MMA Policies

2026

(reflects policies adopted through November 30, 2026)

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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)

10.11 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)

10.15 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)

20.08 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) (Retained BT 09-26)

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)

20.16 Gender-Affirming Healthcare Access & Protections

Right to Gender-Affirming Healthcare

The MMA affirms the right to gender-affirming healthcare as a component of comprehensive healthcare. For the purposes of this policy, gender-affirming healthcare means treatment of clinically diagnosed gender dysphoria/incongruence, including, but not limited to, counseling, psychotherapy, pubertal suppression therapy, gender-affirming hormone therapy, and/or gender-affirming surgeries.

Recognized Standards of Care

The MMA affirms that gender-affirming healthcare should be performed in accordance with the prevailing evidence-based standards of care published by the World Professional Association of Transgender Health (WPATH) to the greatest extent permissible under law while recognizing that variations, taking into account individual circumstances, may be appropriate.

Insurance Coverage

The MMA supports public and private health insurance coverage for medically necessary gender-affirming healthcare services and medications in accordance with the prevailing evidence-based standards of care.

Minors' Access, Parent/Guardian Involvement and Consent

Consistent with the prevailing evidence-based standards of care, the MMA recognizes that minors can be diagnosed with gender dysphoria/incongruence and that, under specific clinical guidelines, it is appropriate for these minors to receive certain types of gender-affirming healthcare. The MMA affirms that healthcare professionals should encourage and facilitate increased familial understanding and support of minors' gender identities and gender-affirming healthcare needs unless familial involvement is harmful to the minor or not feasible.

The MMA understands that, in some cases, parents and guardians will remain steadfast in their disapproval of their child's gender identity and gender-affirming healthcare needs. The MMA urges professionals who provide gender-affirming healthcare to exercise caution with respect to applicable laws on minor consent. To facilitate this caution, and to empower physicians to care for minor patients to the maximum legal extent, the MMA will educate its members on minor consent laws as it relates to gender-affirming healthcare.

Support of Efforts to Increase Access

The MMA will collaborate with appropriate stakeholders to strategize and pursue efforts to increase access to gender-affirming healthcare in Minnesota.

Opposition to Government Restrictions

The MMA opposes laws and regulatory actions designed to restrict access to gender-affirming healthcare, including, but not limited to:

(1) government-based civil or criminal penalties imposed on people who seek, obtain, provide, or otherwise facilitate gender-affirming healthcare;

(2) state cooperation with out-of-state subpoenas, warrants, and investigations related to out-of-state civil or criminal penalties imposed on people who seek, obtain, provide, or otherwise facilitate gender-affirming healthcare.

Protections from Out-of-State Interventions

The MMA recognizes, and supports the continuation of, protections available to Minnesota individuals and organizations with respect to not responding to out-of-state subpoenas, warrants,

and investigations related to people who seek, obtain, provide, or otherwise facilitate appropriate gender-affirming healthcare.

Condemnation of Threats and Acts of Violence

The MMA condemns threats and acts of violence against people who provide, seek, or facilitate gender-affirming healthcare services and will support policies that aim to deter such threats and acts.

Legal Clarifications of This Policy

The guidance contained in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. (BT 02-24) (Reaffirmed BT 03-26)

20.17 Continued Research on Gender-Affirming Healthcare

The MMA supports continued research on the benefits and risks of gender-affirming healthcare, including, but not limited to, puberty blockers, hormone replacement therapy, and gender-affirmation surgeries as treatment for gender dysphoria/incongruence.

The MMA delegation to the AMA shall bring forward a resolution to the AMA to expand AMA policy to align with this newly-adopted MMA policy. (BT 02-24)

20.18 Correctional Healthcare

Right to Correctional Healthcare

The MMA affirms that people who are incarcerated have a right to quality physical and mental healthcare, including recommended preventive health measures. For the purposes of this policy, “people who are incarcerated” means people confined in any correctional facility, including local jails, state prisons, or federal prisons.

Standards of Care

The MMA affirms that correctional facilities should provide physical and mental healthcare services to people who are incarcerated in a manner consistent with prevailing standards of care for community practice. Additionally, the MMA recognizes that, because correctional facilities are settings with unique custodial obligations for high-risk populations, they should adopt policies and procedures that are consistent with prevailing standards of correctional care.

The MMA joins the American Medical Association (AMA) in strongly encouraging all correctional facilities to:

1. adopt policies and procedures consistent with the National Commission on Correctional Healthcare’s (NCCHC) Standards, while recognizing that variations, taking into account individual circumstances, may be appropriate, and

2. seek NCCHC accreditation.

The MMA will collaborate with the NCCHC, the AMA, the Federal Bureau of Prisons (BOP), and the Minnesota Department of Corrections (DOC) to improve the alignment of correctional facility policies with NCCHC standards.

Payment Rates for Correctional Healthcare Workers

The MMA advocates that correctional healthcare workers be paid rates that ensure sufficient access to comprehensive physical and mental healthcare services.

Acceptance Among the Healthcare Workforce

The MMA recognizes that the lack of acceptance of people who are incarcerated among the healthcare workforce reduces access to, and quality of, correctional healthcare. To improve acceptance, the MMA will:

1. Develop or support a campaign to reduce stigma and bias among the healthcare worker community against people who are incarcerated,

2. Collaborate with appropriate stakeholders to create, and inform healthcare workers about, mechanisms that allow healthcare workers to provide correctional healthcare in their clinics without worry of discomforting patients who are not incarcerated (e.g., increasing access to correctional telehealth, scheduling correctional appointments in blocks long before or after other patients are seen, using separate entrances for people who are incarcerated, etc.).

Public Health Insurance Coverage

The MMA recognizes that when public health insurance programs refuse to cover, or pay for services rendered to, otherwise eligible people who are incarcerated, it places undue financial strains on correctional facilities that may incentivize facilities to delay, forgo, or reduce the quality of, correctional healthcare. Therefore, the MMA will:

1. Support the AMA's federal advocacy efforts to:

A. Repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in correctional facilities. The MMA may support a partial repeal that only applies to healthcare services rendered to people awaiting trial in jails as a piecemeal step towards full reform.

B. Revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to Medicare beneficiaries who are held in correctional facilities. The MMA may support a partial repeal that only applies to healthcare services rendered to people awaiting trial in jails as a piecemeal step towards full reform.

The MMA also recognizes that when public health insurance programs make it difficult for people who are incarcerated to apply for and/or maintain enrollment, it threatens continuity of care upon release when people who are incarcerated face exceptional health risks. Therefore, the MMA will:

1. Advocate that the State of Minnesota continue to allow eligible people who are incarcerated to apply for, maintain, and receive Medical Assistance coverage for inpatient hospital services past the April 2023 expiration of Department of Human Services Bulletin #23-21-07.

Cost-Sharing

The MMA joins the AMA in advocating for the prohibition of cost-sharing (i.e., deductibles, copayments, and coinsurance) as a requirement to access healthcare services in correctional facilities.

Health Information Exchange Between Correctional and Healthcare Facilities

The MMA recognizes that seamless health information exchange between correctional and healthcare facilities before, during, and after a person's incarceration is necessary to ensure access to continuous, quality healthcare among people who are incarcerated. Therefore, the MMA will pursue the collaborations, legislation, and rule changes necessary to facilitate health information exchange between correctional and healthcare facilities.

Discharge Planning and Transition of Care

The MMA supports comprehensive discharge planning that ensures continuity of important medications, connection to healthcare facilities in the community, and ensures enrollment in public health insurance programs.

Disclosure of Rights by Medical Facilities

The MMA joins the AMA in advocating for legislation that would require healthcare facilities to inform people who are incarcerated about their rights as a patient, especially as it pertains to patient autonomy, under applicable state and federal law.

Standardized Health Questions Upon Booking, Initial Health Assessment Protocols

The MMA recognizes that the completion of standardized, comprehensive, and timely health questionnaires upon booking (by correctional staff), and initial health assessments shortly thereafter (by correctional healthcare staff) is necessary to ensure that people who enter correctional facilities are screened, and treated/monitored properly for, physical and mental health conditions, especially in cases of suicidality and substance use intoxication or withdrawal.

The MMA advocates that all correctional facilities in Minnesota adopt standardized health questionnaires and initial health assessment protocols consistent with the most recent standards of care published by the NCCHC to the greatest extent practicable.

Solitary Confinement

The MMA advocates that correctional facilities and regulatory bodies adopt policies on solitary confinement that are consistent with the NCCHC position statement, "Solitary Confinement (Isolation) (2016)."

Reviews of Deaths, Injuries, and Near-Deaths/-Injuries

The MMA affirms that deaths, injuries, and near-deaths/-injuries among people who are incarcerated are serious matters that warrant comprehensive reviews by professionals who are not employed by, or associated with, the correctional facility in question or the contracted medical provider at the facility in question.

The MMA advocates that the Minnesota Department of Corrections (DOC) and Minnesota Department of Health (MDH) adopt standardized protocols for reviewing deaths, injuries, and near-deaths/-injuries in Minnesota correctional facilities consistent with the most recent standards of care published by the NCCHC to the greatest extent practicable.

Enforcement of Standards and Effectiveness of Penalties

The MMA affirms that the effectiveness of correctional healthcare standards is limited to the extent that said standards are meaningfully enforced by regulatory bodies, with the involvement of third-party professionals as appropriate.

Therefore, the MMA will collaborate with the appropriate state authorities to identify a sustainable, third-party oversight mechanism to regularly monitor and improve the enforcement of standards, and the effectiveness of penalties, on correctional facilities and correctional healthcare staff in Minnesota. The MMA recommends that this third-party oversight mechanism be housed under the Minnesota Department of Health due to its experience and qualifications.

