, expanding the state sales tax to other professional services, and even an income tax surcharge instead of any increase in the provider tax. For spending cuts, the MMA believes that all programs/sectors should be considered (i.e., there should be no sacred cows). Within the health and human services category of spending, preserving eligibility for public programs will be the MMA's top priority, followed by preserving payment rates for medical services, and minimizing changes to benefits/covered services. Any changes in benefits should be made within the context of broader health care reform and the development of an essential benefit set. (EC 02/09 and reaffirmed, in part, and edited, in part EC 04/09)

540.45 Rural Referral Centers Under Medicare

The MMA supports the continuation of favorable payment rates for all currently diagnosed Rural Referral Centers until the geographical payment disparity is eliminated. (HD-R13-1990)

540.49 Medicare On-Call Reimbursement Code for Rural Hospitals and Emergency Room Coverage

The MMA will cooperate with other professional health care organizations to explore means of establishing sufficient Medicare reimbursement for hospital emergency room coverage in order to ensure adequate provision of emergency medical service. The MMA recommends that the Health Care Financing Administration develop a system whereby rural hospitals are reimbursed a fee for keeping their emergency rooms open in order to service the Medicare population that uses those facilities. The MMA supports the concept of a new system of reimbursement to rural hospitals to keep their emergency rooms open. (HD-R12-1991) (Retained BT 08-21)

540.57 Medicare Balance Billing

The MMA supports legislation which would repeal existing law and allow Minnesota non-participating Medicare providers to balance bill up to the federal allowed amount (i.e., 115%). (BT-12/94) (BT-12/94) (Retained as Edited 2006)

540.58 MMA Principles for Medicare Reform

The MMA approves the following general reform principles on Medicare reform:

The security of Medicare recipients must be ensured.

Market based reforms must be utilized to introduce greater competition in the existing Medicare program.

Geographic equity in Medicare payment must be achieved for significant reforms to be realized.

The societal value of graduate medical education must be recognized and funded by all payers, public and private (BT-8/95) (Retained 2005) (Retained as edited BT 07-16)

540.59 Medicare User Fees

The MMA opposes the imposition of Medicare user fees on physicians. (HD-R316-1998) (Retained 2008) (Retained as edited BT 07-18)

540.6 Medicare Funding Equity

The MMA shall continue to support changes in federal Medicare reimbursement policy to treat Minnesota seniors and providers fairly, by basing reimbursement on the current, reasonable cost of efficiently providing high quality health care, and by using the payment formula that results in

comparable benefits in every part of the country. (HD-R305-1999) (Retained as edited 2009) (Retained BT 07-19)

540.62 Support Centers For Medicare And Medicaid Services (CMS) Demonstration Project

The Minnesota Medical Association delegation to the American Medical Association (AMA) will carry a resolution to the AMA that directs the AMA to lobby for and support demonstration projects funded by the federal government through the Centers for Medicare and Medicaid Services (CMS) to reduce the cost of Medicare by improving the appropriateness and quality of care provided. (HD-R305-2003)

540.66 Medicare Two-Midnight Rule

The Minnesota Medical Association will sign on to the Congress of Neurological Surgeons and American Association of Neurological Surgeons initial resolution submitted to the American Medical Association House of Delegates regarding Medicare's Two-Midnight Rule. The resolution petitions the Centers for Medicare & Medicaid Services to repeal the August 19 rule regarding Hospital Inpatient Admission Order and Certification. (BT-11/13)

540.67 Critical Access Hospital Necessary Provider Designation

The Minnesota Medical Association will sign on as a co-sponsor to South Dakota's resolution submitted to the American Medical Association House of Delegates regarding critical access hospitals. The resolution (1) calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) asks the AMA to oppose elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) asks the AMA to pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (BT-05/14)

540.68 MinnesotaCare Financing

The MMA continues to support the repeal of the provider tax and reiterates its position that broad-based, general fund revenues should support public health care programs that benefit all Minnesotans. (BT 11-15)

540.69 Medicare Reimbursement for Immunizations

The MMA supports allowing physicians to be reimbursed by Medicare for administering any immunization per the Advisory Committee on Immunization Practices (ACIP) guidelines to a Medicare beneficiary. (BT 05-20)

560 Research

560.02 Humane Treatment of Animals

The MMA confirms its commitment to the humane treatment of research animals. (HD-R19-1988) (Retained 2004) (Retained as edited BT 07-18)

560.03 Appropriate Use of Animal Research

The MMA recognizes the appropriateness and the necessity of animal research to better understand human disease or injury. (HD-R14-1996) (Retained as edited BT 07-16)

560.13 Changing MMA's Policy Statement on Embryonic Stem Cell Research

The Minnesota Medical Association updates its position statement in favor of embryonic stem cell research by adopting the American Medical Association's position so that the MMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology. (CSA Rep. 5, A-03), and rescinds policy 240.121 (Stem Cell Research). (HD-R405-2008) (Retained BT 07-18)

560.14 Comparative Effectiveness Research (CER) Principles

The MMA adopts the following principles to guide CER: A) Confirmation that the principles refer to the application of CER to medical practice and the need to account for individual patient circumstances: The Minnesota Medical Association (MMA) believes physicians play a central role in efforts to improve quality, contain costs, and improve the value of health care, and that providing care based in evidence is central to the ethics and professionalism of medicine. When appropriately applied to the practice of medicine, the MMA believes comparative effectiveness research (CER) is a valuable tool to improve the delivery of care, reduce costs, and inform patients and their doctors about the relative benefits and risks of treatment choices. B) A statement supporting the use of rigorous evidence, accurate interpretation of the evidence, and acknowledgement of the changing evidence base: The MMA encourages federal agencies to establish safe guards to assure the classification of evidence is rigorous and its interpretations are accurate, and that changing evidence is continually reviewed. C) An acknowledgement that CER may not always simultaneously impact the triple aim - quality, patient experience, and costs: CER should seek to impact health care quality, patient experience, and the costs of healthcare. New delivery system designs are simultaneously encouraging improvements to the health of the population, enhancing the patient experience, and reducing or controlling the per-capita cost of health care. While the likelihood that CER is able to impact all three components of the Triple Aim™ is minimal, a priority should be given to research on conditions with important public health consequences, on improving health care quality and access to care, and on addressing overuse and inappropriate use in health care. CER, first and foremost, must be based on improving outcomes for patients rather than on minimizing health care costs. (BT 11-11) (Retained BT 08-21)