Legal Clarifications of This Policy

The guidance contained in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. (BT 02-24)

20.19 Community Health Workers

The MMA recognizes community health workers (CHWs), frontline public health workers who are members of and/or trusted by the communities they serve, as integral members of the Minnesota health workforce. Through their unique training and communal trust, CHWs are able to be effective links between their own communities and systems of care. (BT 12-24)

20.2 Insurance Coverage for People with Undocumented Status

The MMA affirms that people with undocumented status deserve access to affordable, comprehensive health insurance without fear that data provided during enrollment will be used by immigration authorities. To protect and expand coverage options for people with undocumented status, the MMA will: 1) Advocate that the State of Minnesota continue to allow people with undocumented status to enroll in MinnesotaCare in a manner that sufficiently protects identifiable information on members' documentation status within the limits of state and federal law. 2) Support the exploration, study, and/or pilot implementation of state actions that could address

gaps in coverage for people with undocumented status while sufficiently protecting identifiable information on members' documentation status within the limits of state and federal law. These actions include, but are not limited to: a) Increase the income limits for MinnesotaCare eligibility for people with undocumented status, given their lack of coverage options beyond said limits, b) Implement a state-run shopping platform separate from MNsure through which people with undocumented status can purchase health insurance, and c) Implement state-funded premium subsidies and cost-sharing subsidies for people with undocumented status who purchase health insurance through a state-run shopping platform or through an Affordable Care Act (ACA) Health Insurance Marketplace. 3) Urge the American Medical Association (AMA) to lobby for federal actions that could address gaps in coverage for people with undocumented status while sufficiently protecting identifiable information on members' documentation status within the limits of state and federal law. These actions include, but are not limited to: a) Allow people with undocumented status to enroll in ACA Health Insurance Marketplace plans, and b) Allow eligible people with undocumented status to receive advance premium tax credits and cost-sharing reductions under the ACA. 4) Oppose any policies that would require health insurance plans to report identifiable information on their members' documentation status, either directly or indirectly, to immigration authorities. 5) Support the efforts of the Minnesota Department of Human Services (DHS) and partner organizations that aim to educate people with undocumented status about their coverage options and to facilitate enrollment. 6) Support the monitoring and study of the non-financial barriers people with undocumented status face when considering health insurance enrollment, including, but not limited to, concerns of status confidentiality from immigration authorities. (BT 02-25)

20.3 Coverage of Therapeutic Shoes and Inserts

The MMA supports public and private health insurance coverage for medically necessary therapeutic shoes and inserts for patients with peripheral neuropathy and/or foot disfigurement, regardless of whether the patient has diabetes. (BT 05-25)

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. (HD-R50-1995) (Retained 2005)(Retained BT 07-16)(Retained as edited BT 09-26)

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)

30.15 Access to HIV Prevention and Management Medications

The MMA affirms that people should have access to medications that prevent and/or manage human immunodeficiency virus (HIV); including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and HIV antiretroviral therapy (ART); as a component of comprehensive healthcare. To facilitate access to HIV medications, the MMA will:

1. Advocate that people not be denied health insurance or face discriminatory premiums on the basis of their HIV status or use of PrEP, PEP, and/or ART;
2. Support public and private health insurance coverage for PrEP, PEP, and/or ART and associated

office visits/lab work, and support no-cost, pre-deductible coverage for these medications and associated office visits/lab work;

3. Support programs that assist uninsured/underinsured Minnesotans in accessing free or reduced-cost PrEP,PEP, and/or ART medications;
4. Advocate for the removal of barriers for all FDA-approved PrEP, PEP, and/or ART medications, including, but not limited to, prior authorization and/or required consultations with infectious disease specialists.

5. Protect Minnesota law that allows trained pharmacists to prescribe and administer PrEP and PEP medications, consistent with Minnesota Board of Pharmacy protocol and Centers for Disease Control and Prevention (CDC)

clinical practice guidelines;

6. Support the education of Minnesota physicians and trainees on HIV incidence and prevalence in Minnesota; the efficacy of PrEP, PEP, and ART; and best practice guidelines for assessing and discussing HIV risk and medications with patients;

7. Support public education efforts focused on informing high-risk Minnesotans on the existence, efficacy and availability of PrEP, PEP, and/or ART. (BT 11-25)

40 Physician/Health Care Advertising

40.01 Advertising of Prescription Drugs

The MMA supports the AMA's opposition to the advertising of prescription drugs directly to the public. (BT-11/85) (Retained 2004) (Retained as edited BT 07-16)(Retained as edited BT 09-26)

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 Substance Use Disorder

The MMA encourages efforts to improve undergraduate medical curriculum content regarding the early identification and treatment of alcohol use disorder and other substance use disorders. (HD-R21-1985) (Retained 2004) (Retained BT 07-16) (Retained as edited BT 09-25)

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)

50.16 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) (Retained BT 09-26)

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)(Retained BT 09-26)

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) (Retained BT 09-26)

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) supports an increase in the excise tax on beer, wine, and spirits by the equivalent of $.10 per standard drink and that these increased funds be used for prevention, treatment, and public safety services related to alcohol use. The MMA shall support

that future alcohol excise tax increases keep pace with inflation. The MMA shall also consider alcohol use, particularly among underage drinkers, one of its public health priority issues. (HD-SR201-2006) (Retained BT 07-16)

50.28 Economic Interventions to Reduce Alcohol Consumption

The Minnesota Medical Association continues to support efforts to reduce 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)(Retained as edited BT 09-26)

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) (Retained BT 09-2026)

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) (Retained BT 09-26)

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).

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.

Education

1. The MMA supports 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) (Retained as edited BT 09-26)

50.4 Substance Use Disorders 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)(Retained as edited BT 09-26)

50.5 Monitoring & Public Communication of Alcohol-Related Harms

The MMA supports transparent, state-level monitoring of various alcohol-related metrics and harms, including alcohol consumption metrics, alcohol-related hospitalizations, alcohol-related deaths, and alcoholrelated costs, ideally on an annual basis.
Moreover, the MMA supports the AMA's efforts to work in conjunction with the broadcasting industry to formulate a sustained public service campaign on the medical and social hazards of alcohol use, and we encourage Minnesota's local broadcasting industry to engage in similar efforts. (BT 05-26)

50.6 Alcohol Use Screening and Treatment

The MMA affirms that alcohol use disorder (AUD) is a treatable medical illness. To improve diagnosis and treatment of AUD in Minnesota, the MMA will:

1) Support efforts to increase access to publicly available managed alcohol programs for people with severe AUD who are unable to complete traditional alcohol treatment programs, and

2) Encourage medical schools and specialty societies to adopt curricula and/or policies that promote the following alcohol screening and treatment protocol: a. Primary care physicians should establish routine evidence-based alcohol screening procedures for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care; b. Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder; c. Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. (BT 05-26)

50.7 Alcohol Use Among Women

The MMA recognizes the increasing prevalence of high-risk alcohol use among women and the significant barriers to diagnosis and treatment. Rates of alcohol use and related harms among women have risen in recent years, and biological differences place women at greater risk for adverse health effects at lower levels of consumption.Despite this, women are less likely to be

screened or receive timely care due to stigma, under-recognition and underdiagnosis in healthcare settings, and structural and logistical barriers such as caregiving responsibilities and co-occurring trauma. These factors all contribute to women facing delayed or unmet treatment needs. To improve diagnosis and treatment of women in Minnesota with alcohol use disorder (AUD) and/or high-risk alcohol use, the MMA will: a) Urge physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for AUD and high-risk alcohol use; b) Encourage physicians to educate women of all ages about the increased risk of cancer including breast cancer, damage to the nervous system, liver, and heart disease from alcohol use and about the effect of alcohol on the developing fetus; c) Encourage adequate funding for research to explore the nature and extent of AUD and high-risk alcohol use among women, effective treatment modalities for women with AUD and high-risk alcohol use, and variations in alcohol use among ethnic and other subpopulations; d) Encourage all medical education programs to provide greater coverage on alcohol use as a significant source of morbidity and mortality in women.

While the MMA supports alcohol screening, diagnosis, and treatment for all populations, we urge targeted, gender-responsive efforts to improve early identification and access to care for women. (BT 05-26)

60 Allied Health Professionals/Services

60.12 Chiropractic Scope of Practice

The MMA reaffirms its position that performing a comprehensive physical examination, which requires the examiner to diagnose the presence or absence of medical conditions, is outside the scope of chiropractic practice. (HD-R5-1996) (Retained 2006) (Retained as edited BT 07-16)(Retained as edited BT 09-26)

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)

60.237 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) (Retained BT 09-26)

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)

60.24 Occupational Therapy

The MMA supports requiring a medical referral prior to initiating occupational therapy. (BT-4/95) (Retained as edited BT 09-25)

60.282 Opposition To Optometrists Performing Invasive Medical Procedures

The Minnesota Medical Association is opposed to allowing optometrists to perform invasive procedures, (e.g., anterior stromal puncture, corneal foreign body removal, corneal epithelial scraping, and corneal flaps). (HD-R217-2003)(Retained as edited BT 07-23)

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)

60.362 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)

60.366 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)

60.421 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)

60.51 Scope Of Practice

The Minnesota Medical Association will 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)(Retained BT 07-23)

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 that (a) Levies fines on the nonuse of vehicle restraints and helmets while operating or riding motorcycles, snowmobiles, and all-terrain-vehicles, and (b) Requires all minors to use bicycle helmets when riding a bicycle. (BT-12/94) (Retained as edited 07-2024) (BT-12/94) (Retained as Edited 2006) (BT 07-24)

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) (Retained BT 09-26)

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 legislating the standard of care for sexual assault victims. (BT-3/03) (Retained as edited BT 07-23)

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)(Retained BT 07-23)

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) (Retained BT 09-26)

80.09 Payment Policy for Long Acting 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) (BT 09-2026)

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)

100.24 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 healthcare professionals delivering medical services. (HD-R404-2005) (Retained BT 07-16) (Retained as edited BT 11-26)

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)

100.27 IMG Licensure Pathway

The MMA acknowledges the value of creating an alternative pathway to licensure for highly qualified international medical graduates (IMGs), while also recognizing the need to maintain Minnesota's high standard of care and to ensure that IMGs have the necessary training and experience to be successful. Although some concerns remain, the MMA will not oppose the 2025 alternative pathway legislation with the recent additional attestation requirements. (EC 02-25)

110 Children and Youth

110.03 Sleep Deprivation in Adolescents Educational Campaign

The MMA supports educational efforts explaining the biological shift to a later sleep pattern in adolescence, and the impact of inadequate sleep on driving safety and school performance. The MMA supports efforts by local school districts to eliminate early starting hours of school for teenagers. (HD-R30-1993) (Retained 2004)(Retained as edited BT 07-23)

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 Minor Consent For Medical Treatment

The MMA supports the rights of minors to 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)(Retained as edited BT 07-23)

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 and parenting classes, as appropriate. (HD-R44-1994) (Retained 2006) (Retained as edited BT 07-24)

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 allowing 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 for the purpose of dependent health insurance coverage. (BT-07/2005) (Retained BT 07-16)(Retained as edited BT 09-26)

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) (Retained BT 09-26)

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)

110.2795 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) (Retained BT 09-26)

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) (Retained BT 09-26)

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 opposes a mandate for comprehensive eye exams for all children, given the lack of scientific evidence to support such a requirement. (BT 03-15) (Retained as edited 09-25)

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)

110.54 Social Media and Youth Mental Health

The MMA acknowledges that social media can provide community and connection with others who share similar identities, abilities, and interests.

The MMA further acknowledges that social media also increases the risk of harm to the mental health and well-being of children and adolescents – risks that can oftentimes outweigh the benefits.

The MMA believes that urgent action must be taken to create digital environments that are both safe and healthy, and that minimize harm and that safeguard mental health and well-being during the most critical stages of childhood development.

To accomplish this, the MMA:

1) Urges physicians to (1) educate themselves about social media; and (2) be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and (3) consider expanding clinical interviews to inquire about social media use.

2) Encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health.

3) Supports technology and social media companies to provide the public with data transparency, including access to anonymized platform-level data for qualified independent research.

4) Supports raising awareness among physicians, educators, and the public on digital media literacy and the health effects of social media.

5) Supports statewide public health campaigns promoting age-appropriate, healthy social media use and media literacy for youth and caregivers.

6) Encourages the inclusion of digital literacy and online safety education in school health curricula, developed in collaboration with medical and mental health professionals.

7) Recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).

8) Supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms. (BT 03-16)

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) (Retained BT 09-26)

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 any effort to remove sexual orientation as a protected class under the Human Rights Act. (BT-3/03) (Retained as edited BT 07-23)

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)

130.13 Prison Labor & Health

The MMA affirms that people who are incarcerated are not slaves or indentured servants and should have safe working conditions and reasonable pay for their work. The MMA urges state and federal governments to consider the health impacts of:

a. Paying people who are incarcerated pennies on the dollar compared to the federal minimum wage,

b. Garnishing the majority of those wages with fines, taxes, restitution, room-and-board fees, and/or fees used to finance prison infrastructure, and

c. Refusing to invest an appropriate amount of said payroll savings or garnishment revenues toward programs that help people who are incarcerated reenter society, gain employment, and avoid recidivism.
When people who are incarcerated are released without adequate savings or training from their prison labor, they and their families face greater barriers to the social determinants of health (e.g., housing, food, etc.).

Furthermore, the MMA encourages state and federal governments to expand vocational programs for people who are incarcerated, especially in industries with current labor demand. Evidence suggests that these programs improve employment prospects upon release, which in turn decreases the risk of recidivism and its associated harms to health. (BT 12-25)

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 for Prescription Medications

The Minnesota Medical Association will continue to advocate for efforts to address the challenges and administrative burdens present in the prior authorization process for prescription medications. Including, but not limited to, the following:

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) (Retained as edited BT 09-25)

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 efforts 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)(Retained as edited BT 07-23)

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." 7. Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians' provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient." (BT 11-14) (Retained as edited BT 07-24)

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)(Retained BT 07-24)

150.19 Network Transparency and Out of Network Referrals

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) (Retained as edited BT 09-25)

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) (Retained BT 07-24)

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) (Retained BT 09-26)

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)(Retained BT 07-23)

160.39 All-payers claims database (APCD)

The Minnesota Medical Association supports the retention of Minnesota's all-payers claims database (APCD) to support analyses of population health, utilization of care, practice patterns, access to care, and results of care. (BT 01/14; Retained as edited BT 07-2024) (BT- 01/14) (Retained as edited 07-24)

160.40 Physician-Consensus Measures of Performance to Advance Quality & Safety

The MMA adopts the following recommendations from the Physician-Consensus Measures of Performance to Advance Quality and Safey Work Group:

1. That the MMA adopt the work group's guiding principles, measure selection criteria, and core measure set as follows:
    - Guiding Principles:
        - Measure What Matters to People
        - Systemic Reach
        - Parsimonious
        - Learning System Built with Attention to Value
        - Fairness and Equity
        - Technical Integrity
    - Selection Criteria:
        - Importance for Health
        - Potential to Advance Health Equity
        - Actionable
        - Meaningful to Patients and Caregivers
        - Technical Integrity
        - Potential for Broad System Impact
        - Feasible & Without Undue Burden
        - Accountability
        - Outcome Focused

- Core Measures Set:

DOMAIN	FOCUS	BEST MEASURE	DATA SOURCE
Healthy People	Life Expectancy	Life Expectancy at Birth	CDC Vital Statistics System and Minnesota Department of Health
	Well-being	Health-related Quality of Life (HRQOL)	Behavioral Risk Factor Surveillance System
	Overweight and Obesity	Percentage of Adults with BMI over 25	Behavioral Risk Factor Surveillance System, Minnesota Department of Health, CDC National Health and Nutritional Examination Survey,
	Addictive Behavior	Addiction Death Rate	CDC WONDER online database and CDC Underlying Causes of Death, Multiple Cause of Death Files
	Unintended Pregnancy	Teen Pregnancy Rate	Minnesota Department of Health and CDC Vital Statistics System
	Healthy Communities	Kindergarten Readiness	Minnesota Department of Education
Care Quality	Preventive Services	Childhood Immunization Rate or Combo 10	CDC National Immunization Survey - Child, Minnesota public health data access
	Access to Care	Unmet Care Need	Minnesota Health Access Survey
	Patient Safety	Hospital-acquired Infection Rate	National Healthcare Safety Network
	Evidence-based Care	Total Hospital Days	Minnesota Hospital Association
	Patient-centered Care	Patient-clinician Communication Satisfaction	Consumer Assessment of Health care Providers and System
Care Cost	Affordability	High Spending Relative to Income	Medical Expenditure Panel Survey
	Population Spending burden	Per Capita Expenditures on Health Care	CMS National Health Expenditure Data and Minnesota Department of Health's Health Economics Program.
Engaged People	Individual Engagement	Rate of adults with advance care plan documented in medical record	Needs to be developed
	Community Engagement	Social Support	Behavioral Risk Factor Surveillance System

2. That the MMA seek feedback on the core measure set from relevant stakeholders to help understand its value and limitations.
3. That the MMA work to embed the core measure set in applicable Minnesota measurement efforts at the state, health plan, and community levels.
4. That the MMA partner with relevant stakeholders to use the core measure results to identify health improvement goals for Minnesota and to drive action to achieve such goals.
5. That the MMA develop educational programs to inform physicians about the core measure set and strategies to improve performance measurement.

6. That the MMA work to develop tools and resources that will support and enable physicians to lead community health improvement efforts linked to the defined state health improvement goals.
7. That the MMA advocate that payers use the core measure set to capture data that can be used for accountability for results that matter most to personal and population health, refine the analytics involved, and give physicians access to data to support continuous improvement.

(BT 11-2019)

160.43 Moving Minnesota Quality Measurement toward a Core Measurement Set

To streamline the burden of quality measurement, the MMA will 1) work to move measurement in Minnesota to a parsimonious, core set of measures as recommended by the Institute of Medicine; 2) 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) pursue changes to Minnesota's statewide quality reporting and measurement system (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)(Retained as edited BT 09-26)

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

180.04 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

190.05 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) (Retained BT 09-26)

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) (Retained BT 09-26)

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

220.12 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) (Retained BT 07-24)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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)

230.19 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) (Retained BT 09-25)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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) (Retained BT 07-24)

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)(Retained BT 07-24)

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) (Retained BT 09-25)

230.28 Advocacy for Substitution of Per-/polyfluoroalkyl Substances

Per- and polyfluoroalkyl substances (also known as PFAS), defined as any substance that contains at least one fully fluorinated methyl (CF3-) or methylene (-CF2-) carbon atom (without any H/Cl/Br/I attached to it), have health impacts from environmental and manufacturing exposure.

The MMA acknowledges the efforts that have been taken to position Minnesota as a national leader in PFAS pollution prevention. The MMA encourages Minnesota to continue to take the steps

necessary to ensure that PFAS exposure is reduced in the environment and in consumer goods. As such, the MMA supports the phase-out of PFAS and similar “forever chemicals” from manufacturing and processing of goods. To raise awareness of the health impacts of PFAS, the MMA will disseminate evidence-based resources to physicians and their patients.