580 Rural Health and Underserved Areas

580.01 Rural Physicians' Associate Program

The MMA urges the continued support of the Rural Physicians' Associate Program and the Metropolitan Physician Associate Program. (HD-SR17-1982) (Retained 2004) (Retained as edited BT 09-22)

590 Sports & Physical Fitness

590.01 Face Masks in Hockey

The MMA endorses the mandatory use of hockey face masks in all amateur, high school and college hockey programs throughout the nation. (HD-R1-1980)

590.07 Eye Protection for Racquet Sports

The MMA endorses the use of industrial safety lenses (plain or prescription) meeting or exceeding standard Z87.1-1968 established by the American National Standards Institute and mounted in a sturdy industrial or athletic frame for racquetball, squash and handball. (HD-R9-1983) (Retained 2004)

590.08 Protective Headgear for Horse Events Within the State of Minnesota

The MMA encourages riding schools, horse shows and other events in which persons participate with horses to promote use of protective headgear during activities. (HD-SR21-1984) (Retained 2004) (Retain as edited BT 01-15)

590.09 Boxing

The MMA believes that the sport of boxing should be banned. The State of Minnesota is strongly encouraged to adopt specific safety regulations for boxing in order to decrease the hazards of the sport. (BT-3/85) (Retained 2004) (Retained as edited BT 07-16)

590.11 CPR Training for Employees of Supervised Exercise Facilities

The MMA recommends that all supervised exercise facilities and physical fitness centers have employees on site, trained in Cardiopulmonary Resuscitation (CPR) techniques. (HD-R9-1987) (Retained 2004) (Retained BT 07-17)

590.12 Pre-Participation Athletic Exams

The MMA will not actively pursue "preparticipation athletic physical" exams, but will continue to monitor activities of the Minnesota State High School League and offer advice and services as requested. (BT-7/92)

590.14 Protective Headgear

The MMA supports the mandatory use of headgear for minors involved in the following sports: rollerblading, downhill skiing in licensed ski areas, riding off-road vehicles, such as four wheelers and motorcycles, and riding bicycles in the state of Minnesota. (HD-R115-1998) (Retained 2008) (Retained as edited BT 07-18)

590.15 "No Check"Hockey

The MMA urges the Minnesota Amateur Hockey Association, the Minnesota State High School League, parents, youth, coaches, and the public about the risks of injury associated with checking in hockey. (HD-R318-1998) (Retained as edited BT 07-18)

590.16 The Importance Of Physical Activity For The Health Maintenance Of Minnesotans

The Minnesota Medical Association will urge its physician membership to encourage and prescribe physical activity for their patients to prevent chronic disease states, and the MMA will also encourage its physician membership to increase their own daily physical activity. The Minnesota Medical Association supports efforts to increase awareness among physicians and Minnesotans of the importance of physical activity, and promote physical activity among Minnesota youth by encouraging physical education classes in grades K-12. (HD-R307-2002) (Retained as edited BT 09-22)

590.17 Requirement of Minnesota School Districts to Provide Physical Education for Grades K-8

The Minnesota Medical Association supports efforts to increase the level of physical activity for students in grades K – 8. (HD-R401-2008) (Retained as edited BT 07-18)

600 Support Services for Physicians

600.04 Physician Wellbeing

The MMA supports the development and ongoing support for a physician well-being initiative that includes work to: 1) advance an advocacy agenda to reduce administrative burden, improve the culture of medicine, and increase efficiencies in practice; 2) build and promote a learning network for wellness leaders and champions to a) present information and examples of work occurring across the state; b) review and discuss experiences and lessons; c) encourage broad sharing of work and activities; 3) curate and maintain resource hubs for individual physicians and wellness leaders to provide actionable, high-yield content; 4) offer informational resources (regular articles in Minnesota Medicine, web-based resources and other) to advance awareness of the prevalence of physician burnout and methods to remedy it; 5) educate members through the creation or the promotion of existing seminars, workshops, webinars, retreats, CMEs and other offerings on the topic of physician wellbeing. (BT 01-11) (Retained as edited BT 08-21)

610 Surgery

610.03 Mandated Second Opinion Policy

If a patient sees a physician expressly for the purpose of a mandated second opinion, the MMA discourages the second opinion physician from actively seeking to provide further medical care to that patient. (HD-RPT22-1988) (Retained 2004)

610.04 Laser Surgery

The MMA adopts the policy that laser surgery is the practice of medicine and should be performed only by individuals licensed to practice medicine and surgery or by those practitioners currently licensed by the state to perform surgery. (HD-R37-1991) (Retained 2004) (Retained BT 08-21)

610.05 Post-Operative Care

The MMA adopts the policy that it is the responsibility of a physician to determine who should provide post-operative care through the convalescent period. (HD-R36-1991) (Retained 2004) (Retained as edited BT 08-21)

610.06 Establishment Of Ethical Guidelines For Co-Management Of Surgical Patients

The Minnesota Medical Association adopts a policy that a surgeon should only engage in co-management of post-operative care when he/she feels it is in the best interest of the patient, and be it further and the MMA adopt a policy that when post-operative care is planned to be transferred to a co-managing practitioner, a pre-procedural informed consent shall be obtained which includes:

1. The reason for the transfer;

2. The licensure or certification and qualifications of the provider who will be managing the patient's care post-operatively;

3. The post-operative availability of the surgeon needs to be disclosed;

4. That there is no pre-determined time when the patient shall be sent back to the referring provider; and

5. Any special risks that may result from the surgical co-management. (HD-R202-2003)

610.07 Delegation Of Lasers And Intense Pulsed Light Source Procedures

The Minnesota Medical Association will work to create public awareness about the risks of scarring and blindness associated with the use of treatments from lasers, intense pulse light sources, radio frequency devices and related technologies and the importance of having such treatments performed or supervised by a knowledgeable physician. The Minnesota Medical Association also will modify existing MMA Policy to include supporting legislative or regulatory efforts to: 1) define the laser, intense pulsed light procedures, radio frequency devices and related technologies that require physician supervision; 2) require that every patient receive a physician evaluation before he/she receives treatment with any of these defined technologies; 3) establish minimum physician supervision requirements for these technologies; and 4) require that the use of these technologies on or in the eye and on ocular adnexa only be performed by licensed doctors of medicine or osteopathy. (HD-R200-2005) (Retained BT 07-16)

620 Technology

620.02 Assessment of Health Care Technology

The MMA supports the concept of technology assessment and will monitor the development of technology assessment activities in the state to assure that medicine is adequately represented at the table. (BT-3/91) (Retained 2004) (Retained BT 08-21)

620.08 Pathology Consultations Under Telemedicine Regulations

The MMA encourages the Board of Medical Practice to narrow the telemedicine consultation interpretation so that it does not exempt pathology altogether. (EC-2/03)

620.1 Imaging Task Force

The MMA adopts the following recommendation from the MMA Imaging Task Force:

1. To address the lack of current, useful, and valid data on imaging services in Minnesota, the MMA supports efforts to develop community-wide data to: a) understand Minnesota-specific imaging utilization trends; b) identify specific modalities of concern; c) consider issues of both overuse, underuse, and misuse; and, d) discern the impact of imaging services on patient outcomes, treatment decisions, quality of life, and productivity."

2. Given the lack of publicly available data, the MMA will work aggressively to pressure health plans/payers to clearly document and share relevant data regarding claims of inappropriate utilization of high-tech imaging services.

3. In order to reduce the inappropriate use of imaging (and other) services associated with defensive medicine, the MMA will explore possible changes to medical malpractice law to protect physicians who rely on evidence-based clinical guidelines.

4. The MMA will work to educate Minnesota physicians about self-referral laws/regulations.

5. As part of its commitment to supporting and promoting medicine's professional ethics, the MMA will work to educate physicians on their responsibility to recognize the potential financial conflict of interest associated with self-referral for imaging services.

6. The MMA reaffirms current MMA policy on self-referral and anti-kickback laws (280.19 and 240.06) as follows:

280.19 MMA Policy Principles on Health Care Supply (in part) Federal (Stark) limitations on physician self-referral are sufficient and the current exceptions, including the in-office ancillary exception to physician self-referral laws, should be maintained. (BT-3/06)

240.06 Conflicts of Interest The MMA approves the following: 1. Support state legislative and rulemaking efforts pertaining to the issue of conflicts of interest that are not more restrictive than the federal Medicare anti-kickback statute and safe harbor regulations. 2. Support state legislative and rulemaking efforts pertaining to the issue of conflicts of interest that provide adequate safeguards for preventing abuse by physicians who refer to entities in which they have a financial interest. (1992-09)

7. The MMA supports the development, dissemination, and implementation of appropriateness criteria (i.e., guidelines) to improve the delivery of evidence-based imaging services.

8. The MMA urges specialty societies to continue to develop guidelines to support evidence-based delivery of imaging services. In the event that guidelines from different societies conflict or overlap, the MMA urges the development of a collaborative inter-specialty process to reconcile differences.

9. The MMA supports the use of decision-support tools to improve the appropriate delivery of high-tech imaging services, but urges review of the long-term return-on-investment for decision support as it may be variable across physician practices.

10. The MMA recognizes the value of valid and transparent imaging accreditation programs/processes, but does not support accreditation as an absolute criterion given concerns about access to care in certain geographic areas.

11. The MMA continues to oppose the use of utilization review/prior notification as a tool to mitigate high-tech imaging utilization and supports a moratorium on its expansion.

12. The MMA supports efforts to develop meaningful and valid comparative price information for imaging services.

13. The MMA will work with Minnesota Community Measurement to develop and publish meaningful quality metrics for imaging services.

14. The MMA recognizes the role of patient demand/expectations on the utilization of imaging services and supports efforts to incorporate reasonable financial cost-sharing arrangements into insurance benefit design, consistent with MMA's policy for an essential benefit set.

15. The MMA will promote efforts to educate the public regarding the risks to health and safety associated with inappropriate use of imaging services.

16. The MMA will develop resources for physicians describing the relative radiation exposure risks associated with various imaging services.

(BT 03/08) (Reaffirmed: HD-R206-2010) (Retained BT 08-20)

630 Third Party Payers (See also, Ethics)

630.04 Disclosure and Access to Benefits and Coverage in Health Care Plans

The MMA believes that HMOs and other third party payers, both public and private, should provide full disclosure of accurate information concerning all benefits and services to their actual or potential enrollees or subscribers including but not limited to the following: the experience and qualification of the providers whom the patient will see, the opportunity for reimbursed referral or consultation, the copayment amount, if any, and the number of visits or days which are covered by the HMO or third party payment program. (HD-SR11-1984) (Retained 2004) (Retain as edited BT 01-15)

630.09 Role of Physicians in Governing Bodies

The MMA encourages third party payers to formally and significantly involve physicians on their boards of directors and advisory councils. (HD-R16-1994) (HD-R16-1994) (Retain BT 01-15)

630.104 Yearly Health Insurance Recontracting

The MMA supports health care contracting practices that provide for long-term, more stable relationships among the public, health plans, and physicians. (HD-R308-1999) (Retained 2009) (Retained BT 07-19)

630.1092 Health Plan Legal Liability

The Minnesota Medical Association supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care. (HD-R409-2004) (Retain as edited BT 01-15)

630.1094 Principles for Pay for Performance (P4P)

1. P4P programs must be designed to drive improvements to health care quality and the systems in which quality care is delivered.