(BT 07-24)

240 Ethics

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)(Retained BT 07-23)

240.09 AMA Council on Ethical and Judicial Affairs

The MMA will periodically evaluate, as appropriate, the opinions published by the AMA Council on Ethical and Judicial Affairs to inform MMA policy. (BT-5/94) (Retained 2006) (Retained as edited BT 07-24)

240.1 Self-Treatment or Treatment of Family Members

The MMA encourages physicians to be familiar with the current AMA Code of Medical Ethics, as it relates to AMA Council on Ethics and Judicial Affairs' Opinion 8.19, self-Treatment or the 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)(Retained as edited BT 09-26)

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) (Retained BT 09-26)

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 Informed Consent via Telehealth for Reproductive Healthcare Services

A patient receiving reproductive health care via a telehealth visit may provide informed consent through the same means as could be provided for any other healthcare service. (BT 01/15) (Retained as edited BT 09-25)

240.1236 Telehealth Task Force Reccommendations

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) (Retained BT 09-25)

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 Potentially Impairing Substances

The MMA recognizes that physicians hold a particular safety-sensitive position that requires a high level of ethical responsibility. Because of the safety sensitivity of their position, physicians have an ethical obligation not to be impaired in their practice. There are many legal and illegal substances that, when consumed, Many substances, including medical cannabis, have the potential to impair a physician's practice. Therefore, a physician that consumes a potentially impairing substance, whether it is legal or illegal, 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.

While the MMA recognizes that employers may utilize random drug screening as a tool to assess impairment, it also recognizes that drug screens are an imperfect measure of impairment. Until

able to accurately assess impairment, drug screens should not be used as the definitive means in determining impairment. The MMA will encourage employers to utilize referrals to services such as the Health Professionals Services Program as a first step after a positive drug screen when impairment is a concern. The MMA will also educate physicians on the professional risks associated with consuming potentially impairing substances outside of the workplace, including the risk of having a positive drug screen which could negatively impact their medical license and employment. (BT 04-18) (Retained as edited BT 09-25)

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)(Retained BT 09-26)

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. (HD-SR30-1992) (Retained 2004)(Retained as edited BT 09-26)

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)

240.45 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 supports the development of a multi-disciplinary task force to investigate the problems associated with the guardianship process. (BT-09/14) (Retained as edited BT 07-24)

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:

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

(2) must require patient self-administration;

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

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

(5) 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)

240.6 Support for Completion of Medical Directives Before Elective Surgeries

The MMA supports physicians and healthcare institutions in encouraging adult patients to complete medical directives, inclusive of an advance directive and medical power of attorney, prior to elective surgeries involving anesthesia or significant risk of harm that could render the patient incompetent to make medical decisions.

The MMA will pursue a resolution to align AMA policy with this policy. (BT 05-26)

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)

260 Firearms and Dangerous Weapons

260 Firearm Safety

The MMA deems firearm-related deaths and injuries a public health crisis and recognizes that more needs to be done to reduce the morbidity and mortality associated with firearms.

EDUCATION

1. The MMA supports the role of physicians in promoting the use of a locking device on all firearms stored in the home.

2. The MMA encourages conversations between physicians and their patients on responsible firearm ownership and safe storage in the home. The sole purpose of the conversation is to provide counseling on firearm safety. This includes supporting efforts that would:

a. 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; and

b. encourage physicians to provide information or resources on how to safely store a firearm to patients who keep a firearm in their home.

3. The MMA supports educational programs that will help (a) reduce the number of deaths and injuries caused by firearms; and (2) that will alert the public to the dangers of keeping unsecured firearms in the home.

LEGISLATION

1. 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.

2. 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.

3. The MMA supports state investment in Minnesota's firearm surveillance system to improve data collection, analysis, and research on firearm injury prevention.

4. The MMA supports the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes.

5. The MMA supports enabling schools to limit and control the possession and storage of weapons or potential weapons on school property.

6. The MMA supports that schools remain gun-free zones except for school-sanctioned activities and professional law enforcement officers

7. The MMA opposes requirements or incentives for teachers to carry weapons.

8. The MMA supports authorizing the use of firearm ownership data for public health research or epidemiologic investigation.

9. The MMA supports adoption of a Minnesota ban, and a renewal of the federal ban on the sale and possession by private citizens of assault weapons, hi-powered semi-automatic firearms (including AR-15 and AK-47 style assault rifles), as well as a state-wide ban on high-capacity magazines.

10. The MMA supports mandating that firearms be stored locked, unloaded, and separate from ammunition.

11. The MMA supports calling for a waiting period of at least one week before purchasing any form of firearm in the U.S., as well as calling for background checks for all firearm purchasers. The MMA also supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms

12. The MMA supports the destruction of any weapons obtained in local buy-back programs after checking to determine whether the gun is evidence from a crime or stolen property.

13. The MMA opposes "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.

14. The MMA supports 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.

15. The MMA 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.

16. The MMA supports the 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.

17. The MMA supports bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21. The MMA also supports 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). (BT 07-24) (Retained as edited BT 09-25)

270 Gambling

270.01 Compulsive Gambling

The MMA encourages all gambling institutions to 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) (Retaied as edited BT 07-24)

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)(Retained BT 07-23)

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) (Retained BT 07-24)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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)

280.28 MMA Principles on Consolidation in healthcare

The MMA supports a pluralistic and competitive healthcare market and recognizes that there are numerous and complex factors that drive consolidation. The potential advantages of consolidation include preserving access to care, expanding access to capital, generating economies of scale, and aligning and standardizing workflows and processes. The potential disadvantages of consolidation include higher prices, higher healthcare spending, reduced access, lower quality, and, for physicians, reduced practice options. To protect the patient physician relationship and access to high-quality, affordable healthcare, the MMA encourages state scrutiny of proposed healthcare mergers, on a case-by-case basis, to ensure the advantages of consolidation outweigh the disadvantages. (BT 12-22)

280.29 Direct Primary Care

The MMA recognizes "direct primary care (DPC) arrangements" to mean contracts through which individual patients directly pay primary care providers (PCPs) for a defined set of primary care services for a set fee over a specified period of time.

The MMA does not recognize DPC arrangements as health insurance products and opposes any government classifications that do. The MMA advocates that DPC arrangements be supplements to traditional or wrap-around health insurance products.

The MMA supports AMA efforts to have the federal government classify DPC rrangements as qualified medical expenses under taz-exempt medical spending accounts (eg., HSAs, HRAs, FSAs, etc.). Furthermore, the MMA encourages federal and state pilot programs through which DPC is integrated with Medical Assistance, MinnesotaCare, and Medicare. (BT 07-24)

280.3 Private Equity Investments in Healthcare

The MMA recognizes that private equity investments in healthcare pose potential benefits and harms, not only to the autonomy and well-being of clinicians, but also to the health of the populations they serve.

To better understand the reach and impact of private equity investments in healthcare in Minnesota, the MMA advocates for the following:

1. That the State of Minnesota collect and publicly report annual, site-level data describing whether healthcare sites are private equity affiliated. For the purposes of this policy, a "private equity affiliated healthcare site" means a healthcare site whose owners enter into contract with a private equity firm or a private equity firm-owned management services organization.

2. That the State of Minnesota study the effects of private equity investment in healthcare on:

a. healthcare utilization and spending,

b. healthcare costs to patients,

c. healthcare access,

d. healthcare quality,

e. clinician turnover,

f. staffing composition ratios of physicians to non-physician clinicians, and

g. clinical decision-making autonomy

Furthermore, the MMA will educate its members on private equity, its approach and application to physician practices, and considerations for physicians entertaining private equity investments. (BT 07-24)

280.31 Healthcare Supply Chain Resilience

The MMA supports the establishment of -- and funding for -- a program or office within the Minnesota Department of Health to assess and enhance healthcare supply chain resilience. (BT 05-26)

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

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) (Retained BT 09-26)

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)

290.412 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)

290.52 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)(Retained BT 07-23)

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)(Retained BT 07-24)

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

300.22 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 recognizes 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. (HD-R104-2003)(Retain as edited BT 01-15)(Retained as edited BT 07-23)

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) (Retained BT 09-25)

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) (Retained BT 07-24)

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) (Retained BT 07-24)

330 Hospitals

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)

330.09 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)

330.19 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) (Retained BT 09-26)

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) (Retained BT 09-26)

340 Infection Control (See also, Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus)

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)

350 Laboratories

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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)(Retained BT 07-23)

380.0893 Primary Care Physician Workforce Recommendations

The Minnesota Medical Association adopts the following recommendations to expand the primary care physician workforce 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.

3. The MMA will support increases in primary care Medicaid rates to Medicare levels.

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 supports the creation 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 supports 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.

7. 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) (Retained as edited BT 07-24)

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)

380.22 Regulation of CME Subject Matter

The Minnesota Medical Association opposes 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) (Retained as edited BT 07-24)

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)(Retained BT 07-24)

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)

380.45 Insurance Coverage for Medical Students

The MMA affirms that medical students deserve access to affordable health insurance that meets their coverage needs. To that end, the MMA urges Minnesota medical schools to: (1) Educate students on the health insurance options available to them, including school-sponsored insurance, individual market insurance, parent or spouse employer-sponsored insurance, and/or public health insurance programs (i.e., Medical Assistance and MinnesotaCare), (2) Provide students with clear, accessible information on the design features of school-sponsored insurance, if offered. This should include, but is not limited to, a clear explanation of premiums, covered services/prescriptions, excluded services/prescriptions, formularies, and cost-sharing expectations, (3) Provide students with clear, accessible information on how to determine their eligibility for public health insurance programs, and (4) Create a process through which individual students can formally comment on how school-sponsored insurance offerings do not meet their coverage needs (e.g., the student has need for services or prescriptions that are excluded and/or rendered cost-prohibitive under plan formularies or cost-sharing designs, etc.). As part of this process, schools should follow up with students to discuss possible solutions, which may include, but are not limited to, assisting the student with requesting exceptions/appeals and/or exploring alternative/supplemental coverage. (BT 09-25)

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) (Retained BT 09-26)

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)

390.15 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)

390.17 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 supports community-based mental health programs that increase access to clinical mental health services provided by duly licensed mental health professionals and practitioners.

The MMA recognizes that many services provided by community-based mental health programs can be performed safely and effectively by duly licensed mental health professionals and practitioners without physician supervision (e.g., psychotherapy, assessment, etc.). To require that all community-based mental health programs be supervised by physicians is to restrict access to mental health services without sound clinical reasoning and, in some cases, restrict crucial referral pathways to psychiatrists. Therefore, the MMA will pursue an amendment to AMA Policy, "H60.991 Providing Medical Services through School-Based Health Programs," to provide a mental health exception to its position that "health services in schools must be supervised by a physician."

The MMA specifically, but not exclusively, advocates for full funding of the following programs that support community-based mental health programs in Minnesota:

1. School-Linked Behavioral Health Services (SLBH) (i.e., School-Linked Mental Health Services). SLBH is a program that awards state grants to community mental health agencies who agree to place duly licensed mental health professionals and practitioners in partnering public schools (K-12) to provide on-campus, clinical mental healthcare services to students regardless of the students' ability to pay. SLBH is established under Minnesota Statutes Chapter 245.4901. (BT-10/82) (Retained 2004) (Retained as edited BT 09-22) (Retained as edited 07-23)

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 parity in coverage and reimbursement for medical problems which are currently discriminated against as "mental health disorders." The MMA supports 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)(Retained as edited BT 07-23)

400.23 MMA Opposes Health Plan Restrictions on Mental Healthcare

The MMA supports efforts to end discriminatory restrictions on the treatment of mental illness and addictive substance use disorders; supports removal of health plan restrictions to appropriate mental illness and addictive substance use 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) (Retained as edited BT 07-24)

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)

400.39 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) (Retained BT 09-26)

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)

400.51 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)

400.52 Suicide Prevention

Suicide is a serious public health problem. In addition to the lost lives, there are long-lasting effects on families and communities. For the past 20 years, the number of suicides in Minnesota has steadily increased, mirroring patterns across the United States and contributing to a decline in average life expectancy. Suicide is also complex, with a plethora of psychiatric, cultural, and socioeconomic roots. Nearly half of all individuals that die by suicide are known to have visited with a healthcare provider in the four weeks prior to their death. The Minnesota Medical Association recognizes the increasingly important role that physicians have in relation to suicide prevention efforts. Physicians have the ability to advocate for societal change, raise awareness about suicide prevention, connect with their patients about their mental health, recognize signs of suicidal ideation, provide adequate resources, and facilitate appropriate next steps in order to reduce the rate of suicide in Minnesota.

(1) The MMA recognizes that mental health is a uniquely personal aspect of health. Real and perceived stigma deters many from discussing this with their physician. The Minnesota Medical Association will work to combat stigma regarding mental health conditions through the normalization of discussions around depression and suicide and screening of these issues.

(2) The Minnesota Medical Association recognizes that there are a variety of social drivers of health that increase the risk of suicide. Among others, these factors include housing insecurity, economic instability, stigma, and lack of access to mental health resources. The Minnesota Medical Association supports programs and policies that will work to address these social drivers of health with the goal of decreasing suicide risk.

(3) The Minnesota Medical Association recognizes that social isolation is a main driver for suicidal ideation. The Minnesota Medical Association encourages the development of programs and initiatives that aim to improve social support systems for individuals, families, and communities. The Minnesota Medical Association also supports the incorporation of anti-bullying messaging into schools, as being bullied and bullying are both linked with a higher risk of suicidal ideation.

(4) The Minnesota Medical Association recognizes the role that firearms play in suicide. White males and individuals in rural areas are most likely to die by suicide with a firearm, and more needs to be done to address the suicide risk among these, and other high-risk populations. The Minnesota Medical Association will educate physicians and disseminate tools that encourage conversations between physicians and patients that use a harm reduction approach, and that are tailored to each

patient's needs. Some examples include information on how safely storing firearms and ammunition, and safe handling practices, can reduce suicides.

(5) The Minnesota Medical Association recognizes that silence and stigma about suicide exists among many racial and ethnic populations. The Minnesota Medical Association supports initiatives that aim to increase connectedness in one's community and family structure; promote culturally appropriate messaging about suicide; and provide individual, interpersonal, and community level approaches to addressing and preventing suicide among these populations.

(6) The Minnesota Medical Association recognizes the relationship between access to mental health resources and suicide outcomes. The Minnesota Medical Association supports and will advocate for strategies to improve access and availability of mental health resources such as increased funding for more mental health facilities and hospital beds; increasing the numbers of psychiatrists and other mental health professionals, with attention to the shortages that exist in rural and underserved areas. The MMA will also advocate for adequate coverage of mental health conditions by insurance providers. In addition, the Minnesota Medical Association also encourages the investigation of new models of healthcare delivery that aim to ease the burden on current healthcare providers and increase the availability of mental health care services.

(7) The Minnesota Medical Association recognizes that the ability to (1) screen for depression and suicide risk in a patient; and (2) address suicidal ideation, are critical skills for physicians. The Minnesota Medical Association will encourage Minnesota's medical schools and residency programs to incorporate suicide risk assessment and management into their curriculum. The Minnesota Medical Association will also encourage medical specialty societies to offer continuing medical education on assessing and managing suicide risk for their members. The Minnesota Medical Association will also continue to promote physician participation in evidence-based suicide prevention training programs such as Question-Persuade-Refer (QPR) and Counseling on Access to Lethal Means (CALM).

(8) The Minnesota Medical Association recognizes that compared to the general population, physicians are at a higher risk of suicide and suicidal ideation. Physician risk factors include burnout, unidentified or inadequately managed mental health conditions, stigma around mental health conditions, emotional distress, lack of personal support systems, and historic systemic deterrents (i.e., licensing and credentialing process) to seeking care. Through its wellbeing initiatives, the Minnesota Medical Association will continue to work to address the factors and stigma that are contributing to suicide – both among physicians and physicians-in-training.

(BT 05-23)

400.53 ED Boarding of Patients with Psychiatric Diagnoses

1. Recommendations Spanning the ED Boarding Continuum

*Publicize and circulate this report to inform and empower leaders

- *Support the creation of a Minnesota ED boarding database

- *Collaborate to improve the usefulness of mental healthcare search tools in Minnesota
- Strategize to improve the size, distribution, and diversity of the mental healthcare workforce in Minnesota
- *Protect and expand the use of telehealth for mental health services

2. Recommendations for Inflow Factors

- Support the financial sustainability of 988 call centers in Minnesota
- Explore emergency transport diversion to EDs in hospitals with patient-appropriate inpatient mental health beds
- *Leverage healthcare workers and facilities to educate the public about mental health resources
- *Support legislation to require Minnesota health plans to reimburse for Collaborative Care Model services

3. Recommendations for Stalling Factors

- Support the development and evaluation of alternative emergency facilities for patients with psychiatric diagnoses who await disposition
- *Advocate for an increase in ED-designated mental healthcare workers

4. Recommendations for Outflow Factors

- Advocate for more inpatient mental health hospital beds in Minnesota
- Advocate for more residential treatment beds in Minnesota
- Monitor and engage in the development of locked Intensive Residential Treatment Services (IRTS) facilities in Minnesota
- *Support legislation to require Minnesota health plans to cover Psychiatric Residential Treatment Facilities (PRTF) and Intensive Residential Treatment Services (IRTS)
- Collaborate to reduce the burdens of corporate foster care on ED boarding

(BT 05-23)

410 Health Disparities and Health Equity

410.02 Racial and Ethnic Disparities in Health Care

The MMA recognizes racially and culturally based disparities in health care, and supports initiatives to alleviate these disparities in Minnesota. (HD-R39-1996) (Retained 2006) (Retained as edited BT 07-16)(Retained as edited BT 09-26)

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) (Retained BT 09-26)

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 and Inequities

Raising Physician Knowledge/Awareness of Racial and Ethnic Health Disparities and Inequities

1. The Minnesota Medical Association will raise physician knowledge and awareness of racial and ethnic health disparitiesand inequities by providing education to physicians, residents and medical students on topics related to race and racism, including structural/institutional 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 H*ealth Disparities and Inequities*

2. The Minnesota Medical Association will connect physicians with available practical tips, tools, and resources to assist them in reducing racial and ethnic health disparitiesand inequities 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 backgrounds historically underrepresented in medicine.

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 and inequities 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 and inequities, 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 individuals from backgrounds historically underrepresented 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 and inequities.

(BT 09-16)(Retained as edited BT 09-26)

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)

410.11 Due Process for Immigrant Health Professionals

The MMA recognizes the value that immigrant health professionals and immigrant health-professionals-in-training offer to the United States healthcare system.