• P4P programs should measure quality across the full continuum of care. Quality should be measured comprehensively considering the Institute for Healthcare Improvement Triple Aim of improving the patient experience, improving the health of populations, and reducing the per capita cost of health care.

• P4P programs must demonstrate improvements to health care quality, so that patient care is safer and more effective as a result of the program implementation.

• P4P programs must offer increased value to health care consumers.

• P4P programs should improve systems of care by encouraging use of health information technology (HIT), promoting collaboration among all members of the health care team, supporting implementation of evidence-based clinical guidelines, and increasing patient access to care that is high-quality and appropriate.

2. P4P programs must promote and strengthen the partnership between patients and physicians.

• Physicians are ethically required to use sound medical judgment and hold the best interests of the patient as paramount. Programs should respect patient preferences and physician judgment.

• Target goals should reflect the need for patient-centered care; therefore, performance goals should not be set at 100%. Thresholds for any P4P program should also reflect the role of patient adherence to treatment plans.

• Programs must make sure that access to care is not limited. Systems must be in place to ensure that physicians are not discouraged from providing care to patients who are members of underserved and high-risk patient populations).

• Patient privacy must be protected during all data collection, analysis, and reporting. Data collection must be consistent with the Health Insurance Portability and Accountability Act (HIPAA). and Minnesota health care privacy rules.

3. P4P programs should support and facilitate broad participation and minimize barriers to participation.

• P4P programs must work to include physician groups across the continuum of health care.

• Participation in P4P programs must not create undue financial or administrative burdens on physicians and/or their practices (i.e., implementation, data collection, and reporting of data).

• Elective P4P programs should allow clinics to take into account their ability to participate based on resources, patient population, and number of patients affected by the condition being measured. Physician groups, regardless of size, specialty, or HIT capability, should have the opportunity to participate in P4P programs if they have the resources and patient population needed to do so.

• Groups should be aware of P4P programs and clearly understand what the rewards will be relative to their level of participation so that they can accurately assess the cost/benefit of participation.

• Individual physician information must be protected. Data collected as part of P4P programs must not be used against physicians in obtaining professional licensure and certification.

4. P4P program design and implementation must be credible, reliable, transparent, scientifically valid, administratively streamlined, and useful to patients and physicians.

• Practicing physicians from the appropriate specialty should be integrally involved in the design, maintenance, and implementation of accountability and performance-improvement measures.

o Clinical performance measures must be objective, transparent, reliable, evidence-based, current, statistically valid, clinically relevant, and cost-effective; the methodology should be prospectively defined.

o Clinical performance measures should be selected for diseases that create a great burden on the health care system and for areas that have significant potential for clinical improvement.

o P4P programs should collect, report upon, and link payment to both process and outcome measures.

o Statistical validity is essential to measurement and reporting. Data collection, data analysis, and public reporting must utilize sample sizes large enough to ensure statistical validity, whether at the facility, group, or individual physician level. If valid sample sizes are not possible at the individual physician level, measurement and reporting must occur at the medical group or facility level.

o Risk adjustment is complex, and current methodology has serious limitations. To date, risk adjustment does not adjust adequately for confounding factors. Developers should use the best available methods for risk adjustment and update statistical methodology as the science of risk adjustment advances. Risk adjustment should account for factors that are outside the physician's control (i.e., pre-existing conditions, demographics, and co-morbidities).

• Pilot testing should not be disregarded in order to introduce a program into the marketplace quickly. Developers of P4P programs and performance measures must allow for pilot testing that will adequately

assess the reliability and validity of the measures. Measures should be reviewed at regular intervals and revised as needed to reflect changes in the evidence base.

• A clear description of the quality measures and methods used to assess and reward physician performance should be provided prior to implementation.

• Public reporting must reflect the full scope of the health system, and must be useful to both patients and physicians.

• Programs must allow physicians to review the data collected and its analysis prior to using it for public reporting, rating or rewards programs. Results should be reported back to individual physicians and physician groups to facilitate process and systems quality improvement.

• When comparing and reporting among clinical groups or across hospitals, public reports should include a clear notation on the complexity and limitations of risk adjustment.

• Clinics should know about any changes in program requirements and evaluation methods as they occur. In order to compare data, changes should occur no more often than annually.

• P4P programs should make an effort to reduce or eliminate duplicative measurement and reporting. A common data set should be adopted across communities, and data pertaining to a patient's care should be collected only once.

5. P4P programs should reward those physicians and clinics that: 1) show measurable improvements to the process of providing quality care; 2) show measurable improvements in patients' clinical outcomes; 3) meet or exceed stated clinical goals; 4) make efforts to improve the systems in which they practice; or 5) work to successfully coordinate patients' care among providers.

• There is value in selecting a pre-specified goal and rewarding physicians who achieve the goal or make significant improvements toward the goal.

• The MMA supports rewards, bonuses, and systems improvements as opposed to

withholds as a more effective incentive for improving quality and building systems of care.

• Programs ought to reward groups that build systems capacity in order to deliver high-quality care (e.g., providing telephonic care, installation of HIT, computerized pharmacy-order entry and clinical decision-support systems, disease and case management, and team-based care). Pay for performance programs should make efforts to help transition clinics from manual to electronic patient data collection.

• There are significant costs associated with data collection and reporting. Rewards should sufficiently cover the added practice expenses and administrative costs associated with collecting and reporting data.