The MMA affirms that immigrant health professionals and immigrant health-professionals-in-training should not be refused the rights and privileges afforded to them under their visas or residency permits without due process. (BT 09-25)

420 MMA Administration/Membership

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)

420.49 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) (Retained BT 09-25)

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)

430.06 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) (Retained BT 09-26)

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)

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)

440.07 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 supports removal of barriers to timely transfer of patients from hospitals to nursing homes and will work with physicians, nursing homes, and others, as appropriate. (HD-R17-1994) (Retained 2006) (Retained as edited 07-24)

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) (Retained BT 07-24)

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) (Retained BT 09-25)

470 Practice of Medicine

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)

470.37 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) (Retained BT 09-26)

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) (Retained BT 09-26)

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 healthcare professionals 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) (Retained as edited BT 11-26)

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 interstate licensure compact for physicians. (BT 11-14) (Retained as edited BT 07-24)

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) (Retained BT 09-25)

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 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) (Retained as edited BT 07-24)

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)

490.24 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)

490.47 Physician-Specific Prescribing Data

The MMA opposes pharmaceutical manufacturers and wholesale drug distributors purchasing physician-specific prescribing data. (EC-4/03)(Retained as edited BT 07-2023)

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) (Retained BT 09-25)

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. (HD-R207-2013)(Retained BT 07-23)

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 cautions physicians in certifying, authorizing, or otherwise directing persons in the area of medicinal marijuana outside of scientific clinical trials.

(BT-03/14) (Retained as edited 07-24)

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. (BT 11-15) (Retained as edited 09-25)

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 supports a patient's access to primary care services provided by a physician and that they 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. A physician's ability to be reimbursed for providing primary care services should be determined by the training and competence of the physician, and not by the specialty or sub-specialty designation of the physician. (HD-R3-1993) (Retained 2004)(Retained as edited BT 07-23)

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)

500.09 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. (HD-R17-1993) (Retained as edited 2007)(Retained as edited BT 07-23)

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) (Retained BT 07-24)

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)

520.06 Restrictive Covenants

Restrictive covenants lessen competition, can disrupt continuity of care, and may limit access to care.

The MMA opposes restrictive covenants in physician employment contracts.

For purposes of this policy, restrictive covenant means a provision in an agreement between an employer and employee which, upon termination of the employment of the employee, prevents the employee from practicing in competition with or becoming employed by a competitor of the employer. Restrictive covenant does not include a covenant prohibiting use of disclosure of trade secrets or inventions. (BT 02-23)

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 Physician Collective Bargaining

The MMA supports the right of physicians and physicians-in-training to engage in collective bargaining, including physician unionization, and supports the expansion of the number of physicians and physicians-in-training eligible for that right under state and federal law. (BT 07-24)

530 Public Health & Safety (See also, Health Education)

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) (Retained BT 09-26)

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)

530.1000 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)

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)

530.107 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) (Retained BT 09-25)

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) (Retained BT 09-26)

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)

530.26 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)

530.62 Health Plan Coverage For The Treatment Of Obesity

The Minnesota Medical Association suppports 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)(Retained as edited BT 07-23)

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 state's authority to require isolation and quarantine of individuals to protect individuals and the public from serious communicable diseases.. BT-11/2003 (Retained as edited BT 07-2023)

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) (Retained BT 09-25)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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) (Retained BT 09-26)

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)

531 Decriminalization of Simple Possession of Illicit Drugs

Preamble

The MMA recognizes that criminal penalties for simple possession, or the possession of a small quantity of illicit drug for personal use and/or the possession of drug paraphernalia, are only justified if they yield a net benefit to population health.

Criminal penalties for simple possession yield one potential benefit to population health in its claimed ability to deter drug use. However, there is insufficient evidence to support this claim.

Criminal penalties for simple possession yield numerous, real harms to population health. These harms include, but are not limited to, arrests, convictions, incarcerations, criminal records, and diverted public investment.

Accordingly, the MMA concludes that criminal penalties for simple possession in Minnesota are unjustified.

Decriminalization

Decriminalization is supported by several national and international organizations including the United Nations, World Health Organization, American Pharmacists Association, and the American Civil Liberties Union. While there is not much data from the United States as of 2022, data from Portugal indicates that the benefits of decriminalization outweigh the harms. Actions taken in Portugal included (a) the removal of criminal penalties for simple possession, (b) the creation of administrative panels to refer simple possession offenders to treatment, and (c) expanded access to harm reduction and medication for opioid use disorder (MOUD) programs in 2001. Seven years after these actions, data showed significant decreases in HIV prevalence, Hepatitis C prevalence, and drug-related deaths, as well as a significant increase in the number of drug users in treatment. Notably, the introduction of the Portugal Model is not correlated with alarming increases in drug-induced morbidity and mortality–certainly not to an extent which surpasses the health harms imposed by Minnesota's current system of criminalization.

Given the health consequences of criminalizing simple possession, the MMA supports a decriminalization model in Minnesota that includes the following general components:

1.The removal of criminal penalties for the possession of a small quantity of illicit drug for personal use and/or the possession of drug paraphernalia,

2.The creation of administrative panels which may render treatment referrals and civil penalties to offenders of simple possession,

3.An increased investment in statewide harm reduction and medication for opioid use disorder (MOUD) programs,

4.The release of individuals incarcerated for simple possession from detention settings, and

5. The expungement of criminal records for simple possession.

The MMA will support the aforementioned decriminalization model in a variety of ways, including, but not limited to:

1.Educating policymakers of the inefficacy of criminal penalties for simple possession as a deterrent of drug use,

2.Educating policymakers of the health harms associated with imposing ineffective criminal penalties for simple possession,

3.Educating policymakers on the costs of criminalizing drug use (the cost of incarceration) versus the much lower cost of increasing access to treatment for substance use disorders

4.Urging policymakers and state agencies to monitor data out of Portugal, and other jurisdictions which have decriminalized simple possession, that illustrate how decriminalization may or may not correlate with trends in drug-induced morbidity and mortality. (BT 12-22)

531.1 MN Department of Health - Childhood Blood lead Screening Guidelines for Minnesota

The Minnesota Medical Association endorses and supports the updated Childhood Blood Lead Screening Guidelines for Minnesota, issued by the Minnesota Department of Health in December 2022. (BT 12-22)

531.2 Harm Reduction of Illicit Drug Use

Harm Reduction of Illicit Drug Use

Preamble

The MMA recognizes that all people who use drugs (PWUD) are deserving of care and respect by the medical community and society at-large. For the entirety of this policy, “drugs” means illicit drugs, or substances for which use, possession, sales, and/or production are prohibited under law, including the non-medical use of narcotics and other prescription medications.

Reducing Stigma Associated with Drug Use

The MMA recognizes that stigma associated with drug use leads to discriminatory policies that further harm PWUD. To combat this stigma, the MMA will:

(1) Create an educational campaign to reduce stigma and bias within the healthcare worker community about drug use.

(2) Develop or support campaigns that aim to reduce the stigma associated with drug use among the greater public in partnership with other organizations that represent Minnesota communities. This campaign may consider education on:

(a) the prevalence and impact of drug use and substance use disorder,

(b) the biological basis of substance use disorder as a medical condition,

(c) the narrative accounts of PWUD,

(d) the disproportionate stigmatization, and higher frequency of enforcement of drug-related criminal statutes, against people of color who use drugs.

(3) Only use person-centered language when referring to PWUD, or people with substance use disorder, in its own publications and events. Non-person-centered terminology focuses on a behavior rather than the whole person and detracts from that person's humanity.

(4) Urge external organizations and individuals in power to use person-centered language when referring to PWUD or people with substance use disorder.

(5) Urge health systems to consider the harms associated with protocols that further stigmatize and alienate patients suspected of using drugs, including, but not limited to, room searches, personal belonging confiscation, patient isolation, and bans on visitors. The MMA encourages hospitals to develop patient plans, based on harm reduction principles, aimed at reducing the risk that the patient leaves against medical advice. Hospitals may instead focus on increasing access to Medications for Opioid Use Disorder (MOUD), increasing access to syringe exchanges upon discharge, decreasing stigma associated with substance use disorder (SUD), and decreasing overdose and consequences of injection drug use.

Drug Checking

The MMA recognizes that drug checking, or the ability of PWUD to measure the presence and/or quantity of dangerous adulterants in substances they intend to consume, is a crucial tool for reducing drug-related injury and overdose associated with consuming unknown substances. To increase access to drug checking, the MMA will:

(1) support the exclusion of any equipment that detects the presence and/or quantity of dangerous adulterants in illicit drugs for personal use from the statutory definition of drug paraphernalia.

(2) amplify the efforts of, and advocate greater funding for, community-based drug-checking equipment distribution programs and community-based advanced chemical analysis programs.

Access to Safe Drug Use Supplies and Infection Control Supplies

The MMA recognizes that access to safe drug use supplies, including, but not limited to, syringes, cookers, tourniquets, antibiotic ointment, and cotton balls, is crucial for reducing harm associated with people who use injectable drugs. To increase access to safe drug use supplies, the MMA will:

(1) Advocate for the decriminalization of all drug paraphernalia, including, but not limited to, syringes, hypodermic needles, pipes, test strips, and disposable cookers.

(2) Support state legislation to allow any pharmacy or licensed pharmacist to sell sterile syringes and hypodermic needles in quantities greater than 10, including, but not limited to, an amendment to Minnesota Statutes Chapter 151.4, Subdivision 2, Part (a).

(3) Amplify the efforts of, and advocate greater funding for, community-based safer drug use programs, including, but not limited to, syringe service programs.

The MMA also recognizes that access to infection control supplies, including, but not limited to, condoms, take-home infectious disease tests, pre-exposure prophylaxis (PrEP), and bleach, is crucial for reducing harm associated with injection drug use. To increase access to infection control supplies, the MMA will advocate that community-based harm reduction programs continue to offer infection control supply distribution services.