• Pay-for-performance programs should reward physicians for providing effective disease management services (e.g., telephone care, care that is not provided in person) and coordinating treatment effort s among primary care physicians and hospitalists or specialists. Programs should recognize and reward groups that successfully get patients to adhere to agreed-upon treatment plans.

• Funding for P4P programs ought to be obtained through generated savings or new investments. (BT 05/07; Reaffirmed: HD-R204-2008; Retained as edited BT 05-14)

(BT 05/07) (Reaffirmed: HD-R204-2008) Retained as edited 5/14

630.111 Fair Contracting Legislation

The MMA supports the Fair Contracting Legislation, HF606, as amended introduced during the 2003 legislative session. (BT-3/03)

630.13 Reimbursement of Cognitive Services

The MMA supports the concept that third party payors should provide more equitable reimbursement for physicians' cognitive service in comparison with their procedural services. (Retain BT 01-15)

630.16 Insurance Coverage Disclosure

The MMA encourages the development of truth in health insurance legislation for the benefit of patients. The MMA will analyze the contracts of various health care plans and provide information to physicians regarding the benefits and risks associated with each. The MMA will also analyze whether transfer of risk by payers to physicians undermines the quality and availability of care to patients and determine whether legislative reform in this regard is necessary. (HD-SR23-1984) (Retained 2004)

630.22 Determination of Usual and Customary Fees by Third Party Payers

The MMA supports defining usual and customary fees based only on comparisons of like trained professionals and request procedural codes which denote the professional activity of such professionals. (HD-R31-1988) (Retained 2004) (Retained as edited BT 07-18)

630.26 Appeals Process for Investigational Therapies

The MMA urges third-party payers to create a process whereby, in special cases, patients and/or physicians can receive individual consideration for payment of therapies otherwise considered investigational or experimental, because, in some cases, such therapies may be the only treatment option. (HD-R15-1990) (Retained 2004) (Retained BT 08-20)

630.33 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

The MMA supports the efforts of the National Alliance for the Mentally Ill, the American Psychiatric Association, and other organizations working toward parity in coverage and reimbursement for medical problems which are currently discriminated against as "mental health disorders." The MMA approves the pursuit, with appropriate state regulatory agencies and the legislature, a requirement that all third party payors provide coverage and reimbursement for the evaluation and medical treatment of learning disabilities and of Attention Deficit Hyperactivity Disorder (ADHD) at the same level as provided for other neurodevelopmental conditions. (HD-R12-1993) (Retained 2004)

630.36 MMA Opposes Health Plan Restrictions

The MMA supports efforts to end discriminatory restrictions on the treatment of mental illness and addictive disorders, and supports removal of health plan restrictions to appropriate mental illness and

addictive disorder treatment by primary care physicians. (HD-R23&25-1994) (Retained 2006) (Retained as edited BT 07-16)

630.391 Payment for Out-of-Network Prescriptions

The Minnesota Medical Association will work with Minnesota health plans to provide coverage for pharmaceutical prescriptions that are compliant with plan formularies, when written by physicians who are otherwise eligible for health plan reimbursement according to the enrollee's health plan contract. (HD-R310-2000)

630.39106 Reimbursement for Language Interpreter Services

The MMA supports the use of culturally sensitive and appropriately trained interpreters when physicians provide care to patients with limited English proficiency. The MMA will support efforts to ensure that both public and private third-party payers provide reimbursement for the cost of these services.

The MMA will provide information to physicians regarding their responsibilities in providing interpreter services to their patients, including the laws governing interpreters, how to obtain interpreter services, and options available for physicians using interpreter services. (HD-SR408-2001) (Retained BT 08-21)

630.392 Reimbursement Incentives

The MMA opposes reimbursement arrangements that create undue economic pressure to withhold medically necessary care. (HD-LR323-1997)

630.394 Fair Coverage for Contraceptive Medications and Devices

The MMA supports insurance coverage for all FDA-approved contraceptive medications and devices, which require prescriptions, as they would for other prescription medications. The MMA supports the continuation of policies that require all-FDA approved contraception methods to be available to patients free of cost sharing. The MMA encourages appropriate prescribing of contraceptive medications/devices to acknowledge the cost of the relevant medication or device. (HD-R300-1998) (Retained 2008) (BT 01/15) (Retained as edited BT 11-17)

630.396 Retroactive Denials

The MMA supports legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed, or

incorrect information provided at the time such prior approval was obtained. (HD-R315-1998) (Retained as edited 2008) (Retained as edited BT 07-18)

630.399 Physician Reimbursement Systems/Models

The Minnesota Medical Association supports physician reimbursement systems/models that recognize the knowledge, skill, effort and time of physicians.

The MMA believes that assessing charges for a physician's work and time related to prescription changes, such as from the result of health plan formulary changes, is an individual physician's decision and should include an appropriate risk management assessment.

In situations where charges are assessed, the MMA supports public and private reimbursement for such services in accordance with CPT case management services guidelines. (BT-9/00) (Retained 2010) (Retained BT 08-20)

630.3992 Prompt Pay Legislation

The MMA supports HF606 as amended (introduced during the 2003 legislative session) and continues to support HF458/SF455, introduced during the 2003 legislative session. (BT-3/03)

630.3993 Terminology Of Medical Necessity

The Minnesota Medical Association supports usage of the term "medical necessity" that is consistent between the medical profession and the insurance industry, and urge health plan denials for non-covered services be stated explicitly and not confounded with determinations of lack of "medical necessity." (HD-R308-2003)

630.3994 Health Plan Coverage For The Treatment Of Obesity

The Minnesota Medical Association will continue its ongoing dialogue with the Minnesota Council of Health Plans to strongly encourage full coverage for evidence-based obesity care in the State of Minnesota, including ancillary services (such as dietitians, exercise physiologists, and psychologists) and medication coverage under appropriate physician supervision. (HD-R313-2003)