Drug Testing

The MMA recognizes that drug testing requirements of current and prospective employees, students, and public program beneficiaries are barriers to an array of social drivers of health for PWUD. Drug tests determine the presence of a drug metabolite in a person's system, not the immediate or general capacity of a person to perform safely and effectively as an employee or student, nor their deservingness of education or public benefits.

Except for specific types of drug testing imposed on employees in select safety-sensitive positions, there is insufficient empirical evidence that drug testing affects drug use or drug-related injury in workplaces and in schools. Furthermore, employers have ample means to discipline or terminate employees who do not perform safely and/or effectively, regardless of that employee's drug use.

The MMA urges organizations that adopt drug testing policies to be cognizant of the unintended harms of drug testing and to confirm positive test results by confirmatory tests. In cases that yield positive test results, the MMA recommends the results be used as an indication for assessment and evaluation for potential treatment, instead of being used for punitive measures, including the withdrawal of scholarships and public benefits.

Medication for Opioid Use Disorder (MOUD)

The MMA recognizes that Medication for Opioid Use Disorder (MOUD) is the main treatment for patients with Opioid Use Disorder. MOUD can reduce withdrawal and cravings, prevent opioid overdose, decrease use of non-prescribed opioids, decrease infections secondary to injection drug use, and save lives. To increase access to all three FDA-approved forms of MOUD (i.e., methadone, buprenorphine, and naltrexone), the MMA will:

(1) Create an educational campaign to reduce stigma and bias associated with MOUD, increase awareness of MOUD, and decrease MOUD-related prescriber hesitancy within the healthcare worker community.

(2) Develop or support a campaign that aims to reduce the stigma associated with MOUD, and increase awareness of MOUD, among the greater public, in partnership with other organizations which represent Minnesota communities.

(3) Advocate that private and public health insurance entities impose cost-sharing for MOUD services and medications consistent with other medical conditions.

(4) Advocate for state legislation to require commercial and public plans in Minnesota to cover all MOUD medications and services without prior authorization.

(5) Advocate for legislative, regulatory, and financial actions that increase access to all MOUD medications in Minnesota jails and prisons, including, but not limited to, legislation that would require all jails and prisons in Minnesota to provide all MOUD medications and ensure referrals to outpatient MOUD services.

(6) Advocate for legislative, regulatory, and financial actions that increase access to all MOUD treatments across all healthcare and community settings, especially in settings where patients most frequently present (e.g., emergency departments and acute care hospitals).

(7) Advocate for legislative, regulatory, and financial actions that increase access to MOUD treatment through telemedicine or mobile health care teams composed of professionals representative of the communities they serve.

Naloxone Access

The MMA recognizes that access to naloxone, a drug which reverses opioid overdose, is a crucial tool for reducing drug-related overdoses. To increase access to naloxone, the MMA will:

(1) Advocate for policies that reduce or remove cost-sharing burdens for Minnesotans who seek naloxone through individual prescriptions or the state protocol order, including, but not limited to:

(a) supporting legislation to require health insurers to include at least one form of naloxone on the lowest tier of an insurer's drug formulary;

(b) supporting the launch of a statewide program to make naloxone free to all Minnesotans who seek it and oppose tracking those who seek it;

(2) Amplify the efforts of, and advocate greater funding for, community-based overdose education and naloxone distribution programs;

(3) Advocate for the legal and financial infrastructure necessary for jail- and prison-based overdose education and naloxone distribution (OEND) programs across the state of Minnesota.

Opioid Overdose Prevention Training

The MMA recognizes that opioid overdose prevention training programs are crucial tools for equipping friends and families of PWUD, and the broader public, with the knowledge to identify, respond to, and seek help for opioid overdoses.

To increase access to opioid overdose training, the MMA will:

(1) Inform its members of online and in-person opioid overdose prevention training opportunities;

(2) Amplify efforts of, and advocate greater funding for, online and in-person training, especially those based in Minnesota communities.

Good Samaritan Laws

The MMA recognizes that Good Samaritan laws, or laws that offer legal protections for people experiencing or witnessing overdose who seek medical attention, are crucial tools for preventing overdose deaths. Research confirms that the primary deterrent for seeking medical assistance at an overdose scene is fear of police involvement, and legal repercussions thereafter, for both the person experiencing the overdose and the bystander seeking medical assistance.

The MMA recognizes that the efficacy of any Good Samaritan law is dependent on the breadth of protections offered by, and public awareness of, the law. Accordingly, the MMA advocates for a Good Samaritan law in Minnesota with the following features:

(1) Immunity from arrest, not just prosecution, for the following crimes:

(a) All non-violent drug-related crimes;

(b) Trespassing as provided in MN Statutes Chapter 609.605;

(c) Drug-induced homicide as provided in MN Statutes Chapter 609.19;

(2) Protections from parole and probation violations.

(3) Protections from immigration violations.

(4) Protections from child welfare violations.

(5) Protections from outstanding warrants for non-violent crimes.

(6) No stipulation that parties must cooperate with authorities for immunities or protections offered by the law.

Additionally, the MMA will amplify the efforts of, and advocate greater funding for, strategic public education campaigns about the Good Samaritan law.

Overdose Prevention Centers

The MMA recognizes that overdose prevention centers (OPCs; i.e., supervised injection sites, drug consumption rooms), or facilities that allow PWUD to use previously obtained substances under the supervision of healthcare professionals, are powerful tools for reducing drug-related overdose morbidity and mortality. Research on OPCs in other countries confirms that the introduction of OPCs is associated with lower rates of overdose-induced mortality and morbidity, safer injection behaviors (decreasing infections related to injection technique), greater access to addiction treatment programs, and constant, or lower, rates of crime and drug-related public nuisance. Notably, there has not been a single overdose death reported at an OPC worldwide. While this evidence may not be generalizable to OPCs that may open in the United States, it supports the argument that U.S.-based OPC pilot programs and evaluations should be sanctioned and performed.

Accordingly, the MMA adopts the following policy language based on AMA policy "Pilot Implementation of Supervised Injection Facilities H-95.925:"

The MMA supports the development and implementation of OPCs in Minnesota that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of OPCs in reducing harms and healthcare costs related to injection drug use.

Additionally, the MMA will:

(1) Submit a resolution to the AMA to amend their policy on SIFs to advocate for the removal of federal barriers to SIFs/OPCs.

(2) Educate state and municipal legislators and executives of the evidence basis of OPCs in other countries and the status of federal sanction for U.S.-based OPC pilot programs and evaluations;

(3) Amplify and circulate results of U.S-based OPC pilot program evaluations once published.

(BT 02-23)

531.2 Built Environment and its Impact on Health

The Minnesota Medical Association recognizes that the neighborhood and built environment, the constructed or modified structures that provide people with living, working, and recreational spaces, is a social determinant of health that impacts communities differently, creating a wide array of inequities. Moreover, many individuals do not have opportunities to walk and bike within their communities and do not have access to green spaces, or access to safe and clean air or water. Many individuals experience inadequate housing, transportation, and recreational resources, - thus negatively impacting their overall safety, health, and quality of life.

As such, the Minnesota Medical Association will:

(a) Raise awareness of the impact that the built environment has on health outcomes and will work to share resources for physicians and the patients and communities that they serve.

(b) Encourage the Minnesota Department of Health to continue to conduct health impact assessments in order to evaluate how a proposed development project, policy, or land use plan might affect the health of a community.

(c) Ensure that health professionals and healthcare systems are involved in conversations and are lending their voice to interventions and policy changes at the local, state, and federal level that can help reduce health and safety risks associated with the built environment and promote health.

(BT 09-25)

531.3 Decriminalization of Homelessness

The MMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities.

The MMA opposes laws that criminalize people experiencing homelessness for conducting life-sustaining activities in public spaces that do not harm others or others' property.

The MMA generally opposes justice-focused solutions or laws to address public health concerns because, according to available evidence, they result in net harm to population health, including increased morbidity and mortality and decreased access to employment and other social supports. With respect to the issue of homelessness, such laws have not delivered on their claimed ability to reduce or deter homelessness, incentivize use of formal shelters and/or treatment, or improve public safety.

[Although this policy uses the term "homelessness" for consistency across policies, the MMA recognizes the similar appropriateness of the term "houselessness" and its ability to distinguish a house (i.e., physical structure) from a home (i.e., a place, with or without a structure, that encompasses social connectedness and rootedness to geography that goes beyond shelter).

(BT 02-25)

540 Public Programs

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) (Retained BT 09-26)

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)

540.2692 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)

540.2695 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)(Retained BT 07-23)

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) (Retained BT 09-26)

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)

540.69 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)

540.7 Claims Expenditure Assessment

The MMA will advance a claims expenditure assessment as an alternative to the expiring provider tax during the 2019 legislative session. (BT 11-18)

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) (Retained BT 09-26)

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 encourages the use of industrial safety lenses mounted in a sturdy industrial or athletic frame for individuals playing racquetball, squash and handball. (HD-R9-1983) (Retained 2004)(Retained as edited BT 07-23)

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)(Retained BT 07-24)

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)

600.05 Physician Well-being Advisory Committee Recommendation

The MMA adopts the following recommendations of the MMA Physician Well-being Advisory Committee:

Protect & Optimize Physician Health

A. Develop a compact outlining expectations for physicians and patients, families, and visitors in healthcare interactions; disseminate it, and urge its adoption across healthcare delivery settings.

B. Continue to advocate for changes in credentialing language to reduce stigma and barriers to seeking care for all.

C. Develop an awareness campaign to promote well-being to optimize physician performance.

Promote Innovations to Reduce Work Burden

A. Support the development of care delivery models and associated practices that prioritize the physician-patient relationship by reducing work burdens that do not directly contribute to patient care.