630.3995 Paying For Interpretive Services

The Minnesota Medical Association endorses and supports currently pending federal legislation that provides that physicians are not financially responsible for funding foreign language interpreter services as currently required by the U.S. Department of Health and Human Services. (HD-R408-2003)

630.3998 Reimbursement for Electronic Medical Care

The Minnesota Medical Association supports development of more efficient patient care through the development of appropriate reimbursement for electronic communications that are part of an ongoing physician patient relationship. (BT-11/2004) (Retain BT 01-15)

630.3999 Insurance Billing Practices

The Minnesota Medical Association supports efforts to ensure that patients are informed of what was billed to the insurer and what was actually paid. (HD-R302-2006) (Retained BT 07-16)

630.41 HMO Equalization

The MMA adopts the following positions on HMO equalization:

1. The MMA believes HMOs should be denied the option of using a co-payment based solely on health status or length of time in a plan, so long as an option allowing the HMO to use a co-payment based on health status or length of time in the plan when more than one health plan or insurance company is offered to employees.

2. The frequency which the HMO must notify enrollees of changes in participating providers should be every 90 days.

3. HMOs should not be required to offer second opinions for cases of psychiatry and chemical dependency treatment.

4. The MMA reaffirms its policy to restrict Department of Health access to data in individual offices, particularly medical records.

5. The MMA opposes granting the Department of Health the power to review and retroactively deny contracts between HMOs and providers. (BT-3/84)

630.434 Carveouts of Mental Health and Chemical Dependency Benefits

The Minnesota Medical Association opposes the carving out of psychiatric and chemical dependency treatments from general medical care in health insurance and managed care programs. (HD-R300-2000) (Retained as edited 2010) (Retained as edited BT 08-20)

630.44 Guiding Principles for the Development and Operation of a Preferred Provider Organization (PPO)

1. The PPO plan, as with any other plan, should address overall health care costs to the community, not just cost-cutting mechanisms within its own selected population.

2. The PPO plan should incorporate the concept that physicians must be integrally involved in the planning, organization and management of all plans involving the delivery of health care services.

3. The PPO plan should provide incentives for consumers to make cost-effective choices in their own health care. First dollar coverage and total coverage are disincentives.

4. The PPO plan should provide incentives to hospitals to reduce the expenses of providing their services.

5. The PPO plan should provide financial incentives which reward patients for cost-effective behavior.

6. The PPO plan should support continuity of care, the development of a continuing relationship between physician and patient.

7. PPO planning must recognize the role of the physician as the purchasing agent of health care for his or her patient. The plan should measure this function, and award good performance. This role is probably more important than fee levels in determining who is a high cost and who is a low cost provider.

8. Similarly, the PPO plan must provide for assessment and maintenance of quality of care, by some mechanism of peer (that is physician-controlled) review.

9. The PPO plan must assure the physician's role as advocate for the needs of each patient. The physician must never be placed in a position of becoming the patient's adversary as an agent for a health plan.

10. The PPO plan, as with any other plan, should in some way recognize the need for education in the health sciences, and the costs involved.

11. Data systems relating to physician performance have several requirements.

a. The often complex medical information must be interpreted by physicians.

b. Methodology should be developed to identify the severity/acuity of individual cases so that fair comparisons can be made.

c. Physicians should have access to detailed information concerning their own "practice profile"; the data system should also facilitate the comparison of physicians with similar practices.

d. Aggregate data should be used to establish community norms. Data about any individual should be made available to that individual for personal comparison and education.

Advertising for PPOs, like any physician advertising, must be fair, objective, and truthful. It should clearly state any limitation in the manner in which services are to be provided.

PPOs should not limit physicians to participation in a single PPO. (BT-1/83) (Retained 2004)

630.45 Prospective Online Enrollee Insurance Benefit and Medication Formulary Details

The Minnesota Medical Association supports that health plan/insurance companies make readily available to their enrollees specific, user-friendly detail online about the individual enrollee's health coverage and pharmaceutical benefits. (BT 07/08) (Retained as edited BT 07-18)

630.46 Co-Pay Equality

Payment reform should recognize and reward the development of a continuous, healing relationship between a patient and physician. This relationship is critically important in achieving better clinical outcomes, patient outcomes and reducing cost of care over a period of time. Current health plan payment policies that impose co-pays for visits to primary care physicians or medical home physicians are counter-productive to the goals of improving health in Minnesota. The Minnesota Medical Association will educate patients, policy makers and health plans about the problems caused by co-pays for primary care and advocate that payers eliminate co-pays for primary care physicians and medical home providers. (BT 05/09) (Retained BT 07-19)

640 Tobacco

640.01 Tobacco Advertising

The MMA supports a ban on tobacco advertising. (BT-1/89) (Retained 2004) (Retained as edited BT 07-19)

640.02 Limits on Advertising and Advertising at Government Sponsored Events

The MMA affirms its support of the AMA's call for a total ban on tobacco advertising. If, in the event it should prove impractical for legal or other reasons to enact a total ban on tobacco advertising, such advertising should not portray people or scenery in a false and misleading manner that falsely implies youth, beauty, vitality and virility as attributes associated with smoking. The MMA urges every community and municipality of Minnesota to adopt, as a principle, that they will not accept money, promotional items or other assistance from tobacco companies for the support of sports or other events. (HD-R4-1990) (Retained 2004) (Retained BT 08-20)

640.05 Sale of Tobacco from Vending Machines/Sale of Tobacco to Minors

The MMA supports a total ban on cigarette and e-cigarettes sales from vending machines. Also, the MMA supports efforts to ban the sale of tobacco and e-cigarettes to individuals under 21 years of age. (BT - 1/90) (Retained 2004) (Reaffirmed 2014)

640.14 Tobacco Tax

The MMA supports the use of cigarette tax revenue for tobacco use prevention initiatives and health care. (HD-R43-1995) (Retained as edited 2007) (Retained BT 07-16)