B. Affirm the need to limit low-value documentation requirements to reduce the risk

of medical errors and administrative burden and support the development of AMA policy that will facilitate collaboration with EHR systems developers and regulatory bodies to achieve this goal.

C. Endorse the expectation that physicians be included in development processes for clinical workflow support products, as an industry standard.

Promote Organizational Cultures that Foster a Thriving Physician Workforce

A. Advocate for flexibility in work options to help physicians achieve greater work-home integration.

B. Advocate for prioritizing well-being in organizational decisions, change initiatives and dashboards.

C. Endorse the role of formal well-being leadership representation in practice governance bodies as a best practice.

D. Publicize and circulate this report to inform and empower leaders. (BT 07-24)

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 they feel it is in the best interest of the patient. 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)(Retained as edited BT 07-23)

610.07 Delegation Of Lasers and Intense Pulsed Light Source Procedures

Recognizing the risks of scarring and blindness associated with medical treatments using lasers, intense pulse light sources, radio frequency devices and related technologies, the MMA supports 1) having such treatments performed or supervised by a knowledgeable physician; 2) requiring patients receiving such treatments first obtain a physician evaluation; 3) establishing minimum physician supervision requirements for these technologies; and 4) requiring that the use of these technologies on or in the eye and on ocular adnexa only be performed by licensed physicians. (HD-R200-2005) (Retained BT 07-16)(Retained as edited BT 09-26)

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)

620.1 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)

620.11 Task Force on AI in Healthcare

Report and Recommendations of the MMA AI Task Force

Principle 1: Artificial intelligence 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 advocates for the continued evaluation and monitoring through a state sponsored advisory committee to continually review and improve regulation of AI in healthcare.

b) The MMA advocates for the inclusion of comprehensive AI education in medical school, post graduate curricula, and continuing professional development.

c) The MMA supports the development of a comprehensive regulatory framework for the use of AI in healthcare.

d) The MMA aims to monitor AI regulations that impact healthcare and educate its members on their impact.

Principle 2: Individuals have the right to transparent, honest, and timely information pertaining to their healthcare.

Principle 3: Physicians have a responsibility to educate themselves on artificial intelligence enabled tools utilized in their medical practice.

Policy:

a) The MMA encourages clinical uses of AI that have the potential to impact patient care, or a physician's clinical decision, be disclosed to a patient.

b) The MMA advocates for disclosure of the use of AI in clinical decision communications that have not been reviewed and approved by a healthcare professional.

c) The MMA encourages specialty societies to educate their members on specific AI tools and how to best evaluate and apply them.

d) The MMA encourages developers of AI to provide detailed information about an AI tool including, the AI's intended uses, training data, data collection practices, and risk and discrimination mitigation strategies, to deployers of AI in an effort to promote transparency and accountability.

e) The MMA encourages facilities to make available to their clinicians detailed information about AI tools utilized within the facility.

Principle 4: All patients have a right to receive unbiased healthcare.

Policy:

a) The MMA supports equitable access to the benefits of AI by all patient populations.

b) The MMA acknowledges that the use of AI in healthcare carries a considerable risk of codifying and/or exacerbating existing social inequities.

c) The MMA acknowledges that accounting for bias in AI model design, training, and use is essential in helping to mitigate biases.
d) The MMA encourages policies requiring rigorous and continuous evaluation of AI models for bias when they are used in the healthcare setting.

e) The MMA expects that immediate action will be taken to correct or mitigate encountered bias.

Principle 5: Artificial intelligence should not replace a physician's recommendation for the provision of healthcare.

Policy:

a) The MMA supports efforts to ensure that healthcare professionals always make the final decision regarding the provision of healthcare.

b) The MMA opposes coverage denial processes that utilize artificial intelligence to deny coverage for a healthcare service without the meaningful input of a healthcare professional.

c) The MMA opposes requirements from payors, hospitals, health systems, or governmental entities mandating the use of an AI tool for clinical decision-making as a condition of licensure, participation, payment, or coverage.

Principle 6: Liability for harm involving AI should be focused on the party that is in the best position to identify and mitigate the harm.

Policy:

a) The MMA acknowledges the evolving role of AI in healthcare and therefore, the evolving understanding of liability for the use of AI in healthcare. The MMA supports policies that hold physicians liable only for their own clinical decision-making.
b) The MMA encourages multidisciplinary governance structures within systems that monitor and evaluate the performance and use of AI tools within their system and provide transparent information to clinicians within the system.

(BT 03-26)

630 Third Party Payers (See also, Ethics)

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)(Retained BT 07-24)

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) (Retained BT 09-25)

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)(Retained BT 07-24)

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) (Retained BT 07-24)

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)

630.391 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)

630.3993 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)(Retained BT 07-23)

630.434 Carveouts of Mental Health and Chemical Dependency Benefits

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-R300-2000) (Retained as edited 2010) (Retained as edited BT 08-20)

630.45 Prospective Online Enrollee Insurance Benefit and Medication Formulary Details

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. (BT 07/08) (Retained as edited BT 07-18)

630.46 Co-Pay Equality

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 05/09) (Retained BT 07-19)

640 Tobacco

640.01 Tobacco Advertising

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-1/89) (Retained 2004) (Retained as edited BT 07-19)

640.02 Limits on Advertising and Advertising at Government Sponsored Events

The MMA supports a ban on tobacco advertising. (HD-R4-1990) (Retained 2004) (Retained BT 08-20)

640.14 Tobacco Tax

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-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 cigarette tax revenue for tobacco use prevention initiatives and health care. (HD-SR206-1998) (Retained as edited 2008) (Retained as edited BT 07-18)

640.1594 Smoke Free Housing

The MMA supports the use of tobacco settlement funds only for health care related programs. (HD-R305-2004) (Retain BT 01-15) (Retained BT 09-25)

640.1595 Implementation of Provider Tobacco Cessation Guidelines

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-R211-2007) (Retained BT 07-17)

640.24 Smoking at Building Entrances

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-R20-1995) (Retained 2005) (Retained BT 07-16)

640.26 Smoke-Free Health Care Facilities/Grounds

The MMA will initiate legislation to prohibit smoking within 75 feet of any entrance to a facility which is designated smoke-free. (HD-R402-1998) (Retained as edited BT 07-18)

640.29 Opposition to State Pre-Emption of Local Ordinances Regulating Tobacco

The MMA supports that all health care facilities and grounds are smoke-free. (HD-R201-2000) (Retained 2010) (Retained BT 08-20)

640.37 Restricting the Sale of Tobacco Products

The Minnesota Medical Association opposes attempts to adopt state law that pre-empts local ordinances that restrict the sale and use of tobacco. (BT-07/2005) (Retained as edited BT 07-16) (Retained BT 09-26)

640.38 Adoption of Comprehensive Tobacco Cessation Benefits

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. (HD-R303-2009) (Retained BT 07-19)

640.39 Consequences of Smoking in Cars With Minors

The Minnesota Medical Association supports the coverage of comprehensive tobacco cessation benefits, including counseling and pharmaceutical therapies. (HD-R312-2009) (Retained as edited BT 07-19)

640.41 Electronic Cigarettes Nicotine Delivery Systems

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.

(BT 11/13) (Retained as edited BT 12-19)(Retained BT 07-23)

640.42 Electronic Nicotine Delivery Systems and Health

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 supports 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), as increasingly evidence shows there are serious harms that come from e-cigarette or vaping product use, particularly among teens and young adults.

1. The MMA will advocate for the prohibition of delivery sales, distribution, and non-sale distribution of electronic cigarettes (including deliveries to fulfill orders placed by mail, phone, online) through the U.S. Postal Service or any other public or private postal service unless the age of the product purchaser is verified as 21 years or older at both time of purchase and delivery. Additionally, the container must be conspicuously labeled with "CONTAINS TOBACCO PRODUCTS: SIGNATURE OF PERSON 21 YEARS OF AGE OR OLDER REQUIRED FOR DELIVERY", as well as the health risks that arise from the use of vaping products.

2. The MMA supports the prohibition of the sale of flavored e-cigarettes and flavor enhancers.

3. The MMA recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will work with relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21. These restrictions aim to protect the youth and other vulnerable and marginalized communities who are disparately affected by this public health crisis.

4. The MMA supports efforts to reduce youth access to e-cigarette and vape products by supporting compliance checks (at least quarterly) on establishments that sell vaping and e-cigarette products in order to hold establishments who sell to underage youth legally responsible.

5. The MMA supports the usage of health disclaimers in social media posts that model the usage of vaping or other e-cigarette or tobacco products. These health disclaimers, similar to the ones that highlighted factually inaccurate social media posts during the pandemic, will be present in any posts that are reported to contain speech or behaviors related to vaping product usage.

6. The MMA encourages physicians to educate themselves about electronic nicotine delivery systems, including vapes. Physicians should counsel patients who use e-cigarettes and have children at home on the harmful effects of their use on anyone living with them, including children.

7. The MMA supports research into the long-term health effects of vaping on youth and adults. The MMA encourages funding for research studies that investigate how vaping and other electronic tobacco products might be modified to facilitate cessation of use, including regulating or eliminating nicotine or other harmful or carcinogenic additives such as formaldehyde and nitrosamines.

8. The MMA encourages efforts to improve undergraduate and graduate medical curriculum content regarding the relation between the use of vape and other e-cigarette products and adverse health effects. Physicians-in-training (medical students and residents) are also encouraged to screen early for vaping and other e-cigarette use during clinical experiences, allowing for earlier intervention in vaping-related illness. (BT 03-16)

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) (Retained BT 09-26)

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)(Retained BT 07-23)

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

730.08 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)