640.157 MMA Position on Use of Tobacco Settlement Revenue

The MMA supports the use of tobacco settlement funds only for health care related programs. (HD-SR206-1998) (Retained as edited 2008) (Retained as edited BT 07-18)

640.1594 Smoke Free Housing

The Minnesota Medical Association supports efforts to increase the availability of housing units, both publicly and privately owned, in which smoking is prohibited in all common areas and individual apartments (HD-R305-2004) (Retain BT 01-15)

640.1595 Implementation of Provider Tobacco Cessation Guidelines

The MMA shall actively encourage all Minnesota physicians to 1) follow cessation intervention guidelines such as those included on the ClearWay MinnesotaSM Provider Tobacco Intervention Card, 2) encourage other health care providers to provide tobacco cessation intervention, and 3) support systems changes in their health care organizations to enhance tobacco cessation initiatives. (HD-R211-2007) (Retained BT 07-17)

640.16 Smoking by MMA Employees and Representatives

The MMA adopts the following recommendations:

1. Prohibits smoking by participants in MMA meetings;

2. Request that physicians representing the MMA in the community not smoke;

3. Consider a smoking cessation program for MMA employees who smoke;

Consider incentives in the salary schedule for MMA employees who do not smoke;

Encourage MMA employees to not smoke while they are within the MMA office or when they are representing the MMA. (BT-7/83) (Retained 2004)

640.24 Smoking at Building Entrances

The MMA will initiate legislation to prohibit smoking within 75 feet of any entrance to a facility which is designated smoke-free. (HD-R20-1995) (Retained 2005) (Retained BT 07-16)

640.26 Smoke-Free Health Care Facilities/Grounds

The MMA supports that all health care facilities and grounds are smoke-free. (HD-R402-1998) (Retained as edited BT 07-18)

640.29 Opposition to State Pre-Emption of Local Ordinances Regulating Tobacco

The Minnesota Medical Association opposes attempts to adopt state law that pre-empts local ordinances that restrict the sale and use of tobacco. (HD-R201-2000) (Retained 2010) (Retained BT 08-20)

640.32 Secondhand Smoke

The Minnesota Medical Association and its constituent societies will choose facilities for their meetings, conferences, and conventions based on the facility's smoking policy (including its restaurant and bar policies) as an equal criterion to the facility's size, service, location, cost, and other similar factors, and that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA asking that a similar policy be adopted by the AMA to encourage national medical specialty societies, other state and county medical societies, and other health care organizations to adopt such a policy. (HD-R105-2003)

640.33 Smoking Ban By Minnesota Counties

The Minnesota Medical Association strongly recommends that Minnesota counties eliminate secondhand smoke on or in all county property, including buildings, jails, vehicles and land, and the MMA urges the Association of Minnesota Counties (AMC) to provide support for members in drafting and introducing ordinances to eliminate secondhand smoke on county property and that the counties with smoking restrictions or bans be commended by the AMC. The MMA also urges that county employees who use tobacco receive smoking cessation information and, for those who desire, referral to smoking cessation services in conjunction with their insurance providers and other organizations and the MMA urges counties to purchase health insurance that covers smoking cessation programs, and the MMA convey these policies to all elected county commissioners in Minnesota. (HD-R309-2003)

640.37 Restricting the Sale of Tobacco Products

The Minnesota Medical Association (MMA) supports the development of local, county, and state legislation that would limit the sale of tobacco products to tobacco specialty stores. (BT-07/2005) (Retained as edited BT 07-16)

640.38 Adoption of Comprehensive Tobacco Cessation Benefits

The Minnesota Medical Association supports the coverage of comprehensive tobacco cessation benefits, including counseling and pharmaceutical therapies. (HD-R303-2009) (Retained BT 07-19)

640.39 Consequences of Smoking in Cars With Minors

The Minnesota Medical Association will continue to advocate to decrease secondhand smoke exposure among children, and will support educational efforts, and legislative efforts to reduce children's exposure to secondhand smoke in vehicles. (HD-R312-2009) (Retained as edited BT 07-19)

640.41 Electronic Cigarettes Nicotine Delivery Systems

The Minnesota Medical Association (MMA) acknowledges that the use of electronic nicotine delivery systems, including electronic cigarettes, vapes and other vaping products are a public health concern, posing a significant health risk to children, teens and adults. The MMA will support efforts to prohibit both their availability and use (with the exception of products approved by the U.S. Food and Drug Administration (FDA) for tobacco-cessation purposes), until such time as the appropriate guidance, regulation, and research of all vaping products and substances delivered through these devices is conducted by the FDA and other relevant government entities, and the health effects of these products can be determined. (BT 11/13) (Retained as edited BT 12-19)

650 Tort Reform (See also, Professional Liability)

650.01 Professional Liability Tort Reform Measures

The MMA endorses the following professional liability tort reform measures:

1. Certify meritorious claims by requiring the attorney to swear that an expert has verified that a case exists before the claim is filed.

2. Disclose expert testimony by requiring an attorney to provide the defendant with the name of the expert witness within 120 days of filing a lawsuit or the claim will be dismissed.

3. Provide access to treating physicians by allowing the defendant's attorney to talk to the current and former treating physicians to help in determining the merits of a case.

4. Eliminate punitive damages in medical actions to avoid pitting physicians against insurance companies.

5. Place a cap on pain and suffering awards by limiting non-economic awards to $250,000.

6. Establish a statutory requirement that all awards over $100,000 will be paid over the patient's lifetime. Attorney fees will be reduced since the fee is calculated in the amount of the reduced award.

7. Reduce from 18 years to 7 years the time in which a lawsuit involving a minor must be filed.

8. Require judgments to be offset by any payment which a plaintiff receives from other sources. (BT-1/86) (Retained 2004) (Retained BT 07-16)

650.03 Federal Tort Reform Legislation

The MMA supports inclusion of the following provisions in federal tort reform legislation:

A. Voluntary alternative dispute resolution (ADR) programs

B. Liability reforms including:

1. reasonable periodic payment awards

2. reasonable caps on non-economic damages

3. mandatory offsets for collateral sources of payment

4. limitations on attorney contingency fees

5. payment of punitive damage awards to states for the improvement of health care, and for use by state health care disciplinary boards and/or ADR programs

6. several and not joint liability (liability of each defendant only for the amount of non-economic damages allocated to each defendant), and

7. certification of meritorious claims.

C. Quality improvement reforms and especially those reforms that encourage or require state medical societies to conduct peer review and/or provide educational programs for physicians.

D. Public funding of professional liability insurance for those providing care at migrant and community health centers.

The MMA does not support inclusion of the following provisions in federal legislation.

Mandatory ADR programs that would preempt state law and/or that would provide automatic state grants for ADR programs without requiring states to apply for such grants.

ADR program funding through reduction in Medicaid or Medicare payments or through Medicaid bonuses.

Statute of limitations provisions that would allow a claimant to bring a cause of action beyond the period of time that would be allowed by Minnesota Statutes.

E. Quality improvement reforms that would encourage or require state disciplinary boards to take a more active role in conducting peer review and providing educational programs for physicians. (BT-9/91) (Retained 2004)(Retained BT 08-21)

650.06 Medical Malpractice Legislation

The MMA supports tort reform that includes a cap on non-economic damages at $250,000, includes a sliding scale cap on attorney contingent fees, uses periodic payments for large awards, includes changes to joint and several liability provisions consistent with MMA policy, and provides equal access by the defense and the plaintiff to the physician experts. (HD-R406-1998) (Retained as edited BT 07-18)

650.08 Collaborative Legal Reform

The MMA will continue to support voluntary alternative dispute resolution methods which may include collaborative law agreements. The MMA will continue to review legislative proposals to support adoption of a collaborative law act in Minnesota. (BT 09-12) (Retained BT 09-22)

660 Uninsured/Underinsured

660.01 Economically Disadvantaged Patients

The MMA reaffirms the importance of physicians continuing to render care to all persons without regard to the individual's ability to pay. (HD-R9-1982) (Retained 2004) (Retained as edited BT 09-22)

660.2 Vaccinating the Underinsured

The Minnesota Medical Association supports efforts of the Minnesota Department of Health to request state funding to purchase vaccines for underinsured children, provided for under the Minnesota Vaccines for Children (MnVFC) Program. (BT-5/13)

670 Utilization Review

670.01 Liability Related to Third Party Review

The MMA seeks to ensure that outside initiators of utilization review be prepared to accept the liability which may result from their actions. (HD-R23-1981) (Retained 2004) (Retained BT 08-21)

670.03 Utilization Review of Psychiatric and Chemical Dependency Cases

The MMA endorses the principle of prospective and concurrent review, encourages physicians to make appropriate review information available in a timely fashion, and discourages denial of payment based on retrospective utilization review in both the public and private sector. The MMA will educate its membership concerning contract problems with third party payers which hold the third party harmless from suit in the case of adverse patient outcome. The MMA recommends establishing community based standards for inpatient and outpatient psychiatric and chemical dependency treatment. (HD-R5-1987) (Retained 2004)

670.1 Patient Protection in Utilization Review of Psychotherapy Cases

The Minnesota Medical Association opposes utilization review organizations, health plans, or insurance plans from requiring disclosure of psychotherapy case notes as a condition of medical necessity review or insurance reimbursement. (HD-R309-2000) (Retained 2010) (Retained as edited BT 08-20)

670.11 Utilization Review Reform Bill

The Minnesota Medical Association supports:

1. A requirement that a physician performing UR must be licensed in Minnesota;

2. The requirement that a physician performing UR must be the same of related specialty as the physician ordering the care;

3. A requirement that would give the Board of Medical Practice authority to discipline physicians not using current and prevailing standards of care when making UR determination. (BT-3/01) (Retained as edited BT 08-21)

700 Vital Statistics

700.02 Physician Reimbursement for Death Certificates and Cremation Authorizations

The Minnesota Medical Association supports a physician's ability to charge for completing cremation authorizations and Certificates of Death, and will ask the AMA to support physician reimbursement for professional services related to completing cremation authorizations and certificates of death, including the development of appropriate CPT codes for death certificate completion. The MMA will also seek to work with CMS to accomplish this goal and will provide Minnesota physicians with educational materials on how to complete a death certificate. (HD-R400-2008)

720 Water Safety

720.04 Water Safety

The MMA supports the use of life jackets or personal flotation devices for minors while in watercraft or while water-skiing or windsurfing and supports current Department of Natural Resources guidelines and education campaigns. (HD-R114-1998) (Retained 2008) (Retained BT 07-18)

730 Workers' Compensation

730.01 Timely Return to Work After Disability or Illness

Minnesota physicians should pursue efforts to communicate with insurance companies, personnel managers and appropriate supervisors, to ensure that recovered employees have a timely return to suitable work. The MMA will promote and support continuing medical education programs to assure physician understanding of the workers' compensation system. (HD-R1-1983) (Retained 2004)

730.08 Penalty for Deviation from Workers' Compensation Rule

The MMA strongly opposes provisions in the workers' compensation rules and legislation that provide for criminal penalties on physicians who deviate from the compensation and treatment guidelines included in the rules. (BT-7/93) (Retained 2004)

730.1 Reimbursement for Workers' Compensation Cases

The Minnesota Medical Association will actively oppose any further reductions in the workers' compensation fee schedule for physicians, and will oppose proposals by certified managed care organizations to lower physician compensation for treating patients covered under workers' compensation. (HD-R213-2004) (Retain as edited BT 01-15)